

## **Program Element #25: Emerging Infection Program Activities (EIPA)**

1. **General Description.** Funds provided under the Agreement for this Program Element may only be used, in accordance with and subject to the requirements and limitations set forth below, to deliver activities and outcomes related to the OHA Acute and Communicable Disease Program (ACDP) Emerging Infectious Pathogens (EIP) projects and related public health surveillance. Overarching goals include establishing and conducting enhanced surveillance; supporting special studies for expanded surveillance, disease prevention interventions, or policy development; and generally support Oregon's flexible response to newly emerging pathogens. EIP projects include:
  - a. **Emerging Infections Program Activities (EIPA) .** Establish and conduct enhanced surveillance of residents of Multnomah, Washington and Clackamas Counties with pertussis as reported to these specified Local Public Health Authorities (LPHAs) by medical laboratories and providers in order to:
    - (1) Expand pertussis surveillance activities in the Metropolitan Area.
    - (2) Determine the epidemiology of pertussis in the Metropolitan Area.
    - (3) Correlate laboratory data with clinical and demographic data, including age, vaccination status, and duration of cough illness, etc.
    - (4) Encourage physicians, physician assistants, nurse practitioners to test for pertussis including with culture, on patients with appropriate clinical symptoms.
    - (5) Conduct special studies of pertussis and its control.
    - (6) Develop the experience needed to provide support to OHA ACDP or Immunizations programs in cases of unusual pertussis activity or outbreaks in Oregon outside the Metropolitan Area.
  - b. **Healthcare Acquired Infections and Antibiotic Resistance (HAI/AR) Surveillance and Special Studies.** Conduct activities for enhanced surveillance and special studies to include chart reviews and abstractions; review of long-term care facility (LTCF) and hospital infection prevention surveys; use of existing surveillance systems; descriptive analysis of surveillance and survey data; and literature reviews related to the epidemiology and microbiology of HAIs and other emerging infections.
  - c. **Active Bacterial Core Surveillance (ABCs).** Support enhanced surveillance to monitor the disease burden of ABCs pathogens and track antimicrobial resistance. Activities include chart reviews and abstractions; use of existing surveillance systems; descriptive analysis of surveillance and survey data; and literature reviews related to the epidemiology and microbiology of ABCs pathogens.
  - d. **Influenza.** Support population-based surveillance to provide near real-time weekly rates of laboratory-confirmed influenza-associated hospitalizations during each influenza season. Activities include completing standardized case report forms for hospitalized influenza cases reported in Oregon; and entering the data into a CDC Access database in preparation for electronic submission to CDC.
  - e. **HPV-IMPACT.** Support the evaluation of human papillomavirus (HPV) vaccination programs and vaccine effectiveness through population-based surveillance. Activities include chart reviews and abstractions, and entry of data into Orpheus.
  - f. **Outbreak investigations.** Investigate clusters and outbreaks of emerging infectious diseases and other diseases of public health importance. Plan and conduct epidemiologic investigations, including design of questionnaires, interviews of patients, and review of medical records in collaboration with state and local health officials. Analyze data and summarize findings; make recommendations for prevention and control of outbreaks.

- g. **Data quality review.** Enter data for above activities as required by project protocols. Assure information quality for EIP surveillance and special studies through chart abstraction quality assurance reviews; data cleaning, and preparation of summaries detailing areas for further training to improve accuracy of chart abstractions.
- h. **Other EIP projects** developed by the EIP Network to address emerging data needs.

2. **Definitions Specific to this Program Element 25:**

- a. **Active Bacterial Core Surveillance (ABCs):** Metropolitan area surveillance for cases of invasive group A Streptococcus, *Haemophilus influenzae*, *Neisseria meningitidis*, group B Streptococcus, and *Streptococcus pneumoniae*.
- b. **Candidemia database:** Access database created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed candidemia.
- c. **Designated Area for HPV Surveillance:** for the purposes of HPV surveillance, a 28-zip code region that falls within the Portland Metropolitan Area.
- d. **FluSurv database:** a MS –Access database created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed influenza in hospitalized patients.
- e. **Healthcare Acquired Infections and Antibiotic Resistance (HAI/AR).** HAI/AR-specific definitions are as follows:
  - (1) **Multi-site Gram-negative Surveillance Initiative (MuGSI):** Surveillance for cases of carbapenem-resistant Enterobacteriaceae [CRE], Acinetobacter, and carbapenem-resistant *Pseudomonas aeruginosa* [CR-PA] residing in the Metropolitan Area.
  - (2) **Candidemia:** surveillance for patients with a positive blood culture for *Candida* species isolated in a patient that lives in the Metropolitan Area
  - (3) **Additional HAI pathogens as needed.**
- f. **Healthcare Acquired Infections and Antibiotic Resistance (HAI/AR) Surveillance Databases:** Data from HAI surveillance are typically maintained in Orpheus or in Microsoft Access databases created by CDC and maintained by OHA staff to enter and track cases of laboratory-confirmed HAIs
- g. **HPV-IMPACT:** Histologically confirmed, high-grade cervical dysplasia (CIN2+) among women 18 years and older living in the Designated Area for HPV surveillance.
- h. **Laboratory-Confirmed Influenza-Associated Hospitalizations:** Metropolitan area surveillance for persons with laboratory-confirmed influenza admitted at least one night as an inpatient to a hospital.
- i. **Metropolitan Area:** For the purposes of this Program Element 25, this term is intended to describe Clackamas, Multnomah, and Washington counties and their respective Local Public Health Authorities (LPHA) only.
- j. **Emerging Infection Program Activities(EIPA):** EIPA-specific definitions are as follows:
  - (1) **Pertussis Case:** There are two categories of Pertussis Case, each with its own set of characteristics, as follows:
    - (a) **Pertussis Confirmed Case** - Characterized by:
      - (i) Culture-positive and a cough illness of any duration, **or**
      - (ii) PCR positive and a cough illness lasting at least 2 weeks with any of the following:
        - paroxysms of coughing

- inspiratory “whoop”
- post-tussive vomiting, **or**
- (iii) Epidemiologically linked to a case confirmed by either culture or PCR and a cough illness lasting at least 2 weeks *with* any of the following:
  - paroxysms of coughing
  - inspiratory “whoop”
  - post-tussive vomiting

(b) **Pertussis Probable Case** – Characterized by:

Persons with a compatible illness but neither laboratory confirmed nor close contact of a confirmed case. A compatible illness is defined as cough lasting at least 2 weeks with any of the following:

- (i) paroxysms of coughing
- (ii) inspiratory “whoop”
- (iii) post-tussive vomiting

- k. **Orpheus:** A public health condition surveillance database developed and maintained by OPHD whose functionality includes reporting cases of communicable diseases electronically from LPHAs to the OHA and from OHA to the CDC.
- l. **Pertussis Close Contacts:** Close contacts are defined to include immediate family members (those who spend many hours together or sleep under the same roof) and anyone who had direct contact with respiratory secretions. Although obviously these are somewhat arbitrary distinctions, “close contacts” should also include those who shared confined space (within ~6 feet) for >1 hour during the communicable period. School children sitting within ~3 feet of a case (i.e., adjacent seating) can also be included. *High-risk* close contacts include infants (<1 year old) and pregnant women in the third trimester.

### 3. Procedural and Operational Requirements

- a. EIP program-related activities must be conducted by LPHA in accordance with the following procedural and operational requirements:
  - (1) LPHA must assign adequate staff to conduct the work described, and as compensated through CDC EIP funding. Assigned staff must include a Community Health Nurse to conduct investigations of individuals reported with pertussis, and an Epidemiologist to participate in outbreak investigations and special studies; review quality of data collected by OHA EIP staff; and conduct chart reviews and abstractions, literature reviews, and analyses for the EIP projects in Section 1.b. through g.
  - (2) As available, funds may also be used for reasonable supervisory efforts.
  - (3) LPHA must establish and maintain a more detailed general surveillance system for individuals in the Metropolitan Area reported with pertussis as follows:
    - (a) Follow-up on reported cases (confirmed and probable using CSTE definition on pertussis).
    - (b) Complete case investigation on the confirmed and probable cases using Orpheus.
    - (c) Follow-up on contacts using Orpheus.
    - (d) Conduct medical record reviews for hospitalized infants using Orpheus.

- (e) Attempt to collect NP specimens from cases and symptomatic contacts as described on the pertussis investigative guideline.
  - (f) Provide additional education and outreach activities to medical and school communities.
  - (g) Encourage physicians, physician assistants, nurse practitioners to test for pertussis on patients with appropriate clinical symptoms and encourage specimen submission to OSPHL.
  - (h) Coordinate submission of all *Bordetella pertussis* isolates to CDC.
  - (i) Participate in monthly conference with CDC and other staff involved in the enhanced pertussis surveillance project.
  - (j) Confer with OPHD Epidemiologists as requested regarding study data and progress.
  - (k) Assist with pertussis outbreaks. As position allows, may also assist other counties in outbreak investigation of large pertussis clusters.
  - (l) Participate in special studies with CDC and other enhanced pertussis surveillance sites.
- (4)** LPHA will conduct chart abstractions for the following EIP surveillance systems.
- (a) Cases identified by OHA as potentially having an Invasive Infection by an ABCs Pathogen, at medical centers in the Designated Area. The data-collection form, located in Attachment 3 “Active Bacterial Core Surveillance Case Report” to this Program Element 25, must be completed for each case of Invasive Infection by ABCs Pathogens in residents of the Designated Area identified through review of the foregoing medical records. Data will be entered in to the OHA’s Orpheus database.
  - (b) The data identified on the form located in Attachment 4 “FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form” to this Program Element 25, must be collected through review of medical records of inpatients, identified by OHA as having Laboratory-Confirmed Influenza-Associated Hospitalizations, at medical centers in the Designated Area. Data will be entered into the FluSurv MS-Access database.
  - (c) For HAI and Antibiotic Resistance Surveillance, data will be collected to complete the forms located in Attachments 5 “Multi-site Gram-Negative Surveillance Initiative Healthcare Associated Infection Community Interface Case Report” and Attachment 6 “Feasibility Evaluation: Surveillance of Carbapenem-resistant *Pseudomonas*” of this Program Element 25, these data will be collected from residents of the Metropolitan Area and entered into Orpheus and the MuGSI Access® database. Data will be collected for cases of Attachment 7 “Candidemia” of this Program Element 25 in the Metropolitan Area and entered into the Candidemia database. As needed, this position will collect demographic, clinical, and exposure data for other HAI-related public health surveillance and research activities.
  - (d) Data will also be collected to complete Attachment 8, “Human Papillomavirus Vaccine Impact Monitoring Project,” of this Program Element 25, and entered into Orpheus.
  - (e) As needed, LPHA will: review quality of data collected by OHA EIP staff for EIP surveillance systems described in Section 2(4) above, and additional surveillance

systems as needed; will generate patient lists of sample of confirmed cases each quarter and create schedule of charts that will require a second reviewer; and will review all chart abstractions, identify discrepancies, and prepare summary report with recommendations for further training to improve information quality for EIP surveillance and special studies.

- (5)** As needed, LPHA shall plan and conduct case and outbreak investigations as well as related epidemiologic investigations to address public health threats in the community. This work includes:
- (a)** Plan epidemiologic investigations independently and in close collaboration with state and county;
  - (b)** Determine the feasibility and approach to epidemiologic investigation;
  - (c)** Collaborate with colleagues in other county, state, or federal agencies, and with scientists, economists, physicians and other professional colleagues;
  - (d)** Perform appropriate methodological techniques and processes
  - (e)** Conduct epidemiologic outbreak investigations, including onsite review of facilities and procedures; and
  - (f)** Design of questionnaire and other data collection instruments; and interviews of patients, health care providers, and others involved.

#### **4. Reporting Obligations and Periodic Reporting Requirements.**

- a.** LPHA must submit all clinical data (Excel database) along with pertussis isolate shipments (using the isolate spreadsheet and protocol – Attachment 1) to OHA every other month. Measures of performance: completeness of data, timeliness of reporting, the proportion of cases with isolates sent to CDC and the percent of isolates which are able to be linked to the enhanced epi data.
- b.** LPHA shall provide written semi-annual progress reports that detail the work completed, updates detailing the number of confirmed and probable cases for the year to-date, and characteristics of individuals with confirmed or probable pertussis diagnoses and containing such additional information as may be required by the Centers for Disease Control and Prevention, the federal entity funding EIPA. LPHA shall submit the progress updates in accordance with a format and reporting schedule determined by OHA in consultation with LPHA.
- c.** LPHA EIP Epidemiologist shall complete chart reviews and data entry of EIP-related surveillance and study cases (ABCs, hospitalized influenza, MuGSI, Candidemia, CDI and HPV) within 30 days of receiving notification of assigned cases to be reviewed. Data will be entered into an excel file on a monthly basis for submission to CDC.
- d.** LPHA EIP Epidemiologist shall complete quarterly report on findings from data quality review, including number of cases reviewed from each surveillance system, number and nature of discrepancies, and recommendations to EIP staff for improving quality of chart reviews.
- e.** LPHA EIP Epidemiologist shall, as needed, perform statistical analyses related to epidemiologic investigations conducted, either as outbreak investigation or special studies, and provide monthly progress reports to the Department on study progress and findings to date.



**Attachment 2**  
**2016 Enhanced Pertussis Surveillance Isolate, Specimen & DNA Protocol**  
**Updated November 2015**

**I. Shipping Schedule**

*Bordetella* isolates and clinical specimens or DNA should be batched in preparation for sending to CDC. Shipments should arrive during the third weeks of January, April, July, and October. Shipments should NOT arrive at CDC on Fridays, Saturdays, Sundays, or the day before and on federal holidays. *Please refer to the **2016 Enhanced Pertussis Surveillance Schedule** for exact shipment dates.*

**II. Completing the Excel *Bordetella* Shipping Spreadsheet**

An Excel shipping spreadsheet containing line lists of isolates and clinical specimens or DNA to be shipped to CDC should be completed by site surveillance personnel and laboratory personnel prior to a shipment. Surveillance and site laboratory personnel should be in direct communication with one another regarding all shipments to ensure each shipment includes all isolates, clinical specimens or DNA on the line list. Surveillance personnel should request a list of available *Bordetella* isolates, clinical specimens or DNA for each quarterly EPS shipment from their laboratory colleagues. Surveillance staff should then cross-check the list of available laboratory samples with EPS surveillance data to ensure that all laboratory samples are coded as culture or PCR-positive in the surveillance database and to obtain the cough onset date for the shipping spreadsheet. Once cross-checking is complete, **surveillance staff should send an electronic copy of the finalized laboratory shipping spreadsheet to their laboratory partners; a paper version of the spreadsheet must be included as a shipping manifest inside the box.**

Sites should only routinely ship isolates and specimens or DNA that can be directly linked to epidemiologic case-data with an EPS State ID. *Isolates and clinical specimens or DNA obtained from patients who are not investigated as part of Enhanced Pertussis Surveillance (EPS) should not be sent to CDC as part of a routine EPS isolate shipment without prior notification of CDC laboratory and epidemiology staff.*

The EPS Laboratory Shipping Spreadsheet is used for Enhanced Pertussis Surveillance laboratory samples and will also be used for the Post-exposure Prophylaxis study conducted by a subset of EPS sites. As a result, some of the column-headings differ from the historic EPS isolate shipping spreadsheet. The table below defines each requested piece of information. Please complete each field in its entirety for every isolate, specimen or DNA extract shipped to CDC.

