MDRO case investigation form

Patient demographics

First name:	**Middle name:**	
Last name:		
Date of birth:		
Parent/guardian:		
Address:		
City:	**State:**	**ZIP:**
Is this an address for a long-term care hospital or nursing home?	**Yes** ☐	**No** ☐
Name of facility:	**Facility type:**	
Phone number:	**Sex: M** ☐ **F** ☐	
Email address:		
Primary language:		

Ethnicity		**Race**	
Not Hispanic or Latino ☐	**Hispanic or Latino** ☐	**White** ☐	**Black or African American** ☐
		American Indian or Alaska Native ☐	**Asian** ☐
		Native Hawaiian or other Pacific Islander ☐	**Unknown** ☐

Reporting facility information

Facility name:			**Facility type:**			
Facility address:			**Was the patient in contact precautions for the duration, or part, of their stay?**		**Was this infection healthcare-facility acquired? (In a facility 2 days prior to culture collection and no previous positive culture)**	
Facility city:	**Facility state:**	**Facility ZIP:**	**Duration** ☐	**Part of stay** ☐	**Yes** ☐	**No** ☐
Was the patient admitted to the facility?	**Yes** ☐	**No** ☐	**Did the patient have a history of infection with a carbapenem resistant organism?**	**Yes** ☐		**No** ☐
			Was the patient's carbapenem resistant status communicated to the facility?	**Yes** ☐		**No** ☐

Admit date:	**Discharge date:**	**Died from illness?**	**Yes** ☐	**No** ☐	**Date of death:** *(mm/dd/yy)*

Risk factors

Was the patient admitted to an intensive care unit in the past 6 months?	**Yes** ☐	**No** ☐	**Facility name:** **Month/year:**
Was the patient transferred to any other facility from the reporting facility?	**Yes** ☐	**No** ☐	**Facility name:** **Month/year:**

Acute care hospital ☐	**Long-term care facility** ☐	**Long term acute care hospital** ☐
Was CRE status communicated to the receiving facility?	**Yes** ☐	**No** ☐
Did the patient have any surgical procedures in the past year?	**Yes** ☐	**No** ☐
List surgical procedures:		
Did the patient have any out-patient procedures in the past year?	**Yes** ☐	**No** ☐
List out-patient procedures:		
Is the patient bed-bound?	**Yes** ☐	**No** ☐
Is the patient incontinent?	**Yes** ☐	**No** ☐
Has the patient been on a ventilator in the past year?	**Yes** ☐	**No** ☐

Has the patient had exposure to any of the following devices in place in the past 6 months? (*check all that apply*)

Duodenoscope ☐	Central venous catheter ☐	Peripheral IV ☐	Dialysis catheter ☐
Urinary catheter ☐	ET/NT tube ☐	Gastrostomy tube ☐	NG tube ☐
Tracheostomy ☐	Nephrostomy tube ☐	Surgical drain ☐	Other (please specify):

Travel history

Did the patient travel outside the country in the past year?		**Location:**	**Date:**
Yes ☐	**No** ☐	**Location:**	**Date:**
Did the patient receive medical care outside the U.S.?		**Location:**	**Date:**
Yes ☐	**No** ☐	**Location:**	**Date:**
		Location:	**Date:**

Contacts		
Please list all contacts below and indicate if they are a familial contact, healthcare worker contact, or facility roommate.		
Name: _____	**Phone number:**_____	**Contact type:**_____
Name: _____	**Phone number::**_____	**Contact type:**_____
Name: _____	**Phone number:**_____	**Contact type:**_____
Name: _____	**Phone number:**_____	**Contact type:**_____
Name: _____	**Phone number:**_____	**Contact type:**_____
Name: _____	**Phone number:**_____	**Contact type:**_____
Name: _____	**Phone number:**_____	**Contact type:**_____
Additional notes:		