<b>Shipping Spreadsheet</b>	<b>Instructions</b>
<b>Date Sent to CDC</b>	Date isolate, specimen, or DNA is sent to CDC
<b>Specimen Collection Date</b>	Date of <u>collection</u> of the original specimen; should correspond to the Date Specimen Collected variable on the EPS case report form
<b>Cough Onset Date</b>	Date of patient's cough onset; should be completed by EPS surveillance personnel and correspond to the Cough Onset Date variable on the EPS case report form
<b>Material Submitted</b>	Type of <i>Bordetella</i> -positive material shipped to CDC. Select one of the following: <ul style="list-style-type: none"> <li>• Isolate</li> <li>• Original material (i.e. clinical specimen)</li> <li>• DNA</li> </ul>

<b>Sample Source (Type)</b>	Source of <i>Bordetella</i> -positive clinical specimen. Select one of the following: <ul style="list-style-type: none"> <li>• Nasopharyngeal aspirate</li> <li>• Nasopharyngeal swab</li> <li>• Blood</li> </ul>
<b>State</b>	EPS state of origin (CO, CT, GA, MN, NM, NY, OR)
<b>Previous Laboratory Results</b>	Species originally identified by the original testing laboratory (may be public health, hospital or commercial laboratory) <ul style="list-style-type: none"> <li>• Culture-positive <i>B. pertussis</i></li> <li>• Culture-positive <i>B. parapertussis</i></li> <li>• Culture- positive <i>B. holmesii</i></li> <li>• Culture- positive <i>B. bronchiseptica</i></li> <li>• Culture- positive <i>B. pertussis</i> and <i>B. parapertussis</i></li> <li>• Culture- positive <i>B. pertussis</i> and <i>B. holmesii</i></li> <li>• Culture- negative</li> <li>• PCR- positive <i>B. pertussis</i></li> <li>• PCR- positive <i>B. parapertussis</i></li> <li>• PCR- positive <i>B. bronchiseptica</i></li> <li>• PCR- positive <i>B. holmesii</i></li> <li>• PCR- positive <i>B. pertussis</i> and <i>B. parapertussis</i></li> <li>• PCR- positive <i>B. pertussis</i> and <i>B. holmesii</i></li> <li>• PCR- indeterminate <i>B. pertussis</i></li> <li>• PCR- positive <i>B. parapertussis</i>, indeterminate <i>B. pertussis</i></li> <li>• Serology- positive <i>B. pertussis</i></li> <li>• Serology- indeterminate <i>B. pertussis</i></li> </ul>
<b>EPS State ID</b>	Unique alphanumeric identifier assigned to the individual case-patient for surveillance purposes; should match with the State ID transmitted to CDC as part of the EPS epi dataset.
<b>EPS Lab ID or Sample ID</b>	Unique identifier assigned to the isolate/specimen/DNA extract by the submitting state public health laboratory
<b>State PFGE Results</b>	State public health laboratory PFGE results (if applicable)
<b>IS481 Ct Value</b>	For clinical specimens or DNA extracts, the Ct value specifically associated with the IS481 target generated by the original testing laboratory (may be public health, hospital, or commercial laboratory). Should be no greater than 29.
<b>PEP Barcode ID</b>	This identifier is used for the post-exposure prophylaxis study that a subset of EPS sites is conducting; <b>this should not be filled in for routine EPS laboratory shipments and may be ignored by sites not participating in the PEP study.</b>
<b>Date of Next PEP Sub-study Blood Draw</b>	Where appropriate, please list the PEP participant's next scheduled blood draw date.

Sites participating in the Post-exposure Prophylaxis (PEP) study (CO, MN, NM, NY) should ship PEP-specific laboratory specimens according to the usual EPS laboratory shipping schedule. If sites require a more routine shipping schedule due to increases in volume or project-specific requirements, CDC should be notified and shipments should be sent on a monthly basis. During months in which EPS shipments are scheduled, PEP samples should be sent in the same shipment.

### III. Emailing Completed Excel Shipping Spreadsheets

Completed Excel shipping spreadsheets **MUST** be e-mailed to CDC **prior** to the shipment of laboratory samples. **All shipment spreadsheets should be e-mailed to Amanda Faulkner (iqq2@cdc.gov), Christine Miner (jyy8@cdc.gov), AND Pam Cassiday (pxc1@cdc.gov) at least one day prior to the arrival of a shipment at CDC.**

***NOTE: A paper copy of the completed Excel shipping spreadsheet should also be included in every shipping box.***

### IV. Preparation of Isolates

CDC would prefer that isolates be shipped frozen in batches; however, fresh isolates will be accepted if necessary.

#### A. Freezing Isolates:

All *Bordetella* isolates should be frozen on the Microbank cryobeads\* provided by CDC, as follows:

1. Isolates that will be frozen must be grown on Regan Lowe or Bordet Gengou agar for no more than four days. Isolates older than four days become too sticky.
2. For each isolate, label two Microbank cryovials with the EPS State ID and Sample ID number. One vial will be shipped to CDC and the other vial should be maintained at the site lab in case there is a problem with the vial shipped to CDC.
3. Use a sterile inoculating loop to scrape *Bordetella* growth from the plate. Suspend the growth in the cryovial by gently spinning the loop. Both vials can be prepared from one plate.  
  
Replace cap on cryovial and invert gently 4-5 times to distribute cells evenly on the beads.
4. Using a pipette, aseptically remove and discard all the liquid from the cryovial.
5. Store cryovials in -70°C freezer before shipping.

#### B. Fresh Isolates:

1. Fresh *Bordetella* isolates will be accepted by CDC but MUST be shipped in Regan-Lowe transport medium.
2. Labeling of vials for transport should be the same as for frozen specimens.
3. Fresh isolates sent in Reagan-Lowe or on slants should not be shipped on dry ice but can be sent with cold packs or at room temperature.

**\*If your site has run out of cryobeads, please contact Pam Cassiday (pxc1@cdc.gov) for replacements.**

## V. **Batching and Storing Clinical Specimens/DNA Extracts**

- A. Any *Bordetella*-positive **(with an IS481 Ct value of < 29 following PCR)** leftover clinical specimens or DNA extracts should be banked and stored for shipment to CDC.
1. A minimum of > 200 µL of clinical specimen suspensions and > 50 µL of DNA extract should be available for submission to CDC.
  2. Clinical specimens and DNA extracts should be stored in a screw-top cryovial (Eppendorf tubes are not recommended) and kept frozen at -20 to -80 degrees Celsius.

## VI. **Shipping**

### A. **General Shipping Instructions for All *Bordetella* species:**

1. All vials should be labeled with the EPS State ID and isolate accession number as listed on the Excel shipping spreadsheet. Labels that can withstand dry ice and water should be used. Large labels that require “flagging” should not be used (i.e., those where the label wraps around and the excess length is stuck to itself) as they can become ripped and samples could be misidentified.
2. If sending a non-pertussis *Bordetella* isolate culture on a slant, label the slant with the EPS State ID, isolate accession number, and date prepared/inoculated.
3. Isolates and clinical specimens or DNA extracts should be shipped by FedEx. Frozen isolates, specimens, and DNA should be shipped on dry ice. Fresh isolates should be sent with cold packs or at room temperature.
4. All isolates, specimens and DNA should be sent in compliance with shipping regulations for infectious substances. Additionally, each package should have the following written on the outside of the package: “DO NOT expose to extreme temperatures”. When shipping via FedEx, a typewritten or computer generated “Shipper’s Declaration for Dangerous Goods (DG)” must be included.

Send all shipments (containing one vial of each isolate) to:

Centers for Disease Control and Prevention

Attn: Pam Cassiday

STAT Unit 12

1600 Clifton Road NE

Atlanta, GA 30333

E-mail: [pxc1@cdc.gov](mailto:pxc1@cdc.gov)

Tel: (404) 639-1231

Fax: (404) 639-4421

# Attachment 3

## Active Bacterial Core Surveillance Case Report

- ACTIVE BACTERIAL CORE SURVEILLANCE CASE REPORT -

Patient's Name: \_\_\_\_\_ (Last, First, MI.) Phone No.: ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ (Number, Street, Apt. No.) Patient Chart No.: \_\_\_\_\_  
 \_\_\_\_\_ (City, State) \_\_\_\_\_ (Zip Code) Hospital: \_\_\_\_\_

- Patient identifier information is not transmitted to CDC -  
 DEPARTMENT OF HEALTH AND HUMAN SERVICES  
 CENTERS FOR DISEASE CONTROL  
 AND PREVENTION  
 ATLANTA, GA 30329

### 2016 ACTIVE BACTERIAL CORE SURVEILLANCE (ABCs) CASE REPORT

A CORE COMPONENT OF THE EMERGING INFECTIONS PROGRAM NETWORK



OMB No. 0920-0978

- SHADED AREAS FOR OFFICE USE ONLY -

<b>1. STATE:</b> <i>(Residence of Patient)</i> <input type="text"/>	<b>2. STATE I.D.:</b> <input type="text"/>	<b>3. DATE FIRST POSITIVE CULTURE COLLECTED</b> <i>(Date Specimen Collected)</i> Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>	<b>4. Date reported to EIP site:</b> Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>	<b>5. CRF Status:</b> 1 <input type="checkbox"/> Complete    3 <input type="checkbox"/> Edited & Correct 2 <input type="checkbox"/> Incomplete    4 <input type="checkbox"/> Chart unavailable after 3 requests
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<b>6. COUNTY:</b> <i>(Residence of Patient)</i> _____	<b>7a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED:</b> _____	<b>7b. HOSPITAL I.D. WHERE PATIENT TREATED:</b> _____
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<b>8. DATE OF BRTH:</b> Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>	<b>9a. AGE:</b> <input type="text"/>	<b>10. SEX:</b> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<b>11a. ETHNIC ORIGIN:</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown	<b>11b. RACE: (Check all that apply)</b> 1 <input type="checkbox"/> White    1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Black    1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> American Indian or Alaska Native    1 <input type="checkbox"/> Unknown
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<b>12a. BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:</b> 1 <input type="checkbox"/> <i>Neisseria meningitidis</i> 3 <input type="checkbox"/> Group B <i>Streptococcus</i> 5 <input type="checkbox"/> Group A <i>Streptococcus</i> 2 <input type="checkbox"/> <i>Haemophilus influenzae</i> 4 <input type="checkbox"/> <i>Listeria monocytogenes</i> 6 <input type="checkbox"/> <i>Streptococcus pneumoniae</i>	<b>12b. OTHER BACTERIAL SPECIES ISOLATED FROM ANY NORMALLY STERILE SITE:</b> <i>(specify)</i> _____
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<b>13. STERILE SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)</b> 1 <input type="checkbox"/> Blood    1 <input type="checkbox"/> Peritoneal fluid    1 <input type="checkbox"/> Bone    1 <input type="checkbox"/> Joint 1 <input type="checkbox"/> CSF    1 <input type="checkbox"/> Pericardial fluid    1 <input type="checkbox"/> Muscle/Fascia/Tendon    1 <input type="checkbox"/> Pleural fluid 1 <input type="checkbox"/> Other normally sterile site (specify) _____    1 <input type="checkbox"/> Internal body site (specify) _____	<b>14. OTHER SITES FROM WHICH ORGANISM ISOLATED: (Check all that apply)</b> 1 <input type="checkbox"/> Placenta    1 <input type="checkbox"/> Wound    1 <input type="checkbox"/> Sinus 1 <input type="checkbox"/> Amniotic fluid    1 <input type="checkbox"/> Middle ear
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**INFLUENZA 15. Did this patient have a positive flu test 10 days prior to or following any ABCs positive culture?** 1  Yes 2  No 9  Unknown

<b>16. WAS PATIENT HOSPITALIZED?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<b>If YES, date of admission:</b> Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>	<b>Date of discharge:</b> Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>	<b>17. If patient was hospitalized, was this patient admitted to the ICU during hospitalization?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
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<b>18a. Where was the patient a resident at time of initial culture?</b> 1 <input type="checkbox"/> Private residence    4 <input type="checkbox"/> Homeless    7 <input type="checkbox"/> Non-medical ward 2 <input type="checkbox"/> Long term care facility    5 <input type="checkbox"/> Incarcerated    8 <input type="checkbox"/> Other (specify) _____ 3 <input type="checkbox"/> Long term acute care facility    6 <input type="checkbox"/> College dormitory    9 <input type="checkbox"/> Unknown	<b>18b. If resident of a facility, what was the name of the facility?</b> _____ <b>Facility ID:</b> _____	<b>19a. Was patient transferred from another hospital?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>19b. If YES, hospital I.D.:</b> <input type="text"/>
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<b>20a. WEIGHT:</b> _____ lbs _____ oz OR _____ kg OR <input type="checkbox"/> Unknown	<b>21. TYPE OF INSURANCE: (Check all that apply)</b> 1 <input type="checkbox"/> Private    1 <input type="checkbox"/> Military    1 <input type="checkbox"/> Other (specify) _____ 1 <input type="checkbox"/> Medicare    1 <input type="checkbox"/> Indian Health Service (IHS)    1 <input type="checkbox"/> Uninsured 1 <input type="checkbox"/> Medicaid/state assistance program    1 <input type="checkbox"/> Incarcerated    1 <input type="checkbox"/> Unknown
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<b>20b. HEIGHT:</b> _____ ft _____ in OR _____ cm OR <input type="checkbox"/> Unknown	<b>22. OUTCOME:</b> 1 <input type="checkbox"/> Survived 2 <input type="checkbox"/> Died 9 <input type="checkbox"/> Unknown
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**22a. If survived, patient discharged to:** 1  Home 2  LTC/SNF FAC ID \_\_\_\_\_ 3  LTACH FAC ID \_\_\_\_\_ 4  Other \_\_\_\_\_ 9  Unknown

**23. If patient died, was the culture obtained on autopsy?** 1  Yes 2  No 9  Unknown

<b>24a. At time of first positive culture, patient was:</b> 1 <input type="checkbox"/> Pregnant    3 <input type="checkbox"/> Neither 2 <input type="checkbox"/> Postpartum    9 <input type="checkbox"/> Unknown	<b>24b. If pregnant or postpartum, what was the outcome of fetus:</b> 1 <input type="checkbox"/> Survived, no apparent illness    4 <input type="checkbox"/> Abortion/stillbirth    9 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Survived, clinical infection    5 <input type="checkbox"/> Induced abortion 3 <input type="checkbox"/> Live birth/neonatal death    6 <input type="checkbox"/> Still pregnant	<b>25. If patient &lt;1 month of age, indicate gestational age and birth weight. If pregnant, indicate gestational age of fetus, only.</b> Gestational age: <input type="text"/> (wks)    Birth weight: <input type="text"/> (gms)
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<b>26. TYPES OF INFECTION CAUSED BY ORGANISM: (Check all that apply)</b>							
1 <input type="checkbox"/> Bacteremia without Focus	1 <input type="checkbox"/> Pneumonia	1 <input type="checkbox"/> Hemolytic uremic syndrome (HUS)	1 <input type="checkbox"/> Pericarditis	1 <input type="checkbox"/> Septic arthritis	1 <input type="checkbox"/> Endocarditis	1 <input type="checkbox"/> Necrotizing fasciitis	1 <input type="checkbox"/> Other (specify) _____
1 <input type="checkbox"/> Meningitis	1 <input type="checkbox"/> Cellulitis	1 <input type="checkbox"/> Abscess (not skin)	1 <input type="checkbox"/> Septic abortion	1 <input type="checkbox"/> Osteomyelitis	1 <input type="checkbox"/> Endometritis	1 <input type="checkbox"/> Puerperal sepsis	
1 <input type="checkbox"/> Otitis media	1 <input type="checkbox"/> Epiglottitis	1 <input type="checkbox"/> Peritonitis	1 <input type="checkbox"/> Chorioamnionitis	1 <input type="checkbox"/> Empyema	1 <input type="checkbox"/> STSS	1 <input type="checkbox"/> Septic shock	1 <input type="checkbox"/> Unknown

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden to CDC, CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30329, ATTN: PRA(0920-0978). **Do not send the completed form to this address.**

**27. UNDERLYING CAUSES OR PRIOR ILLNESSES:** (Check all that apply OR if NONE or CHART UNAVAILABLE, check appropriate box) 1  None 1  Unknown

1 <input type="checkbox"/> AIDS or CD4 count <200	1 <input type="checkbox"/> CSF Leak	1 <input type="checkbox"/> IDU, Current	1 <input type="checkbox"/> Plegias/Paralysis
1 <input type="checkbox"/> Alcohol Abuse, Current	1 <input type="checkbox"/> Current Smoker	1 <input type="checkbox"/> IDU, Past	1 <input type="checkbox"/> Premature Birth (specify gestational age at birth) <input type="text"/> (wks)
1 <input type="checkbox"/> Alcohol Abuse, Past	1 <input type="checkbox"/> Deaf/Profound Hearing Loss	1 <input type="checkbox"/> Leukemia	1 <input type="checkbox"/> Seizure/Seizure Disorder
1 <input type="checkbox"/> Asthma	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Multiple Myeloma	1 <input type="checkbox"/> Sickle Cell Anemia
1 <input type="checkbox"/> Atherosclerotic Cardiovascular Disease (ASCVD)/CAD	1 <input type="checkbox"/> Diabetes Mellitus	1 <input type="checkbox"/> Multiple Sclerosis	1 <input type="checkbox"/> Solid Organ Malignancy
1 <input type="checkbox"/> Bone Marrow Transplant (BMT)	1 <input type="checkbox"/> Emphysema/COPD	1 <input type="checkbox"/> Nephrotic Syndrome	1 <input type="checkbox"/> Solid Organ Transplant
1 <input type="checkbox"/> Cerebral Vascular Accident (CVA)/Stroke	1 <input type="checkbox"/> Heart Failure/CHF	1 <input type="checkbox"/> Neuromuscular Disorder	1 <input type="checkbox"/> Splenectomy/Asplenia
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> HIV Infection	1 <input type="checkbox"/> Obesity	1 <input type="checkbox"/> Systemic Lupus Erythematosus (SLE)
1 <input type="checkbox"/> Current Chronic Dialysis	1 <input type="checkbox"/> Hodgkin's Disease/Lymphoma	1 <input type="checkbox"/> Parkinson's Disease	1 <input type="checkbox"/> Other prior illness (specify) _____
1 <input type="checkbox"/> Chronic Skin Breakdown	1 <input type="checkbox"/> Immunoglobulin Deficiency	1 <input type="checkbox"/> Other Drug Use, Current	_____
1 <input type="checkbox"/> Cirrhosis/Liver Failure	1 <input type="checkbox"/> Immunosuppressive Therapy (Steroids, Chemotherapy, Radiation)	1 <input type="checkbox"/> Other Drug Use, Past	_____
1 <input type="checkbox"/> Cochlear Implant		1 <input type="checkbox"/> Peripheral Neuropathy	_____

**- IMPORTANT - PLEASE COMPLETE FOR THE RELEVANT ORGANISM -**

**HAEMOPHILUS INFLUENZAE**

**28a. What was the serotype?** 1  b 2  Not Typeable 3  a 4  c 5  d 6  e 7  f 8  Other (specify) \_\_\_\_\_ 9  Not Tested or Unknown

**28b. If <15 years of age and serotype 'b' or 'unknown' did patient receive Haemophilus influenzae b vaccine?** 1  Yes 2  No 9  Unknown  
If YES, please complete the list below.

DOSE	DATE GIVEN			VACCINE NAME	MANUFACTURER	LOT NUMBER
	Mo.	Day	Year			
1	<input type="text"/>	<input type="text"/>	<input type="text"/>			
2	<input type="text"/>	<input type="text"/>	<input type="text"/>			
3	<input type="text"/>	<input type="text"/>	<input type="text"/>			
4	<input type="text"/>	<input type="text"/>	<input type="text"/>			

**28c. Were records obtained to verify vaccination history? (<5 years of age with Hib/unknown serotype, only)**

1  Yes 2  No

**If YES, what was the source of the information? (Check all that apply)**

- 1  Vaccine Registry  
1  Healthcare Provider  
1  Other (specify) \_\_\_\_\_

**28d. Is the HI case a stillbirth or fetal death associated with placenta and/or amniotic fluid isolate or a neonate (<22 wks gestation)?** 1  Yes 2  No  
If YES, then count as ABCs, if NO, then do not count as ABCs

**NEISSERIA MENINGITIDIS**

**29. What was the serogroup?** 1  A 2  B 3  C 4  Y 5  W135 6  Not Groupable 8  Other \_\_\_\_\_ 9  Unknown

**30. Is patient currently attending college?** 1  Yes 2  No 9  Unknown

**31a. Did patient receive meningococcal conjugate vaccine (MenACWY)?** 1  Yes 2  No 9  Unknown  
If YES, please complete the following information:

DOSE	DATE GIVEN			VACCINE NAME	MANUFACTURER	LOT NUMBER
	Mo.	Day	Year			
1	<input type="text"/>	<input type="text"/>	<input type="text"/>			
2	<input type="text"/>	<input type="text"/>	<input type="text"/>			
3	<input type="text"/>	<input type="text"/>	<input type="text"/>			

**STREPTOCOCCUS PNEUMONIAE**

**32. Did patient receive pneumococcal vaccine?**

1  Yes 2  No 9  Unknown

**If YES, please note which pneumococcal vaccine was received: (Check all that apply)**

- 1  Prevnar<sup>®</sup> 7-valent Pneumococcal Conjugate Vaccine (PCV7)  
1  Prevnar-13<sup>®</sup> 13-valent Pneumococcal Conjugate Vaccine (PCV13)  
1  Pneumovax<sup>®</sup> 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)  
1  Vaccine type not specified

**If between ≥2 months and <5 years of age and an isolate is available for serotyping, please complete the Invasive Pneumococcal Disease in Children expanded form.**

**31b. Did patient receive serogroup B meningococcal vaccine (MenB)?** 1  Yes 2  No 9  Unknown  
If YES, please complete the following information:

DOSE	DATE GIVEN			VACCINE NAME	MANUFACTURER	LOT NUMBER
	Mo.	Day	Year			
1	<input type="text"/>	<input type="text"/>	<input type="text"/>			
2	<input type="text"/>	<input type="text"/>	<input type="text"/>			
3	<input type="text"/>	<input type="text"/>	<input type="text"/>			

**GROUP A STREPTOCOCCUS** (#33-35 refer to the 14 days prior to first positive culture)

**33. Did the patient have surgery or any skin incision?** 1  Yes 2  No 9  Unknown

If YES, date of surgery or skin incision:  Mo.  Day  Year

**34. Did the patient deliver a baby (vaginal or C-section)?**

1  Yes 2  No 9  Unknown

If YES, date of delivery:  Mo.  Day  Year

**35. Did patient have:**

- 1  Varicella 1  Surgical wound (post operative)  
1  Penetrating trauma 1  Blunt trauma  
1  Burns

**If YES to any of the above, record the number of days prior to the first positive culture (if > 1, use the most recent skin injury)**

1  0-7 days 2  8-14 days

**36. COMMENTS:** \_\_\_\_\_

**- SURVEILLANCE OFFICE USE ONLY -**

**37. Was case first identified through audit?** 1  Yes 2  No 9  Unknown

**38. Does this case have recurrent disease with the same pathogen?** 1  Yes 2  No 9  Unknown

If YES, previous (1st) state I.D.:

**39. Initials of S.O.:** \_\_\_\_\_

Submitted By: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Physician's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_

# Attachment 4

## FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form

U.S. DEPARTMENT OF  
HEALTH AND HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL  
AND PREVENTION  
ATLANTA, GA 30333

### 2016-17 FluSurv-NET Influenza Hospitalization Surveillance Project Case Report Form



Form Approved  
OMB No. 0920-0978

Case ID: 1 6 1 7

#### A. Patient Data – THIS INFORMATION IS NOT SENT TO CDC

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Chart Number: \_\_\_\_\_  
 Address: \_\_\_\_\_ (Number, Street, Apt. No.)  
 \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) Census Tract: \_\_\_\_\_ Address Type: \_\_\_\_\_  
 Emergency Contact 1: \_\_\_\_\_  
 Phone No.1: \_\_\_\_\_ Phone No.2: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_  No PCP  
 PCP/Clinic Name 1: \_\_\_\_\_ PCP Phone 1: \_\_\_\_\_ PCP Fax 1: \_\_\_\_\_  
 PCP/Clinic Name 2: \_\_\_\_\_ PCP Phone 2: \_\_\_\_\_ PCP Fax 2: \_\_\_\_\_  
 Site Use 1: \_\_\_\_\_ Site Use 2: \_\_\_\_\_ Site Use 3: \_\_\_\_\_

#### B. Reporter Information – THIS INFORMATION IS NOT SENT TO CDC

1. Reporter Name: \_\_\_\_\_ 2. Date Reported: \_\_\_\_/\_\_\_\_/\_\_\_\_

#### C. Enrollment Information

<b>1. Case Classification:</b> <input type="checkbox"/> Prospective Surveillance <input type="checkbox"/> Discharge Audit		<b>2. Admission Type:</b> <input type="checkbox"/> Hospitalization <input type="checkbox"/> Observation Only		<b>3. County:</b> _____	<b>4. State:</b> _____	<b>5. Case Type:</b> <input type="checkbox"/> Pediatric <input type="checkbox"/> Adult	
<b>6. Date of Birth:</b> ____/____/____	<b>7. Age:</b> <input type="checkbox"/> Years <input type="checkbox"/> Days (if < 1 month) <input type="checkbox"/> Months (if < 1 yr)	<b>8. Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>9. Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian/Pacific Islander		<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Multiracial <input type="checkbox"/> Not specified		
<b>10. Ethnicity:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Not Specified	<b>11. Hospital ID Where Patient Treated:</b> _____ <b>11a. Admission Date:</b> ____/____/____ <b>11b. Discharge Date:</b> ____/____/____		<b>12. Was patient transferred from another hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>12a. Transfer Hospital ID:</b> _____ <b>12b. Transfer Hospital Admission Date:</b> ____/____/____ <b>12c. Transfer Date:</b> ____/____/____				
<b>13. Where did patient reside at the time of hospitalization?</b> (Indicate TYPE of residence.) <input type="checkbox"/> Private residence <input type="checkbox"/> Hospitalized at birth <input type="checkbox"/> Assisted living/Residential care <input type="checkbox"/> Unknown <input type="checkbox"/> Homeless/Shelter <input type="checkbox"/> Rehabilitation facility <input type="checkbox"/> LTACH <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Nursing home /Skilled Nursing Facility <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Group home/Retirement home <input type="checkbox"/> Alcohol/Drug Abuse Treatment <input type="checkbox"/> Hospice <input type="checkbox"/> Mental Hospital							
<b>13a. If resident of a facility, indicate NAME of facility:</b> _____							

#### D. Influenza Testing Results

<b>1. Test 1:</b> <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Alere™ / Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown							
<b>1a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____							
<b>1b. Specimen collection date:</b> ____/____/____		<b>1c. Testing facility ID:</b> _____		<b>1d. Specimen ID:</b> _____			
<b>2. Test 2:</b> <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Alere™ / Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown							
<b>2a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____							
<b>2b. Specimen collection date:</b> ____/____/____		<b>2c. Testing facility ID:</b> _____		<b>2d. Specimen ID:</b> _____			
<b>3. Test 3:</b> <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Alere™ / Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown							
<b>3a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____							
<b>3b. Specimen collection date:</b> ____/____/____		<b>3c. Testing facility ID:</b> _____		<b>3d. Specimen ID:</b> _____			
<b>4. Test 4:</b> <input type="checkbox"/> Rapid Antigen <input type="checkbox"/> Molecular Assay <input type="checkbox"/> Alere™ / Rapid Molecular Assay <input type="checkbox"/> Viral Culture <input type="checkbox"/> Serology <input type="checkbox"/> Fluorescent Antibody <input type="checkbox"/> Method Unknown							
<b>4a. Result:</b> <input type="checkbox"/> Flu A (no subtype) <input type="checkbox"/> H1, Seasonal <input type="checkbox"/> Flu B (no lineage) <input type="checkbox"/> Flu A & B <input type="checkbox"/> Negative <input type="checkbox"/> 2009 H1N1 <input type="checkbox"/> H3 <input type="checkbox"/> Flu B, Victoria <input type="checkbox"/> Flu A/B (Not Distinguished) <input type="checkbox"/> H3N2v <input type="checkbox"/> H1, Unspecified <input type="checkbox"/> Flu A, Unsubtypable <input type="checkbox"/> Flu B, Yamagata <input type="checkbox"/> Unknown Type <input type="checkbox"/> Other, specify: _____							
<b>4b. Specimen collection date:</b> ____/____/____		<b>4c. Testing facility ID:</b> _____		<b>4d. Specimen ID:</b> _____			

Public reporting burden of this collection of information is estimated to average 17 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB Control Number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Request Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0978).

**E. Admission and Patient History**

1. Was patient discharged from any hospital within one week prior to the current admission date?  Yes  No  Unknown

2. Acute signs/symptoms at admission (within 2 weeks prior to positive flu test): (Write Y or N/Unk next to signs/symptoms)

<input type="checkbox"/> Altered mental status/confusion	<input type="checkbox"/> Cough*	<input type="checkbox"/> Headache	<input type="checkbox"/> Seizures	<input type="checkbox"/> Wheezing*
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Myalgia/muscle aches	<input type="checkbox"/> Shortness of breath/resp distress*	<input type="checkbox"/> Other, non-respiratory
<input type="checkbox"/> Congested/runny nose*	<input type="checkbox"/> Fatigue/weakness	<input type="checkbox"/> Nausea/vomiting	<input type="checkbox"/> Sore throat*	<input type="checkbox"/> No signs/symptoms documented
<input type="checkbox"/> Conjunctivitis/pink eye	<input type="checkbox"/> Fever/chills	<input type="checkbox"/> Rash	<input type="checkbox"/> URI/ILI*	

\*These are considered acute respiratory symptoms

3. Date of onset of acute respiratory symptoms (within 2 weeks prior to positive flu test): \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Unknown  Not applicable

4. Date of onset of acute condition resulting in current hospitalization: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  Unknown

5. BMI: _____ <input type="checkbox"/> Unknown	6. Height: _____ <input type="checkbox"/> In <input type="checkbox"/> Cm <input type="checkbox"/> Unknown	7. Weight: _____ <input type="checkbox"/> Lbs <input type="checkbox"/> Kg <input type="checkbox"/> Unknown	8. Smoker: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unknown	9. Alcohol abuse: <input type="checkbox"/> Current <input type="checkbox"/> Former <input type="checkbox"/> No/Unknown	11. Substance abuse: <input type="checkbox"/> Current <input type="checkbox"/> No/Unknown
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10. Did patient have any of the following pre-existing medical conditions? Check all that apply.  Yes  No  Unknown

<p>10a. Asthma/Reactive Airway Disease <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p>10b. Chronic Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Cystic fibrosis</p> <p><input type="checkbox"/> Emphysema/COPD</p> <p><input type="checkbox"/> Chronic bronchitis</p> <p><input type="checkbox"/> Chronic respiratory failure</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10c. Chronic Metabolic Disease <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Diabetes Mellitus</p> <p><input type="checkbox"/> Thyroid dysfunction</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10d. Blood disorders/Hemoglobinopathy <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Aplastic anemia</p> <p><input type="checkbox"/> Sickle cell disease</p> <p><input type="checkbox"/> Splenectomy/Asplenia</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10e. Cardiovascular Disease <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Aortic aneurysm</p> <p><input type="checkbox"/> Aortic stenosis</p> <p><input type="checkbox"/> Atrial Fibrillation</p> <p><input type="checkbox"/> Cardiomyopathy</p> <p><input type="checkbox"/> Atherosclerotic cardiovascular disease (ASCVD)</p> <p><input type="checkbox"/> Cerebral vascular incident/Stroke</p> <p><input type="checkbox"/> Congenital heart disease</p> <p><input type="checkbox"/> Coronary artery disease (CAD)</p> <p><input type="checkbox"/> Ischemic cardiomyopathy</p> <p><input type="checkbox"/> Non-ischemic cardiomyopathy</p> <p><input type="checkbox"/> Heart failure/CHF</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10f. Neuromuscular disorder <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Duchenne muscular dystrophy</p> <p><input type="checkbox"/> Muscular dystrophy</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Mitochondrial disorder</p> <p><input type="checkbox"/> Myasthenia gravis</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10g. Neurologic disorder <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Cognitive dysfunction</p> <p><input type="checkbox"/> Dementia/Alzheimer's disease</p> <p><input type="checkbox"/> Developmental delay</p>	<p><input type="checkbox"/> Down syndrome</p> <p><input type="checkbox"/> Plegias/Paralysis</p> <p><input type="checkbox"/> Seizure/Seizure disorder</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10h History of Guillain-Barré Syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p>10i. Immunocompromised Condition <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> AIDS or CD4 count &lt; 200</p> <p><input type="checkbox"/> Cancer: current/in treatment or diagnosed in last 12 months</p> <p><input type="checkbox"/> Complement deficiency</p> <p><input type="checkbox"/> HIV Infection</p> <p><input type="checkbox"/> Immunoglobulin deficiency</p> <p><input type="checkbox"/> Immunosuppressive therapy</p> <p><input type="checkbox"/> Organ transplant</p> <p><input type="checkbox"/> Stem cell transplant (e.g., bone marrow transplant)</p> <p><input type="checkbox"/> Steroid therapy (taken within 2 weeks of admission)</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10j. Renal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Chronic kidney disease/chronic renal insufficiency</p> <p><input type="checkbox"/> End stage renal disease/Dialysis</p> <p><input type="checkbox"/> Glomerulonephritis</p> <p><input type="checkbox"/> Nephrotic syndrome</p> <p><input type="checkbox"/> Other, specify: _____</p> <p>10k. Other <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p><input type="checkbox"/> Intravenous drug use</p> <p><input type="checkbox"/> Liver disease (e.g., cirrhosis, chronic hepatitis, hepatitis B or C)</p> <p><input type="checkbox"/> Systemic lupus erythematosus/SLE/Lupus</p> <p><input type="checkbox"/> Active Tuberculosis/TB</p> <p><input type="checkbox"/> Morbidly obese (ADULTS ONLY)</p> <p><input type="checkbox"/> Obese</p> <p><input type="checkbox"/> Pregnant</p> <p><input type="checkbox"/> If pregnant, specify gestational age in weeks: _____</p> <p><input type="checkbox"/> Unknown gestational age</p> <p><input type="checkbox"/> Post-partum (two weeks or less)</p> <p><input type="checkbox"/> Other, specify: _____</p> <p><b>10l. PEDIATRIC CASES ONLY</b></p> <p>Abnormality of upper airway <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p>History of febrile seizures <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p>Long-term aspirin therapy <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p>Premature <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown</p> <p>(gestation age &lt; 37 weeks at birth for patients &lt; 2yrs)</p> <p>If yes, specify gestational age at birth in weeks: _____</p> <p><input type="checkbox"/> Unknown gestational age at birth</p>
--	---

**F. Intensive Care Unit and Interventions**

<p>1. Was the patient admitted to an intensive care unit (ICU)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>1a. Number of ICU Admissions: _____ <input type="checkbox"/> Unknown</p> <p>1b. Date of first ICU Admission: ____ / ____ / ____ <input type="checkbox"/> Unknown</p> <p>1c. Date of first ICU Discharge: ____ / ____ / ____ <input type="checkbox"/> Unknown</p>	<p>2. Did patient receive mechanical ventilation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>3. Did patient receive extracorporeal membrane oxygenation (ECMO or 'on bypass')? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>
---	--



**J. Chest Radiograph – Based on radiology report only**

1. Was a chest x-ray taken *within 3 days of admission*?  Yes  No  Unknown

2. Were any of these chest x-rays abnormal?  Yes  No  Unknown

2a. Date of first abnormal chest x-ray: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2b. For first abnormal chest x-ray, please check all that apply:

<input type="checkbox"/> Report not available	<input type="checkbox"/> Cannot rule out pneumonia	<input type="checkbox"/> Lung infiltrate
<input type="checkbox"/> Air space density	<input type="checkbox"/> Consolidation	<input type="checkbox"/> Interstitial infiltrate
<input type="checkbox"/> Air space opacity	<input type="checkbox"/> Cavitation	<input type="checkbox"/> Lobar infiltrate
<input type="checkbox"/> Bronchopneumonia/pneumonia	<input type="checkbox"/> ARDS (acute respiratory distress syndrome)	<input type="checkbox"/> Other

**K. Discharge Summary**

Did the patient have any of the following new diagnoses at discharge? (check all that apply)  No discharge summary available

Acute encephalopathy/encephalitis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Bronchiolitis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Pneumonia <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute Myocardial Infarction <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Congestive Heart Failure <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Sepsis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute Myocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	COPD exacerbation <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute Renal Failure <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Diabetic Ketoacidosis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Stroke (CVA) <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown
Acute respiratory distress syndrome (ARDS) <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Guillan-Barre syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	
Acute respiratory failure <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Hemophagocytic syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	
Asthma exacerbation <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Reyes syndrome <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	
Bacteremia <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	Rhabdomyolysis <input type="checkbox"/> Yes <input type="checkbox"/> No/Unknown	

2. What was the outcome of the patient?  Alive  Deceased  Unknown

2a. If discharged alive, please indicate to where:

<input type="checkbox"/> Private residence	<input type="checkbox"/> Rehabilitation Facility	<input type="checkbox"/> Group home/Retirement home
<input type="checkbox"/> Homeless/Shelter	<input type="checkbox"/> Jail/Prison	<input type="checkbox"/> Mental Hospital
<input type="checkbox"/> Nursing home /Skilled Nursing Facility	<input type="checkbox"/> Hospice	<input type="checkbox"/> Unknown
<input type="checkbox"/> Alcohol/Drug Abuse Treatment	<input type="checkbox"/> Assisted living/Residential care	<input type="checkbox"/> Other, specify: _____
<input type="checkbox"/> Home with services	<input type="checkbox"/> LTACH	

3. If patient was pregnant on admission, indicate pregnancy status at discharge:  Still pregnant  No longer pregnant  Unknown

3a. If patient was pregnant on admission but no longer pregnant at discharge, indicate pregnancy outcome at discharge:  Miscarriage  Ill newborn  Newborn died  Healthy newborn  Abortion  Unknown

4. Additional notes regarding discharge:

**L. ICD-10 Discharge Diagnoses – To be recorded in order of appearance**

<input type="checkbox"/> ICD codes not available	1. _____	4. _____	7. _____
	2. _____	5. _____	8. _____
	3. _____	6. _____	9. _____

**M. Vaccination History**

Specify vaccination status and date(s) by source:

1. Medical Chart:  Yes, full date known  Yes, specific date unknown  No  Unknown  Not Checked  Unsuccessful Attempt

1a. If yes, specify dosage date information: 1) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown 2) (Pediatrics Only) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown

1b. If patient < 9 yrs, specify vaccine type:  Injected Vaccine  Nasal Spray/FluMist  Combination of both  Unknown type

2. Vaccine Registry:  Yes, full date known  Yes, specific date unknown  No  Unknown  Not Checked  Unsuccessful Attempt

2a. If yes, specify dosage date information: 1) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown 2) (Pediatrics Only) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown

2b. If patient < 9 yrs, specify vaccine type:  Injected Vaccine  Nasal Spray/FluMist  Combination of both  Unknown type

3. Primary Care Provider / LTCF:  Yes, full date known  Yes, specific date unknown  No  Unknown  Not Checked  Unsuccessful Attempt

3a. If yes, specify dosage date information: 1) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown 2) (Pediatrics Only) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown

3b. If patient < 9 yrs, specify vaccine type:  Injected Vaccine  Nasal Spray/FluMist  Combination of both  Unknown type

4. Interview:  Patient  Proxy  Yes, full date known  Yes, specific date unknown  No  Unknown  Not Checked  Unsuccessful Attempt

4a. If yes, specify dosage date information: 1) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown 2) (Pediatrics Only) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  Date Unknown

4b. If patient < 9 yrs, specify vaccine type:  Injected Vaccine  Nasal Spray/FluMist  Combination of both  Unknown type

5. If patient < 9 yrs, did patient receive any seasonal influenza vaccine in previous seasons?  Yes  No  Unknown

**N. Miscellaneous**

1. Additional Comments:

# Attachment 4

## Multi-site Gram-Negative Surveillance Initiative

### Healthcare Associated Infection Community Interface Case Report

Form Approved OMB No. 0920-0978

Patient ID: \_\_\_\_\_

DEPARTMENT OF  
HEALTH & HUMAN SERVICES  
CENTERS FOR DISEASE CONTROL  
AND PREVENTION  
ATLANTA, GA 30333

## 2016 Multi-site Gram-Negative Surveillance Initiative (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report



Patient's Name \_\_\_\_\_ Phone no. (\_\_\_\_) \_\_\_\_\_  
*(Last, First, MI)*

Address \_\_\_\_\_ MRN \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Hospital \_\_\_\_\_

— Patient Identifier Information is NOT transmitted to CDC —

1. STATE: <input type="checkbox"/> <input type="checkbox"/>	2. COUNTY: _____	3. STATE ID: _____	4a. LABORATORY ID WHERE CULTURE IDENTIFIED: _____	4b. FACILITY ID WHERE PATIENT TREATED: _____
--	---------------------	-----------------------	--	---

<b>5. Where was the patient located on the 4<sup>th</sup> calendar day prior to the date of initial culture?</b> <input type="checkbox"/> Private residence <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Homeless <input type="checkbox"/> Incarcerated <input type="checkbox"/> Hospital Inpatient <b>Was the patient transferred from this hospital?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Facility ID: _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	<b>6. DATE OF BIRTH:</b> ____ / ____ / ____	<b>7a. AGE:</b> ____
<b>7b. Is age in day/mo/yr?</b> <input type="checkbox"/> Days <input type="checkbox"/> Mos <input type="checkbox"/> Yrs		

<b>8a. SEX:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>8c. RACE (Check all that apply):</b> <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown	<b>8d. WEIGHT:</b> _____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unknown <b>8e. HEIGHT:</b> _____ ft _____ in OR _____ cm <input type="checkbox"/> Unknown <b>8f. BMI (Record only if ht and/or wt is not available):</b> _____ <input type="checkbox"/> Unknown
---	--	---

**9. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?**  
 Yes  No  Unknown

If yes: Date of admission \_\_\_\_\_ Date of discharge \_\_\_\_\_  
 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>10a. DATE OF INITIAL CULTURE</b> ____ / ____ / ____	<b>11a. Was the patient in the ICU in the 7 days <u>prior</u> to their initial culture?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>10b. LOCATION OF CULTURE COLLECTION:</b> <table style="width: 100%;"> <tr> <td style="width: 33%;"> <b>Hospital Inpatient</b>  <input type="checkbox"/> ICU  <input type="checkbox"/> Surgery/OR  <input type="checkbox"/> Radiology  <input type="checkbox"/> Other Unit  <input type="checkbox"/> Emergency Room                 </td> <td style="width: 33%;"> <b>Outpatient</b>  <input type="checkbox"/> Clinic/Doctors Office  <input type="checkbox"/> Surgery  <input type="checkbox"/> Other Outpatient  <input type="checkbox"/> Dialysis Center  <input type="checkbox"/> Observational Unit/Clinical Decision Unit                 </td> <td style="width: 33%;"> <input type="checkbox"/> LTCF Facility ID: _____  <input type="checkbox"/> LTACH Facility ID: _____  <input type="checkbox"/> Autopsy  <input type="checkbox"/> Unknown                 </td> </tr> </table>	<b>Hospital Inpatient</b> <input type="checkbox"/> ICU <input type="checkbox"/> Surgery/OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other Unit <input type="checkbox"/> Emergency Room	<b>Outpatient</b> <input type="checkbox"/> Clinic/Doctors Office <input type="checkbox"/> Surgery <input type="checkbox"/> Other Outpatient <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Observational Unit/Clinical Decision Unit	<input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Unknown	<b>11b. Was the patient in the ICU on the date of or in the 7 days <u>after</u> the initial culture?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Hospital Inpatient</b> <input type="checkbox"/> ICU <input type="checkbox"/> Surgery/OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other Unit <input type="checkbox"/> Emergency Room	<b>Outpatient</b> <input type="checkbox"/> Clinic/Doctors Office <input type="checkbox"/> Surgery <input type="checkbox"/> Other Outpatient <input type="checkbox"/> Dialysis Center <input type="checkbox"/> Observational Unit/Clinical Decision Unit	<input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Unknown		

**12. PATIENT OUTCOME:**  Survived  Died  Unknown

If survived, transferred to:  
 Private residence  
 LTCF Facility ID: \_\_\_\_\_  
 LTACH Facility ID: \_\_\_\_\_  
 Unknown  
 Other (specify): \_\_\_\_\_

If died, date of death: \_\_\_\_\_  
 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Was the organism cultured from a normally sterile site or urine, < calendar day 7 before death?  
 Yes  No  Unknown

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0978)

<p><b>13a. ORGANISM ISOLATED FROM INITIAL NORMALLY STERILE SITE OR URINE:</b>  Carbapenem-resistant:  <input type="checkbox"/> <i>Enterobacteriaceae</i> (CRE):  <input type="checkbox"/> <i>E. coli</i>  <input type="checkbox"/> <i>Enterobacter cloacae</i>  <input type="checkbox"/> <i>Enterobacter aerogenes</i>  <input type="checkbox"/> <i>Klebsiella pneumoniae</i>  <input type="checkbox"/> <i>Klebsiella oxytoca</i>  <input type="checkbox"/> <i>A. baumannii</i> (CRAB)</p>	<p><b>13b. Was the initial culture polymicrobial?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <hr/> <table style="width:100%;"> <tr> <td style="width:33%; vertical-align: top;"> <p><b>13c. Was the initial isolate tested for carbapenemase?</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Laboratory Not Testing  <input type="checkbox"/> Unknown</p> </td> <td style="width:33%; vertical-align: top;"> <p><b>If yes, what testing method was used</b>  (check all that apply):  <input type="checkbox"/> Automated Molecular Assay (specify): _____  <input type="checkbox"/> CarbaNP <input type="checkbox"/> E Test  <input type="checkbox"/> PCR <input type="checkbox"/> Modified Hodge Test (MHT)  <input type="checkbox"/> Other (specify): _____  <input type="checkbox"/> Unknown</p> </td> <td style="width:33%; vertical-align: top;"> <p><b>If tested, what was the testing result?</b>  <input type="checkbox"/> Positive  <input type="checkbox"/> Negative  <input type="checkbox"/> Indeterminate  <input type="checkbox"/> Unknown</p> </td> </tr> </table>	<p><b>13c. Was the initial isolate tested for carbapenemase?</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Laboratory Not Testing  <input type="checkbox"/> Unknown</p>	<p><b>If yes, what testing method was used</b>  (check all that apply):  <input type="checkbox"/> Automated Molecular Assay (specify): _____  <input type="checkbox"/> CarbaNP <input type="checkbox"/> E Test  <input type="checkbox"/> PCR <input type="checkbox"/> Modified Hodge Test (MHT)  <input type="checkbox"/> Other (specify): _____  <input type="checkbox"/> Unknown</p>	<p><b>If tested, what was the testing result?</b>  <input type="checkbox"/> Positive  <input type="checkbox"/> Negative  <input type="checkbox"/> Indeterminate  <input type="checkbox"/> Unknown</p>
<p><b>13c. Was the initial isolate tested for carbapenemase?</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Laboratory Not Testing  <input type="checkbox"/> Unknown</p>	<p><b>If yes, what testing method was used</b>  (check all that apply):  <input type="checkbox"/> Automated Molecular Assay (specify): _____  <input type="checkbox"/> CarbaNP <input type="checkbox"/> E Test  <input type="checkbox"/> PCR <input type="checkbox"/> Modified Hodge Test (MHT)  <input type="checkbox"/> Other (specify): _____  <input type="checkbox"/> Unknown</p>	<p><b>If tested, what was the testing result?</b>  <input type="checkbox"/> Positive  <input type="checkbox"/> Negative  <input type="checkbox"/> Indeterminate  <input type="checkbox"/> Unknown</p>		

<p><b>14. INITIAL CULTURE SITE:</b>  <input type="checkbox"/> Blood <input type="checkbox"/> Joint/synovial fluid  <input type="checkbox"/> CSF <input type="checkbox"/> Bone  <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Urine  <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Other normally sterile site _____  <input type="checkbox"/> Pericardial fluid _____</p>	<p><b>URINE Cultures ONLY:</b>  <b>14a. How was the urine collected?</b>  <input type="checkbox"/> Clean Catch  <input type="checkbox"/> In and Out Catheter  <input type="checkbox"/> Indwelling Catheter  <input type="checkbox"/> Condom Catheter  <input type="checkbox"/> Other: _____  <input type="checkbox"/> Unknown</p>	<p><b>URINE Cultures ONLY:</b>  <b>14b. Record the colony count for the organism indicated in Q13a:</b>  _____  <input type="checkbox"/> Unknown</p>
--	---	--

**URINE Cultures ONLY:**  
**14c. Signs and Symptoms associated with urine culture. Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before and the 2 calendar days after the day of initial culture:**

<input type="checkbox"/> Altered mental status	<input type="checkbox"/> Fever	<input type="checkbox"/> Pyuria	<input type="checkbox"/> None
<input type="checkbox"/> Acute pain, swelling or tenderness of the testes, epididymis or prostate	<input type="checkbox"/> Frequency	<input type="checkbox"/> Retention	
<input type="checkbox"/> Chills	<input type="checkbox"/> Hematuria	<input type="checkbox"/> Suprapubic tenderness	
<input type="checkbox"/> Cloudy	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Unspecified abdominal pain/tenderness	
<input type="checkbox"/> Costovertebral angle pain or tenderness	<input type="checkbox"/> Leukocytosis	<input type="checkbox"/> Urgency	
<input type="checkbox"/> Dysuria	<input type="checkbox"/> Malodorous	<input type="checkbox"/> Unknown	
	<input type="checkbox"/> Purulent discharge	<input type="checkbox"/> Other (specify): _____	

**15. Was the same organism (Q13a) cultured from a different sterile site or urine in the 30 days after the date of initial culture (of this current episode)?**  
 Yes  No  Unknown

**If yes, source (check all that apply):**  
 Blood  Joint/synovial fluid  
 CSF  Bone  
 Pleural fluid  Urine  
 Peritoneal fluid  Other normally sterile site \_\_\_\_\_  
 Pericardial fluid \_\_\_\_\_

<b>16. <i>Enterobacteriaceae</i> ONLY:</b> Were cultures of sterile site(s) or urine positive in the 30 days <u>prior</u> to the date of initial culture, for a DIFFERENT organism (Q13a)?	<b>If yes, indicate organism type and associated State ID for the incident closest to the date of initial culture:</b>												
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> NA													
<b>If yes, source (check all that apply):</b> <input type="checkbox"/> Blood <input type="checkbox"/> Joint/synovial fluid <input type="checkbox"/> CSF <input type="checkbox"/> Bone <input type="checkbox"/> Pleural fluid <input type="checkbox"/> Urine <input type="checkbox"/> Peritoneal fluid <input type="checkbox"/> Other normally sterile site _____ <input type="checkbox"/> Pericardial fluid _____	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;">Organism</th> <th style="width:40%;">State ID</th> </tr> </thead> <tbody> <tr><td><i>E. coli</i></td><td></td></tr> <tr><td><i>Enterobacter cloacae</i></td><td></td></tr> <tr><td><i>Enterobacter aerogenes</i></td><td></td></tr> <tr><td><i>Klebsiella pneumoniae</i></td><td></td></tr> <tr><td><i>Klebsiella oxytoca</i></td><td></td></tr> </tbody> </table>	Organism	State ID	<i>E. coli</i>		<i>Enterobacter cloacae</i>		<i>Enterobacter aerogenes</i>		<i>Klebsiella pneumoniae</i>		<i>Klebsiella oxytoca</i>	
Organism	State ID												
<i>E. coli</i>													
<i>Enterobacter cloacae</i>													
<i>Enterobacter aerogenes</i>													
<i>Klebsiella pneumoniae</i>													
<i>Klebsiella oxytoca</i>													

**16a. *A. baumannii* Cultures ONLY:**  
Were cultures of OTHER sterile site(s) or urine positive in the 30 days prior to the date of initial culture, for another *A. baumannii*?  
 Yes  No  Unknown  NA

**If yes, source (check all that apply):**  
 Blood  Joint/synovial fluid  
 CSF  Bone  
 Pleural fluid  Urine  
 Peritoneal fluid  Other normally sterile site \_\_\_\_\_  
 Pericardial fluid \_\_\_\_\_

**If yes, State ID for the organism closest to the date of initial culture:**  
\_\_\_\_\_

<p><b>17a. Was this patient positive for the SAME organism in the year prior to the date of the initial culture (Q10a):</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No (GO TO Q17c) <input type="checkbox"/> Unknown (GO TO Q17c)</p>	<p><b>17b. If yes, specify date of culture and State ID for the first positive culture in the year prior:</b>  <input type="text"/> / <input type="text"/> / <input type="text"/><input type="text"/><input type="text"/><input type="text"/>  State ID: _____</p>
--	--

**17c. *Enterobacteriaceae* ONLY:**  
Was this patient positive for a MuGSI *Enterobacteriaceae* in the year prior to the date of initial culture (Q10a)?  
 Yes  No (GO TO Q18)  Unknown (GO TO Q18)  NA (GO TO Q18)

17d. If yes, specify organism, date of culture and State ID for the first positive *Enterobacteriaceae* culture in the year prior to the date of initial culture (Q10a):

Carbapenem-resistant *Enterobacteriaceae* (CRE):

- E. coli*
- Enterobacter cloacae*
- Enterobacter aerogenes*
- Klebsiella pneumoniae*
- Klebsiella oxytoca*

Date of Culture:

□□ / □□ / □□□□

State ID: \_\_\_\_\_

18. Susceptibility Results: (please complete the table below based on the information found in the indicated data source). Shaded antibiotics are required to have the MIC entered into the MuGSI-CM system, if available.

Data Source	Medical Record		Microscan		Vitek		Phoenix		Kirby-Bauer		E-test	
	MIC	Interp	MIC	Interp	MIC	Interp	MIC	Interp	Zone Diam	Interp	MIC	Interp
Amikacin												
Amoxicillin/Clavulanate												
Ampicillin												
Ampicillin/Sulbactam												
Aztreonam												
Cefazolin												
CEFEPIME												
CEFOTAXIME												
CEFTAZIDIME												
CEFTRIAXONE												
Cephalothin												
Ciprofloxacin												
COLISTIN												
DORIPENEM												
ERTAPENEM												
Gentamicin												
IMIPENEM												
Levofloxacin												
MEROPENEM												
Moxifloxacin												
Nitrofurantoin												
Piperacillin/Tazobactam												
POLYMYXIN B												
TIGECYCLINE												
Tobramycin												
Trimethoprim-sulfamethoxazole												

19. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S) (check all that apply):  None  Unknown

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Abscess, not skin             | <input type="checkbox"/> Chronic ulcer/wound (not decubitus) | <input type="checkbox"/> Peritonitis      | <input type="checkbox"/> Skin abscess                       |
| <input type="checkbox"/> AV fistula/graft infection    | <input type="checkbox"/> Decubitus/pressure ulcer            | <input type="checkbox"/> Pneumonia        | <input type="checkbox"/> Surgical incision infection        |
| <input type="checkbox"/> Bacteremia                    | <input type="checkbox"/> Empyema                             | <input type="checkbox"/> Pyelonephritis   | <input type="checkbox"/> Surgical site infection (internal) |
| <input type="checkbox"/> Bursitis                      | <input type="checkbox"/> Endocarditis                        | <input type="checkbox"/> Septic arthritis | <input type="checkbox"/> Traumatic wound                    |
| <input type="checkbox"/> Catheter site infection (CVC) | <input type="checkbox"/> Meningitis                          | <input type="checkbox"/> Septic emboli    | <input type="checkbox"/> Urinary tract infection            |
| <input type="checkbox"/> Cellulitis                    | <input type="checkbox"/> Osteomyelitis                       | <input type="checkbox"/> Septic shock     | <input type="checkbox"/> Other _____                        |

20. UNDERLYING CONDITIONS (check all that apply):  None  Unknown

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> AIDS/CD4 count < 200        | <input type="checkbox"/> Cystic Fibrosis                    | <input type="checkbox"/> Myocardial Infarct                   |
| <input type="checkbox"/> Alcohol abuse               | <input type="checkbox"/> Decubitus/Pressure Ulcer           | <input type="checkbox"/> Neurological Problems                |
| <input type="checkbox"/> Chronic Liver Disease       | <input type="checkbox"/> Dementia/Chronic Cognitive Deficit | <input type="checkbox"/> Obesity or Morbid Obesity            |
| <input type="checkbox"/> Chronic Pulmonary Disease   | <input type="checkbox"/> Diabetes                           | <input type="checkbox"/> Peptic Ulcer Disease                 |
| <input type="checkbox"/> Chronic Renal Insufficiency | <input type="checkbox"/> Hemiplegia/Paraplegia              | <input type="checkbox"/> Peripheral Vascular Disease (PVD)    |
| <input type="checkbox"/> Chronic Skin Breakdown      | <input type="checkbox"/> HIV                                | <input type="checkbox"/> Premature Birth                      |
| <input type="checkbox"/> Congestive Heart Failure    | <input type="checkbox"/> Hematologic Malignancy             | <input type="checkbox"/> Solid Tumor (non metastatic)         |
| <input type="checkbox"/> Connective Tissue Disease   | <input type="checkbox"/> IVDU                               | <input type="checkbox"/> Spina bifida                         |
| <input type="checkbox"/> Current Smoker              | <input type="checkbox"/> Liver failure                      | <input type="checkbox"/> Transplant Recipient                 |
| <input type="checkbox"/> CVA/Stroke                  | <input type="checkbox"/> Metastatic Solid Tumor             | <input type="checkbox"/> Urinary Tract Problems/Abnormalities |

**21. RISK FACTORS OF INTEREST (check all that apply):**  None  Unknown

- Culture collected > calendar day 3 after hospital admission
- Hospitalized within year before date of initial culture:  
 If yes, enter mo/yr   /     OR  Unknown  
 If known, prior hospital ID: \_\_\_\_\_
- Surgery within year before date of initial culture
- Current chronic dialysis:  Peritoneal  Hemodialysis  Unknown  
 Hemodialysis Access:  AV fistula/graft  CVC  Unknown
- Residence in LTCF within year before date of initial culture  
 If known, facility ID: \_\_\_\_\_
- Admitted to a LTACH within year before initial culture date  
 If known, facility ID: \_\_\_\_\_

- Central venous catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture
- Urinary catheter in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture  
**If checked, indicate all that apply:**  
 Indwelling Urethral Catheter  Suprapubic Catheter  
 Condom Catheter  Other: \_\_\_\_\_
- Any OTHER indwelling device in place on the day of culture (up to time of culture) or at any time in the 2 calendar days prior to the date of culture  
**If checked, indicate all that apply:**  
 ET/NT Tube  Gastrostomy Tube  NG Tube  
 Tracheostomy  Nephrostomy Tube  Other: \_\_\_\_\_
- Patient traveled internationally in the two months prior to the date of initial culture.  
**Country:** \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_  
 Patient was hospitalized while visiting country (ies) listed above

**SURVEILLANCE OFFICE USE ONLY**

<p><b>22. Was case first identified through audit?</b></p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<p><b>23. CRF status:</b></p> <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable	<p><b>24. Date reported to EIP site:</b></p> <div style="text-align: center;"> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> </div>	<p><b>25. SO Initials:</b></p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>
<p><b>26. Comments:</b></p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/>			

## Attachment 6

### Feasibility Evaluation: Surveillance of Carbapenem-resistant Pseudomonas

<b>Patient ID:</b> _____																			
DEPARTMENT OF HEALTH & HUMAN SERVICES CENTERS FOR DISEASE CONTROL AND PREVENTION ATLANTA, GA 30333		<b>Feasibility Evaluation: Surveillance of Carbapenem-resistant Pseudomonas aeruginosa Multi-Site Gram-Negative Surveillance (MuGSI) Healthcare Associated Infection Community Interface (HAIC) Case Report</b>																	
<b>Patient's Name</b> _____ <b>Phone no.</b> (____) _____ <small style="margin-left: 150px;">(Last, First, MI)</small>																			
<b>Address</b> _____ <b>MRN</b> _____																			
<b>City</b> _____ <b>State</b> _____ <b>Zip</b> _____ <b>Hospital</b> _____ <small style="text-align: center;">— Patient Identifier Information is NOT transmitted to CDC —</small>																			
<b>1. STATE</b> <input type="text"/> <input type="text"/>	<b>2. COUNTY:</b> <input type="text"/>	<b>3. STATE ID:</b> <input type="text"/> <input type="text"/>	<b>4. LABORATORY ID WHERE CULTURE IDENTIFIED:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>5. FACILITY ID WHERE PATIENT TREATED:</b> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>															
<b>6. DATE OF BIRTH:</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<b>7a. AGE:</b> <input type="text"/> <input type="text"/> <input type="text"/>	<b>7b. Is age in day/mo/year?</b> 1 <input type="checkbox"/> Days 2 <input type="checkbox"/> Mos 3 <input type="checkbox"/> Yrs															
<b>8a. SEX:</b> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<b>8b. ETHNIC ORIGIN:</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 3 <input type="checkbox"/> Unknown		<b>8c. RACE:</b> 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Unknown																
<b>9a. DATE OF INITIAL CULTURE:</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			<b>9c. Where was the patient located on the 4th calendar day prior to the date of initial culture?</b> 1 <input type="checkbox"/> Hospital Inpatient (If transferred, hospital ID _____) 2 <input type="checkbox"/> Private residence 3 <input type="checkbox"/> Homeless 4 <input type="checkbox"/> Incarcerated 5 <input type="checkbox"/> LTCF 6 <input type="checkbox"/> LTACH 7 <input type="checkbox"/> Other (specify): _____ 9 <input type="checkbox"/> Unknown																
<b>9b. LOCATION OF CULTURE COLLECTION:</b> 1 <input type="checkbox"/> Hospital Inpatient    4 <input type="checkbox"/> Outpatient    7 <input type="checkbox"/> Autopsy 2 <input type="checkbox"/> Emergency Room    5 <input type="checkbox"/> LTCF    9 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Observational Unit/ Clinical Decision Unit    6 <input type="checkbox"/> LTACH			<b>10. WAS PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?</b> 1 <input type="checkbox"/> Yes    0 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown <b>If YES:</b> <b>Date of admission</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <b>Date of discharge</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																
<b>12a. PATIENT OUTCOME:</b> 1 <input type="checkbox"/> Survived    2 <input type="checkbox"/> Died    9 <input type="checkbox"/> Unknown			<b>12c. If died, date of death:</b> <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																
<b>12b. If survived, transferred to:</b> 2 <input type="checkbox"/> Private residence    9 <input type="checkbox"/> Unknown 5 <input type="checkbox"/> LTCF    7 <input type="checkbox"/> Other (specify): _____ 6 <input type="checkbox"/> LTACH			<b>12d. Was CR-PA cultured from any site, other than stool, peri-rectal or rectal swab, or nasal swab, &lt; calendar day 7 before death (Day 1 = date of initial culture)?</b> 1 <input type="checkbox"/> Yes    0 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown																
<b>13. INITIAL CULTURE SITE (any site except stool, peri-rectal or rectal swab, or nasal swab):</b> <i>If urine culture, go to question 14a. If lower respiratory tract (LRT) culture, go to question 15a. For all other sites, go to question 16a)</i>																			
<table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;">1 <input type="checkbox"/> Blood</td> <td style="width: 33%; border: none;">1 <input type="checkbox"/> Pleural fluid</td> <td style="width: 33%; border: none;">1 <input type="checkbox"/> Tracheal aspirate (LRT site, go to Q15a)</td> </tr> <tr> <td style="border: none;">1 <input type="checkbox"/> Bone</td> <td style="border: none;">1 <input type="checkbox"/> Peritoneal fluid</td> <td style="border: none;">1 <input type="checkbox"/> Urine (go to Q14a)</td> </tr> <tr> <td style="border: none;">1 <input type="checkbox"/> Bronchoalveolar lavage (LRT site, go to Q15a)</td> <td style="border: none;">1 <input type="checkbox"/> Pericardial fluid</td> <td style="border: none;">1 <input type="checkbox"/> Wound (specify site) _____</td> </tr> <tr> <td style="border: none;">1 <input type="checkbox"/> CSF</td> <td style="border: none;">1 <input type="checkbox"/> Joint/synovial fluid</td> <td style="border: none;">1 <input type="checkbox"/> Other site _____</td> </tr> <tr> <td style="border: none;">1 <input type="checkbox"/> Internal abscess (specify site) _____</td> <td style="border: none;">1 <input type="checkbox"/> Sputum (LRT site, go to Q15a)</td> <td style="border: none;"></td> </tr> </table>					1 <input type="checkbox"/> Blood	1 <input type="checkbox"/> Pleural fluid	1 <input type="checkbox"/> Tracheal aspirate (LRT site, go to Q15a)	1 <input type="checkbox"/> Bone	1 <input type="checkbox"/> Peritoneal fluid	1 <input type="checkbox"/> Urine (go to Q14a)	1 <input type="checkbox"/> Bronchoalveolar lavage (LRT site, go to Q15a)	1 <input type="checkbox"/> Pericardial fluid	1 <input type="checkbox"/> Wound (specify site) _____	1 <input type="checkbox"/> CSF	1 <input type="checkbox"/> Joint/synovial fluid	1 <input type="checkbox"/> Other site _____	1 <input type="checkbox"/> Internal abscess (specify site) _____	1 <input type="checkbox"/> Sputum (LRT site, go to Q15a)	
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1 <input type="checkbox"/> Internal abscess (specify site) _____	1 <input type="checkbox"/> Sputum (LRT site, go to Q15a)																		

<b>Complete questions 14a–14c for URINE cultures ONLY.</b>		<b>Complete questions 15a–15d ONLY for LRT site cultures or for non-LRT culture where pneumonia is marked in question 19.</b>																																														
<p><b>URINE Cultures ONLY:</b></p> <p><b>14a. How was urine collected?</b></p> <p>1 <input type="checkbox"/> Clean Catch</p> <p>2 <input type="checkbox"/> In and Out Catheter</p> <p>3 <input type="checkbox"/> Indwelling Urethral Catheter</p> <p>4 <input type="checkbox"/> Condom Catheter</p> <p>5 <input type="checkbox"/> Suprapubic Catheter</p> <p>9 <input type="checkbox"/> Unknown</p> <p>6 <input type="checkbox"/> Other: _____</p>	<p><b>URINE Cultures ONLY:</b></p> <p><b>14b. Record the colony count for <i>P. aeruginosa</i>:</b></p> <p>_____</p>	<p><b>15a. Chest Radiology source of results:</b> 1 <input type="checkbox"/> CT 2 <input type="checkbox"/> X-Ray 9 <input type="checkbox"/> Not Done</p> <p><b>15b. Chest Radiology Findings (check all that apply):</b></p> <p>1 <input type="checkbox"/> Air space density/opacity</p> <p>1 <input type="checkbox"/> Multiple lobar infiltrate (bilateral)</p> <p>1 <input type="checkbox"/> Bronchopneumonia/pneumonia</p> <p>1 <input type="checkbox"/> New or changed infiltrate</p> <p>1 <input type="checkbox"/> Cannot rule out pneumonia</p> <p>1 <input type="checkbox"/> No evidence of pneumonia</p> <p>1 <input type="checkbox"/> Cavitation</p> <p>1 <input type="checkbox"/> Not available</p> <p>1 <input type="checkbox"/> Consolidation</p> <p>1 <input type="checkbox"/> Pleural effusion</p> <p>1 <input type="checkbox"/> Interstitial infiltrate</p> <p>1 <input type="checkbox"/> Single lobar infiltrate</p> <p>1 <input type="checkbox"/> Multiple lobar infiltrate (unilateral)</p> <p>1 <input type="checkbox"/> Other (specify): _____</p>																																														
<p><b>14c. Signs and Symptoms associated with urine culture.</b></p> <p>Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before and the 2 calendar days after the date of initial culture. Then go to question 16a.</p> <p>1 <input type="checkbox"/> None</p> <p>1 <input type="checkbox"/> Altered mental status</p> <p>1 <input type="checkbox"/> Acute pain, swelling or tenderness of the testes, epididymis or prostate</p> <p>1 <input type="checkbox"/> Chills</p> <p>1 <input type="checkbox"/> Cloudy</p> <p>1 <input type="checkbox"/> Costovertebral angle pain or tenderness</p> <p>1 <input type="checkbox"/> Dysuria</p> <p>1 <input type="checkbox"/> Fever [temperature <math>\geq 100.4</math> °F (38 °C)]</p> <p>1 <input type="checkbox"/> Frequency</p> <p>1 <input type="checkbox"/> Hematuria</p> <p>1 <input type="checkbox"/> Hypotension</p> <p>1 <input type="checkbox"/> Incontinence</p> <p>1 <input type="checkbox"/> Leukocytosis [<math>\geq 11,000</math> WBC/mm<sup>3</sup>]</p> <p>1 <input type="checkbox"/> Low body temperature/hypothermia [<math>\leq 95</math> °F (35 °C)]</p> <p>1 <input type="checkbox"/> Malodorous</p> <p>1 <input type="checkbox"/> Purulent discharge</p> <p>1 <input type="checkbox"/> Pyuria [<math>\geq 5</math> WBC/mm<sup>3</sup> in urine]</p> <p>1 <input type="checkbox"/> Retention</p> <p>1 <input type="checkbox"/> Suprapubic tenderness</p> <p>1 <input type="checkbox"/> Unspecified abdominal pain/tenderness</p> <p>1 <input type="checkbox"/> Urgency</p> <p>1 <input type="checkbox"/> Unknown</p>		<p><b>15c. Signs and Symptoms associated with lower respiratory tract culture.</b></p> <p>Please indicate if any of the following symptoms were reported during the 5 day time period including the 2 calendar days before and the 2 calendar days after the date of initial culture. Then go to question 15d.</p> <p>1 <input type="checkbox"/> None</p> <p>1 <input type="checkbox"/> Altered mental status</p> <p>1 <input type="checkbox"/> Apnea (new onset or worsening)</p> <p>1 <input type="checkbox"/> Change in character of sputum</p> <p>1 <input type="checkbox"/> Cough (new onset or worsening)</p> <p>1 <input type="checkbox"/> Dyspnea (new onset or worsening)</p> <p>1 <input type="checkbox"/> Fever [temperature <math>\geq 100.4</math> °F (38 °C)]</p> <p>1 <input type="checkbox"/> Increased O<sub>2</sub> requirements</p> <p>1 <input type="checkbox"/> Increased suctioning</p> <p>1 <input type="checkbox"/> Increased ventilator demand</p> <p>1 <input type="checkbox"/> Leukocytosis [<math>\geq 11,000</math> WBC/mm<sup>3</sup>]</p> <p>1 <input type="checkbox"/> Leukopenia [<math>&lt; 4000</math> WBC/mm<sup>3</sup>]</p> <p>1 <input type="checkbox"/> Low O<sub>2</sub> desaturation [pulse oximetry <math>&lt; 94\%</math> or PaO<sub>2</sub>/FIO<sub>2</sub> <math>\leq 240</math>]</p> <p>1 <input type="checkbox"/> New onset purulent sputum</p> <p>1 <input type="checkbox"/> Rales/crackles/bronchial breath sounds</p> <p>1 <input type="checkbox"/> Tachypnea (new onset or worsening)</p> <p>1 <input type="checkbox"/> Unknown</p>																																														
<p><b>16a. Was the initial culture polymicrobial?</b></p> <p>1 <input type="checkbox"/> Yes (go to 16b)</p> <p>0 <input type="checkbox"/> No (go to 17)</p> <p>9 <input type="checkbox"/> Unknown (go to 17)</p>		<p><b>15d. Risk factors of interest for LRT cultures.</b></p> <p>1 <input type="checkbox"/> Non-invasive positive pressure ventilation (CPAP or BIPAP) at any time in the 7 calendar days prior to the date of initial culture</p> <p>1 <input type="checkbox"/> Nebulizer treatment at any time in the 7 calendar days prior to the date of initial culture</p> <p style="text-align: center;">Go to question 16.</p>																																														
<p><b>16b. Were any of the following organisms cultured from the initial culture (check all that apply)?</b></p> <p>1 <input type="checkbox"/> <math>&gt;1</math> CR <i>P. aeruginosa</i> with two distinct antibiograms</p> <p>1 <input type="checkbox"/> Vancomycin-resistant <i>Enterococci</i> (VRE)</p> <p>1 <input type="checkbox"/> Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA)</p> <p>1 <input type="checkbox"/> Carbapenem-resistant <i>Enterobacteriaceae</i> (CRE)</p> <p>1 <input type="checkbox"/> Carbapenem-resistant <i>Acinetobacter</i> (CRAB)</p> <p>1 <input type="checkbox"/> None of the listed organisms cultured</p>		<p><b>17. Susceptibility Results:</b></p> <p>Please complete the table below based on information found in the medical record. Shaded antibiotics are required data entry, if available.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #333; color: white;">ANTIBIOTIC</th> <th style="background-color: #333; color: white;">MIC</th> <th style="background-color: #333; color: white;">INTERP</th> </tr> </thead> <tbody> <tr><td>Amikacin</td><td></td><td></td></tr> <tr><td>Aztreonam</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>CEFEPIME</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>CEFTAZIDIME</td><td></td><td></td></tr> <tr><td>Ciprofloxacin</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>COLISTIN</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>DORIPENEM</td><td></td><td></td></tr> <tr><td>Gentamicin</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>IMIPENEM</td><td></td><td></td></tr> <tr><td>Levofloxacin</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>MEROPENEM</td><td></td><td></td></tr> <tr><td>Piperacillin-Tazobactam</td><td></td><td></td></tr> <tr style="background-color: #eee;"><td>POLYMYXIN B</td><td></td><td></td></tr> <tr><td>Tobramycin</td><td></td><td></td></tr> </tbody> </table>		ANTIBIOTIC	MIC	INTERP	Amikacin			Aztreonam			CEFEPIME			CEFTAZIDIME			Ciprofloxacin			COLISTIN			DORIPENEM			Gentamicin			IMIPENEM			Levofloxacin			MEROPENEM			Piperacillin-Tazobactam			POLYMYXIN B			Tobramycin		
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POLYMYXIN B																																																
Tobramycin																																																
<p><b>18. Was the patient neutropenic in the period from one calendar day before to the date of culture collection?</b></p> <p>1 <input type="checkbox"/> Yes      0 <input type="checkbox"/> No      9 <input type="checkbox"/> Unknown</p> <p>Neutropenia: ANC <math>\leq 50</math>      OR calculated as: WBC count*(% polys + % bands) <math>\leq 500</math></p> <p>Laboratory calculated ANC: _____      OR _____ *(% _____ + % _____) = _____</p>		<p><b>Date of selected WBC:</b></p> <p>□ □ / □ □ / □ □ □ □</p>																																														

**19. TYPES OF INFECTION ASSOCIATED WITH CULTURE(S) (check all that apply):** 1  None 1  Unknown

- |  |   |   |   |
|--|---|---|---|
| 1 <input type="checkbox"/> Abscess, not skin                   | 1 <input type="checkbox"/> Decubitus/pressure ulcer | 1 <input type="checkbox"/> Pneumonia ( <i>complete Q15a-c</i> ) | 1 <input type="checkbox"/> Surgical site infection (internal) |
| 1 <input type="checkbox"/> AV fistula/graft infection          | 1 <input type="checkbox"/> Ecthyma gangrenosum      | 1 <input type="checkbox"/> Pyelonephritis                       | 1 <input type="checkbox"/> Traumatic wound                    |
| 1 <input type="checkbox"/> Bacteremia                          | 1 <input type="checkbox"/> Empyema                  | 1 <input type="checkbox"/> Septic arthritis                     | 1 <input type="checkbox"/> Urinary tract infection            |
| 1 <input type="checkbox"/> Bursitis                            | 1 <input type="checkbox"/> Endocarditis             | 1 <input type="checkbox"/> Septic emboli                        | 1 <input type="checkbox"/> Other _____                        |
| 1 <input type="checkbox"/> Catheter site infection (CVC)       | 1 <input type="checkbox"/> Meningitis               | 1 <input type="checkbox"/> Septic shock                         |   |
| 1 <input type="checkbox"/> Cellulitis                          | 1 <input type="checkbox"/> Osteomyelitis            | 1 <input type="checkbox"/> Skin abscess                         |   |
| 1 <input type="checkbox"/> Chronic ulcer/wound (not decubitus) | 1 <input type="checkbox"/> Peritonitis              | 1 <input type="checkbox"/> Surgical incision infection          |   |

**20. UNDERLYING CONDITIONS (check all that apply):** 1  None 1  Unknown

- |  |   |  |   |
|--|---|--|---|
| 1 <input type="checkbox"/> AIDS/CD4 count < 200        | 1 <input type="checkbox"/> Congestive Heart Failure           | 1 <input type="checkbox"/> IVDU                              | 1 <input type="checkbox"/> Spina bifida                         |
| 1 <input type="checkbox"/> Alcohol abuse               | 1 <input type="checkbox"/> Connective Tissue Disease          | 1 <input type="checkbox"/> Inflammatory Bowel Disease/Crohns | 1 <input type="checkbox"/> Transplant Recipient                 |
| 1 <input type="checkbox"/> Chronic Bronchiectasis      | 1 <input type="checkbox"/> Current Smoker                     | 1 <input type="checkbox"/> Liver Failure                     | 1 <input type="checkbox"/> Urinary Tract Problems/Abnormalities |
| 1 <input type="checkbox"/> Chronic Liver Disease       | 1 <input type="checkbox"/> CVA/Stroke                         | 1 <input type="checkbox"/> Metastatic Solid Tumor            |   |
| 1 <input type="checkbox"/> Chronic Pulmonary Disease   | 1 <input type="checkbox"/> Cystic Fibrosis                    | 1 <input type="checkbox"/> Myocardial Infarct                |   |
| 1 <input type="checkbox"/> Chronic Renal Insufficiency | 1 <input type="checkbox"/> Decubitus/Pressure Ulcer           | 1 <input type="checkbox"/> Neurological Problems             |   |
| 1 <input type="checkbox"/> Chronic Skin Breakdown      | 1 <input type="checkbox"/> Dementia/Chronic cognitive deficit | 1 <input type="checkbox"/> Obesity or Morbid Obesity         |   |
| (Check all that apply):                                | 1 <input type="checkbox"/> Diabetes                           | 1 <input type="checkbox"/> Peptic Ulcer Disease              |   |
| 1 <input type="checkbox"/> Burn                        | 1 <input type="checkbox"/> Hemiplegia/Paraplegia              | 1 <input type="checkbox"/> Peripheral Vascular Disease (PVD) |   |
| 1 <input type="checkbox"/> Prolonged surgical wound    | 1 <input type="checkbox"/> HIV                                | 1 <input type="checkbox"/> Premature Birth                   |   |
| 1 <input type="checkbox"/> Other                       | 1 <input type="checkbox"/> Hematologic Malignancy             | 1 <input type="checkbox"/> Solid Tumor (non metastatic)      |   |
| 1 <input type="checkbox"/> Unknown                     |   |  |   |

**21. RISK FACTORS OF INTEREST (Check all that apply):** 1  None 1  Unknown

- |   |   |
|---|---|
| 1 <input type="checkbox"/> Culture collected > calendar day 3 after hospital admission  | 1 <input type="checkbox"/> Indwelling device in place at any time in the 7 calendar days prior to the date of initial culture. If checked, indicate all that apply: |
| Hospitalized within year before date of initial culture:  |   |
| 1 <input type="checkbox"/> Yes    0 <input type="checkbox"/> No    9 <input type="checkbox"/> Unknown   | 1 <input type="checkbox"/> Central venous catheter  |
| <i>If YES: Enter number of hospitalizations in year before date of initial culture.</i>   | 1 <input type="checkbox"/> ET/NT Tube   |
| <i>If patient is hospitalized at time of initial culture, do not count that hospitalization here.</i>   | 1 <input type="checkbox"/> NG Tube  |
| Number of hospitalizations: _____   | 1 <input type="checkbox"/> Implants ventricular assist device   |
| 1 <input type="checkbox"/> Surgery within year before date of initial culture   | 1 <input type="checkbox"/> Tracheostomy   |
| 1 <input type="checkbox"/> Residence in LTCF within year before date of initial culture   | 1 <input type="checkbox"/> Gastrostomy Tube   |
| 1 <input type="checkbox"/> Admitted to a LTACH within year before date of initial culture   | 1 <input type="checkbox"/> Jejunostomy Tube   |
| 1 <input type="checkbox"/> Current chronic dialysis: 1 <input type="checkbox"/> Peritoneal    2 <input type="checkbox"/> Hemodialysis    9 <input type="checkbox"/> Unknown | 1 <input type="checkbox"/> Other: _____   |
| Hemodialysis Access: 1 <input type="checkbox"/> AV fistula/graft    2 <input type="checkbox"/> CVC    9 <input type="checkbox"/> Unknown                                    | 1 <input type="checkbox"/> Other: _____   |
|   | 1 <input type="checkbox"/> Patient traveled internationally in the two months prior to the date of initial culture.   |
|   | Country: _____, _____, _____  |

**Complete 22a-22b for hospital inpatients only.**

**22a. Is antimicrobial use (IV or oral) in the 14 days before the date of initial culture collection documented in the H&P or medical administration record?**

- 1  Yes (go to Q22b)    0  No (go to Q23)    9  Unknown (go to Q23)

**22b. If yes, indicate all antibiotics given in the 14 days before the date of initial culture collection:**

1 <input type="checkbox"/> Amikacin (Amikin)	1 <input type="checkbox"/> Cefprozil	1 <input type="checkbox"/> Clindamycin	1 <input type="checkbox"/> Linezolid	1 <input type="checkbox"/> Rifampin
1 <input type="checkbox"/> Amoxicillin	1 <input type="checkbox"/> Ceftaroline	1 <input type="checkbox"/> Colistin	1 <input type="checkbox"/> Meropenem	1 <input type="checkbox"/> Telavancin
1 <input type="checkbox"/> Amoxicillin/Clavulanic Acid	1 <input type="checkbox"/> Ceftazidime	1 <input type="checkbox"/> Dalbavancin	1 <input type="checkbox"/> Metronidazole	1 <input type="checkbox"/> Tetracycline
1 <input type="checkbox"/> Ampicillin/sulbactam	1 <input type="checkbox"/> Ceftazidime-avibactam	1 <input type="checkbox"/> Daptomycin	1 <input type="checkbox"/> Minocycline	1 <input type="checkbox"/> Ticarcillin/Clavulanic Acid
1 <input type="checkbox"/> Azithromycin	1 <input type="checkbox"/> Ceftizoxime	1 <input type="checkbox"/> Doripenem	1 <input type="checkbox"/> Moxifloxacin	1 <input type="checkbox"/> Tigecycline
1 <input type="checkbox"/> Aztreonam	1 <input type="checkbox"/> Ceftriaxone	1 <input type="checkbox"/> Doxycycline	1 <input type="checkbox"/> Nafcillin/Dicloxacillin/Oxacillin	1 <input type="checkbox"/> Tobramycin
1 <input type="checkbox"/> Cefaclor	1 <input type="checkbox"/> Ceftolozane/tazobactam	1 <input type="checkbox"/> Ertapenem	1 <input type="checkbox"/> Nitrofurantoin	1 <input type="checkbox"/> Trimethoprim-Sulfamethoxazole
1 <input type="checkbox"/> Cefazolin	1 <input type="checkbox"/> Cefuroxime	1 <input type="checkbox"/> Erythromycin	1 <input type="checkbox"/> Ofloxacin	1 <input type="checkbox"/> Vancomycin
1 <input type="checkbox"/> Cefdinir	1 <input type="checkbox"/> Cephalexin	1 <input type="checkbox"/> Fosfomycin	1 <input type="checkbox"/> Penicillin	1 <input type="checkbox"/> Other (specify): _____
1 <input type="checkbox"/> Cefepime	1 <input type="checkbox"/> Chloroamphenicol	1 <input type="checkbox"/> Gentamicin	1 <input type="checkbox"/> Piperacillin-Tazobactam	1 <input type="checkbox"/> Other (specify): _____
1 <input type="checkbox"/> Cefotaxime	1 <input type="checkbox"/> Ciprofloxacin	1 <input type="checkbox"/> Imipenem	1 <input type="checkbox"/> Polymyxin B	
1 <input type="checkbox"/> Cefpodoxime	1 <input type="checkbox"/> Clarithromycin	1 <input type="checkbox"/> Levofloxacin	1 <input type="checkbox"/> Quinupristin/dalfopristin	

**23. CRF status:**

- 1  Complete  
2  Pending  
3  Chart unavailable

**24. Date reported to EIP site:**

■ ■ ■ / ■ ■ ■ / ■ ■ ■ ■ ■ ■

**25. SO Initials:**

**26. Comments:**

## Attachment 7 Candidemia

### CANDIDEMIA 2016 CASE REPORT FORM

Patient name: \_\_\_\_\_ Medical Record No.: \_\_\_\_\_  
(Last, First, MI)

Address: \_\_\_\_\_ Hospital: \_\_\_\_\_  
(Number, Street, Apt. No.)

\_\_\_\_\_  
(City, State) (Zip Code)

Acc No. (incident isolate): \_\_\_\_\_

Acc No. (subseq isolate): \_\_\_\_\_

.....cut/tear here and retain portion above at EIP site.....

Check if not a case:  Out of catchment area  Duplicate entry  Not candidemia  Unable to verify address  Other reason: \_\_\_\_\_

1) State ID:  2) County: \_\_\_\_\_ 3) Lab ID where positive culture was identified:

4) Age: \_\_\_\_\_ 1  days 2  mos 3  yrs (check one) 5) Date of birth:  (mm/dd/yyyy)

6) Sex: 1  Male 2  Female 3  Transgendered 7) Date first positive culture for *Candida* was drawn:

8) Source of first positive culture: 1  Blood, from central venous catheter 2  Blood, from peripheral stick 3  Blood, not specified  
 4  Other (specify) \_\_\_\_\_ 5  Blood, from arterial line 6  Unknown

9) *Candida* species (check all that apply):

- |   |  |
|---|--|
| 1 <input type="checkbox"/> <i>Candida albicans</i> (CA)     | 6 <input type="checkbox"/> <i>Candida tropicalis</i> (CT)                          |
| 2 <input type="checkbox"/> <i>Candida glabrata</i> (CG)     | 7 <input type="checkbox"/> <i>Candida</i> , other (CO) _____                       |
| 3 <input type="checkbox"/> <i>Candida krusei</i> (CK)       | 8 <input type="checkbox"/> <i>Candida</i> , gram tube negative/ non albicans (CGN) |
| 4 <input type="checkbox"/> <i>Candida lusitanae</i> (CL)    | 9 <input type="checkbox"/> <i>Candida</i> species (CS)                             |
| 5 <input type="checkbox"/> <i>Candida parapsilosis</i> (CP) | 10 <input type="checkbox"/> Pending  |

9A) Antifungal susceptibility testing (check here  if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation					
		Amphotericin B	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Anidulafungin (Eraxis)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Caspofungin (Cancidas)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Fluconazole (Diflucan)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Flucytosine (5FC)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Itraconazole (Sporanox)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Micafungin (Mycamine)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Posaconazole (Noxafil)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Voriconazole (Vfend)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Amphotericin B	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Anidulafungin (Eraxis)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Caspofungin (Cancidas)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Fluconazole (Diflucan)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Flucytosine (5FC)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Itraconazole (Sporanox)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Micafungin (Mycamine)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Posaconazole (Noxafil)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk
		Voriconazole (Vfend)	<input type="checkbox"/> Unk	<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS	<input type="checkbox"/> ND/Unk

9B) Additional *Candida* species or another *C. glabrata* isolated within 30d of incident culture (If yes, attach additional CRF: Q1, Q8, Q9, Q9A, and Q10):

1  Yes Date drawn:  (mm/dd/yyyy) 2  No 9  Unknown

10) Additional organisms isolated from this blood culture: 1  Yes 2  No 9  Unknown

If yes, specify additional organisms: \_\_\_\_\_

--SURVEILLANCE OFFICE USE ONLY--

<b>a) Date reported to EIP site:</b> <input type="checkbox"/> <input type="checkbox"/>	<b>c) Was case first identified through audit?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	<b>e) Previous candidemia episode?</b> 1 <input type="checkbox"/> Yes If yes, enter 1 <sup>st</sup> state ID: <input type="checkbox"/> <input type="checkbox"/> 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown	<b>f) CRF status:</b> 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Pending 4 <input type="checkbox"/> Chart unavailable	<b>g) SO's initials:</b> _____
---	--	--	--	-----------------------------------

State ID: 

Surveillance Officer Initials: \_\_\_\_\_

**DEMOGRAPHICS****11. Race:**

- 1  White  
 1  Black/African American  
 1  Asian  
 1  Native Hawaiian/Pacific Islander  
 1  American Indian/Alaska Native  
 1  Unknown

**12. Ethnic origin:**

- 1  Hispanic/Latino  
 2  Not Hispanic/Latino  
 9  Unknown

**13. Date of last recorded patient encounter:**

// OR 9  Unk  
 (mm/dd/yyyy)

**14. Outcome at last patient encounter:**

- 1  Alive  
 2  Dead Date of death: / OR 9  Unk  
 9  Unknown (mm/dd/yyyy)

**15. Where was the patient located on the 4<sup>th</sup> calendar day prior to the date of initial culture?**

- 1  Private residence  
 2  Hospital Inpatient (If transferred, complete Q16)  
 3  LTCF  
 4  LTACH  
 5  Homeless  
 6  Incarcerated  
 7  Other (specify): \_\_\_\_\_  
 8  Unknown

**MEDICAL ENCOUNTERS****16. Did the patient require a prior hospitalization in the 90 days before the first positive blood culture for *Candida* was drawn?**

- 1  Yes  
 2  No  
 9  Unknown

**17. Was patient transferred from another hospital to the first treatment hospital?**

- 1  Yes (If yes, transferred hospital ID: )  
 2  No  
 9  Unknown

**18. Was patient hospitalized?**

- 1  Yes (If yes, treatment hospital ID: )  
 2  No  
 9  Unknown

**18A. If patient was hospitalized:**

- Date of admit: // 9  Unk  
 Date of discharge: // 9  Unk  
 (mm/dd/yyyy)

**19A. Was the patient ever in an ICU in the 14 days before the date of first positive culture?**

- 1  Yes  
 2  No  
 3  Not applicable  
 9  Unknown

**19B. Was the patient ever in an ICU on the day of culture or in the 14 days after the date of first positive culture?**

- 1  Yes  
 2  No  
 3  Not applicable  
 9  Unknown

**20. If the patient was alive at discharge, where was the patient discharged to? 0  Not applicable (i.e., patient died, or not hospitalized)**

- 1  Home  
 2  Hospice care at home or in facility  
 3  Skilled nursing facility/nursing home  
 4  Rehabilitation facility  
 5  Long term acute care hospital  
 6  Another acute care hospital  
 7  Other, specify: \_\_\_\_\_  
 9  Unknown

**PREVIOUS CONDITIONS****21. Underlying conditions prior to positive *Candida* culture (check all that apply): 1  Yes 2  No 9  Unknown**Cancer-related diagnoses:

- 1  Leukemia/Lymphoma/Multiple myeloma  
 1  Solid organ malignancy  
 1  Other cancer (specify): \_\_\_\_\_

Inflammatory Bowel Disease 1 Connective Tissue Disease 1 Diabetes 1 Pancreatitis 1 Liver diagnoses:

- 1  Alcohol-related liver disease  
 1  Cirrhosis  
 1  Hepatitis B  
 1  Hepatitis C  
 1  Non-alcoholic fatty liver disease  
 1  Other liver disease (specify): \_\_\_\_\_

Surgeries IN THE 90 DAYS PRIOR:

- 1  Abdominal surgery  
 1  Non-abdominal surgery (specify) \_\_\_\_\_

Renal diagnoses:

- 1  CVVH/CVVHD IN THE 90 DAYS PRIOR  
 1  Hemodialysis – type vascular access:  
 1  AV fistula/graft  
 2  Hemodialysis CVC  
 3  Hemodialysis tunneled catheter  
 9  Unknown

1  Peritoneal dialysisOrgan transplant recipient:

- 1  Stem cell transplant  
 1  Solid organ transplant

Other diagnoses 1  \_\_\_\_\_

State ID:

Surveillance Officer Initials: \_\_\_\_\_

**OTHER CONDITIONS**

22. HIV related diagnoses: 1  HIV infection without AIDS 2  AIDS/CD4 count < 200 9  No HIV-related diagnosis

23. IV drug user: 1  Yes 2  No 3  Drug user - access type unknown 9  Unknown

24. Premature Birth (only for ≤1 year of age) 1  Yes 2  No 3  Not applicable 9  Unknown

If yes, Gestational age at birth:   wks AND Birth weight:     gms or 9  Unk

25. Infection with *Clostridium difficile* 90 days before to 30 days after initial culture date: 1  Yes 2  No 9  Unknown

If yes, date of C. Diff diagnosis:   /   /     or 9  Unk  
(mm/dd/yyyy)

26. Did the patient have a central venous catheter 2 days before, the day before, or on the day the first positive culture was drawn?

- 1  Yes
- 2  No
- 3  Had a CVC but can't find dates
- 9  Unknown

27. Were all CVCs removed or changed within 7 days after the date of first positive culture?

- 1  Yes
- 2  No
- 3  CVC removed, but can't find dates
- 4  Not applicable (no CVC)
- 9  Unknown

28. Was the patient neutropenic\* 2 days before, the day before, or on the day the first positive culture was drawn?

- 1  Yes \*Neutropenia: ANC ≤ 500 OR calculated as: WBC count \* (% polys + % bands) ≤ 500
- 2  No Laboratory-calculated ANC: \_\_\_\_\_ \* (% \_\_\_\_\_ + % \_\_\_\_\_) = \_\_\_\_\_
- 9  Unknown (no WBC days -2 to 0, or no differential)

**MEDICATIONS**

29. Did the patient receive any of these medications in the 14 days before initial positive *Candida* culture date:

Antibacterial, systemic: 1  Yes 2  No 9  Unknown Total parenteral nutrition (TPN): 1  Yes 2  No 9  Unknown

30. Did the patient receive systemic antifungal medication in the 14 days before initial positive *Candida* culture date?

- 1  Yes (fill out the table Antifungal medication prior to culture table)
- 2  No
- 9  Unknown

31. Did the patient receive systemic antifungal medication to treat candidemia on or after positive culture date?

- 1  Yes (fill out the Antifungal medication table)
- 2  No
- 9  Unknown

32. If antifungal medication was not given to treat current candidemia infection, what was the reason?

- 1  Patient died before culture result available to clinicians
- 2  Comfort care only measures were instituted
- 3  Patient discharged before culture result available to clinician
- 4  Medical records indicated culture result not clinically significant
- 5  Other reason documented in medical records, specify:  
\_\_\_\_\_
- 6  Unknown

33. If antifungal medication was given to treat current candidemia, what was the reason for stopping?

- 1  Completion of treatment
- 2  Hospital discharge
- 3  Withdrawal of care/transition to comfort care only
- 4  Death
- 5  Other, specify:  
\_\_\_\_\_
- 6  No additional records/lost to follow-up
- 7  Not applicable, no therapy given
- 8  Unknown

-----IF ANY ANTIFUNGAL MEDICATION WAS GIVEN, COMPLETE NEXT PAGE. OTHERWISE END OF CHART REVIEW FORM-----

State ID:

Surveillance Officer Initials: \_\_\_\_\_

Date of initial culture: \_\_\_\_/\_\_\_\_/\_\_\_\_

**ANTIFUNGAL MEDICATION TABLES**

Drug abbreviations:

- Amphotericin – any IV formulation (Amphotec, Amphocil, Fungizone, Abelcet, AmBiosome, etc.)=AMBIV
- Amphotericin – any inhaled formulation ( )=AMBINH
- Anidulafungin (Eraxis)=ANF
- Caspofungin (Cancidas)=CAS
- Fluconazole (Diflucan)=FLC

- Flucytosine (SFC)=5FC
- Isavuconazole (cresemba)=ISU
- Itraconazole (Sporanox)=ITC
- Micafungin (Mycamine)=MFG
- Other=OTH
- Posaconazole (Noxafil)=PSC
- UNKNOWN DRUG=UNK
- Voriconazole (Vfend)=VRC

**ANTIFUNGAL MEDICATION PRIOR TO CULTURE, DAY -14 to DAY -1**

Drug Abbrev	Indication	Date Start (mm/dd/yyyy)	Date start unknown	Date Stop (mm/dd/yyyy)	Date stop unknown
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy for another fungal infection <input type="checkbox"/> Empiric therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy for another fungal infection <input type="checkbox"/> Empiric therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy for another fungal infection <input type="checkbox"/> Empiric therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	

**ANTIFUNGAL MEDICATION TABLE, DAY 0 TO DAY 30**

Drug Abbrev	Indication	Date Start (mm/dd/yyyy)	Date start unknown	Date Stop (mm/dd/yyyy)	Date stop unknown
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	
	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Therapy <input type="checkbox"/> Unknown	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/>	

-----END OF CHART REVIEW FORM-----

# Attachment 8 Human Papillomavirus Vaccine Impact Monitoring Project



## Human Papillomavirus Vaccine Impact Monitoring Project (HPV-IMPACT) Case Report Form

### I. Patient Identifiers and Other Information—data are not transmitted to CDC

Patient Name (Last, First, M.I.): \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_ Last 4 digits of SSN: \_\_\_\_\_

Submitting Pathologist Name: \_\_\_\_\_ Pathology Lab Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Pathology Lab Medical Record Number/PTID: \_\_\_\_\_

Ordering Provider Name: \_\_\_\_\_

Practice/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Ordering Provider Medical Record Number/PTID: \_\_\_\_\_

Other Managing Provider Name: \_\_\_\_\_

Practice/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone No.: ( ) \_\_\_\_\_ Fax No. ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Other Managing Provider Medical Record Number/PTID: \_\_\_\_\_

### II. Demographics and Insurance

Patient Unique Identifier: \_\_\_\_\_ Date of Birth:     /    /     — — — —  
*mm / dd / yyyy*

**Race** (select all that apply):  White  Black or African American  Asian  American Indian/Alaska Native  
 Hawaiian/Pac Islander  Other (specify) \_\_\_\_\_  Unknown

Source of information (select all that apply):  
 Lab Report  Medical Record  Patient Interview  Vaccine Registry  
 Administrative Database  Intake Form  Other (specify) \_\_\_\_\_

**Ethnicity:**  Hispanic or Latino  Not Hispanic or Latino  Unknown

Source of information (select all that apply):  
 Lab Report  Medical Record  Patient Interview  Vaccine Registry  
 Administrative Database  Intake Form  Other (specify) \_\_\_\_\_

**Health insurance** (select all that apply):

Private/HMO/PPO/managed care plan  Medicaid/state assistance  Indian Health Service  Medicare  Military/VA  
 Self-pay  Other (specify) \_\_\_\_\_  No coverage  Unknown

Source of information (select all that apply):  
 Lab Report  Medical Record  Patient Interview  
 Administrative Database  Intake Form  Other (specify) \_\_\_\_\_

**III. Histopathology Results**

Specimen Collection Date:     /    /     Specimen ID (Accession #): \_\_\_\_\_  
mm / dd / yyyy

Final Diagnosis :  CIN 2  CIN 2/3  CIN 3  CIN 2 + AIS  CIN 2/3 +AIS  CIN 3 +AIS  AIS

Used LAST terminology :  HSIL (CIN2)  HSIL (CIN3)  HSIL (not specified)

Block No.: \_\_\_\_\_

Specimen Diagnosis:  CIN 2  CIN 2/3  CIN 3  CIN 2 + AIS  CIN 2/3 +AIS  CIN 3 +AIS  AIS

IHC stain:  Yes  No  Unknown

IHC antigen (select all that apply):  p16  Ki-67 (MIB-1)  BD ProEx C™  Other (specify) \_\_\_\_\_

Block No.: \_\_\_\_\_

Specimen Diagnosis:  CIN 2  CIN 2/3  CIN 3  CIN 2 + AIS  CIN 2/3 +AIS  CIN 3 +AIS  AIS

IHC stain:  Yes  No  Unknown

IHC antigen (select all that apply):  p16  Ki-67 (MIB-1)  BD ProEx C™  Other (specify) \_\_\_\_\_

Block No.: \_\_\_\_\_

Specimen Diagnosis:  CIN 2  CIN 2/3  CIN 3  CIN 2 + AIS  CIN 2/3 +AIS  CIN 3 +AIS  AIS

IHC stain:  Yes  No  Unknown

IHC antigen (select all that apply):  p16  Ki-67 (MIB-1)  BD ProEx C™  Other (specify) \_\_\_\_\_

Block No.: \_\_\_\_\_

Specimen Diagnosis:  CIN 2  CIN 2/3  CIN 3  CIN 2 + AIS  CIN 2/3 +AIS  CIN 3 +AIS  AIS

IHC stain:  Yes  No  Unknown

IHC antigen (select all that apply):  p16  Ki-67 (MIB-1)  BD ProEx C™  Other (specify) \_\_\_\_\_

**IV. HPV Vaccine History**

Any HPV Vaccine?  Yes, documented  No, documented  Unknown

Source of information (select all that apply):  Lab Report  Medical Record  Patient Interview  Vaccine Registry  
 Vaccine Provider Record  Administrative Database  Other

Specialty of Vaccine Provider:  Pediatrician  Family/Internal Medicine  Ob/Gyn  Other (specify) \_\_\_\_\_  Unknown

Number of doses:  1  2  3  >3  Unknown

Date of 1 <sup>st</sup> Dose	Date of 2 <sup>nd</sup> Dose	Date of 3 <sup>rd</sup> Dose	Date of 4 <sup>th</sup> Dose
Type 1 <sup>st</sup> Dose:	Type 2 <sup>nd</sup> Dose:	Type 3 <sup>rd</sup> Dose:	Type 4 <sup>th</sup> Dose:
<input type="checkbox"/> Quadrivalent (Gardasil)			
<input type="checkbox"/> Bivalent (Cervarix)			
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown

Approximate age at vaccination (if date unknown) \_\_\_\_\_

Comments: \_\_\_\_\_

**V. Cervical Cancer Screening**

Most recent screening test result (trigger test that led to current diagnosis)

Date of Pap test: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm / dd / yyyyPapTest Result:  Not done  Normal  ASCUS/ASC  ASC-H  AGUS/AGC  LSIL  
 HSIL  AIS  Other \_\_\_\_\_  UnknownDate of HPV test: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm / dd / yyyyHPV Test:  Not done  Cervista  Aptima  HC2  cobas  Other \_\_\_\_\_  Unknown

If HPV test performed:

HPV Test Result:  High Risk Positive  High Risk Negative  Unknown

If type-specific test used:

HPV Types (select all that apply):  HPV16  HPV18  Other high risk types**VI. Underlying Illness**HIV infection or AIDS:  Yes  No  UnknownImmunocompromised (ever):  Yes  No  Unknown**VII. Case Reporting****-SURVEILLANCE OFFICE USE ONLY-**Was case first identified by audit?  Yes  NoIf yes, type of audit:  Lab audit  Medical record  Administrative database  Other \_\_\_\_\_If yes, was report eventually received?  Yes  No  Needs to be requestedCRF Status:  Complete  Incomplete

Initials of person completing form: \_\_\_\_\_

Initials of data entry staff: \_\_\_\_\_

**VIII. HPV DNA Typing**

CDC barcode label: \_\_\_\_\_

**IX. Geocoding**Status of geocoding:  Matched  Unmatched

FIPS code (2010 census tract): \_\_\_\_\_ County: \_\_\_\_\_

**ArcGIS**Match score: \_\_\_\_ . \_\_\_\_ % Match type:  Automatic (A)  Manual (M)  Picked from map (PP)Geographic level:  Rooftop (1)  Street (2)  Other (3)  Insufficient (4)**Centrus**

Match code: \_\_\_\_\_

Location code:  Address geocodes (1)  Street centroids (2)  ZIP+4 centroids (3)  Not geocoded (blank)Address type:  Residential (1)  Post office box (2)  Long term care facility (3)  Corrections (4)  Military (5)  
 Homeless (6)  Other (6)  Insufficient (8)  Missing (9)