Patient ID:____ ____ ____ ____ ____ ____ ____ ____

–Healthcare-Associated Infections Community Interface (HAIC) Case Report–

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Patient

Address: _____ Chart Number _____
(Number, Street, Apt. No.)

_____ _____ Hospital: _____
(City, State) (Zip Code)

*– Patient identifiable information is NOT transmitted to CDC –*

# Invasive *Staphylococcus aureus*
# Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2018

Form Approved
OMB No. 0920-0978
Expires xx/xx/xxxx

*– SHADED AREAS BELOW INDICATE CORE VARIABLES –*

**1. STATE:** (Residence of patient) ☐☐

**2. COUNTY:** (Residence of patient) _____

**3. STATE I.D.:** ☐☐☐☐☐☐☐

**4a. HOSPITAL/LAB I.D. WHERE CULTURE IDENTIFIED** ☐☐☐☐☐

**4b. HOSPITAL I.D. WHERE PATIENT TREATED:** ☐☐☐☐☐

**5. SEX**
1 ☐ Male
2 ☐ Female

**6. DATE OF BIRTH** Mo. Day Year ☐☐ ☐☐ ☐☐☐☐

**7a. AGE** _____
**7b.**
1 ☐ days
2 ☐ months
3 ☐ years

**8.STERILE SITE(S) FROM WHICH *STAPHYLOCOCCUS AUREUS* WAS INITIALLY ISOLATED: (Check all that apply)**
☐ Blood ☐ Pericardial fluid ☐ Internal body site (specify) _____
☐ CSF ☐ Joint/Synovial fluid
☐ Pleural fluid ☐ Bone ☐ Other sterile site (specify) _____
☐ Peritoneal fluid ☐ Muscle

**9. DATE OF INITIAL CULTURE** Mo. Day Year ☐☐ ☐☐ ☐☐☐☐
☐ MRSA ☐ MSSA

**10a. WAS THE PATIENT HOSPITALIZED AT THE TIME OF, OR WITHIN 30 CALENDAR DAYS AFTER, INITIAL CULTURE?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
**If YES: Date of admission** Mo. Day Year ☐☐ ☐☐ ☐☐☐☐

**11. WAS CULTURE COLLECTED >3 CALENDAR DAYS AFTER HOSPITAL ADMISSION?**
1 ☐ Yes (HO-SA case) 2 ☐ No

**12a. ETHNIC ORIGIN:**
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
9 ☐ Unknown

**12b. RACE:** (check all that apply)
1 ☐ White
1 ☐ Black or African American
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ Unknown

**10b. IF PATIENT WAS HOSPITALIZED, WAS THE PATIENT ADMITTED TO THE ICU DURING HOSPITALIZATION?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**12c. WEIGHT:** 1 ☐ Unknown
_____ lbs _____ oz OR _____ kg

**12d. HEIGHT:** 1 ☐ Unknown
_____ ft _____ in OR _____ cm

**12e. BMI:** 1 ☐ Unknown
_____ (do not calculate, only if available in the MR)

**13. At the time of the first positive culture, patient was:**
1 ☐ Pregnant
2 ☐ Post-partum
3 ☐ Neither
9 ☐ Unknown

**14. If case is ≤12 months of age, type of birth hospitalization:**
1 ☐ NICU/SCN
2 ☐ Well Baby Nursery
9 ☐ Unknown

**15. Where was the patient located on the 4th calendar day prior to the date of the initial culture?**
1 ☐ Private Residence
1 ☐ Long Term Care Facility
Facility: _____
1 ☐ Long Term Acute Care Hospital
Facility: _____
1 ☐ Homeless
1 ☐ Incarcerated
1 ☐ Hospital Inpatient
Facility: _____
1 ☐ Incarcerated
1 ☐ Other _____
9 ☐ Unknown

**16. LOCATION OF CULTURE:** (Check one)
**Hospital Inpatient**
1 ☐ ICU
6 ☐ Surgery/OR
7 ☐ Radiology
2 ☐ Other Unit
**Outpatient**
8 ☐ Clinic/ Doctors Office
11 ☐ Surgery
15 ☐ Dialysis/Renal Clinic
4 ☐ Other Outpatient
3 ☐ Emergency Room
16 ☐ Observational Unit/Clinical Decision Unit
5 ☐ LTCF Facility: _____
3 ☐ LTACH Facility: _____
14 ☐ Autopsy
9 ☐ Unknown
10 ☐ Other

**17a. Were cultures of the SAME or OTHER sterile site(s) positive within 30 days after initial culture date?**
1 ☐ Yes 2 ☐ No 9 ☐ Unknown

**If yes, indicate site and date of last positive culture:**
1 ☐ Blood, Date: _____
1 ☐ CSF, Date: _____
1 ☐ Pleural fluid, Date: _____
1 ☐ Peritoneal fluid, Date: _____
1 ☐ Pericardial fluid, Date: _____
1 ☐ Joint/Synovial fluid, Date: _____
1 ☐ Bone, Date: _____
1 ☐ Muscle, Date: _____
1 ☐ Internal body site Date: _____
1 ☐ Other sterile site (specify) _____ Date: _____

**18. PATIENT OUTCOME:** 9 ☐ Unknown
1 ☐ Survived Mo. Day Year ☐☐ ☐☐ ☐☐☐☐
2 ☐ Died Mo. Day Year ☐☐ ☐☐ ☐☐☐☐

- If survived, was the patient transferred to a LTCF? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown **If Yes**, Facility: _____
- If survived, was the patient transferred to a LTCAH? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown **If Yes**, Facility: _____

- Was MRSA cultured from a normally sterile site < calendar day 7 before death?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown
- Was MSSA cultured from a normally sterile site < calendar day 7 before death?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown



– IMPORTANT – PLEASE COMPLETE THE BACK OF THIS FORM –

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

| | | | | |
|---|---|---|---|---|
| 1 ☐ Abscess (not skin) | 1 ☐ Cellulitis | 1 ☐ Epidural Abscess | 1 ☐ Septic Arthritis | 1 ☐ Surgical Site (Internal) |
| 1 ☐ AV Fistula/Graft Infection | 1 ☐ Chronic Ulcer/Wound(non-decubitus) | 1 ☐ Meningitis | 1 ☐ Septic Emboli | 1 ☐ Traumatic Wound |
| 1 ☐ Bacteremia | 1 ☐ Decubitis/Pressure Ulcer | 1 ☐ Peritonitis | 1 ☐ Septic Shock | 1 ☐ Urinary Tract |
| 1 ☐ Bursitis | 1 ☐ Empyema | 1 ☐ Pneumonia | 1 ☐ Skin Abscess | 1 ☐ Other: (specify) |
| 1 ☐ Catheter Site Infection | 1 ☐ Endocarditis | 1 ☐ Osteomyelitis | 1 ☐ Surgical Incision | _____ |

**20. UNDERLYING CONDITIONS**: (Check all that apply) (if none or no chart available, check appropriate box) 1 ☐ None 1 ☐ Unknown

| | | | |
|---|---|---|---|
| 1 ☐ Abscess/Boil (Recurrent) | 1 ☐ CVA/Stroke | 1 ☐ IVDU | 1 ☐ Solid Tumor (non metastatic) |
| 1 ☐ AIDS | 1 ☐ Cystic Fibrosis | 1 ☐ Metastatic Solid Tumor | 1 ☐ Other: (specify only for cases ≤ 12 months of age) _____ |
| 1 ☐ Chronic Cognitive Deficit | 1 ☐ Decubitis/Pressure Ulcer | 1 ☐ Myocardial Infarct | |
| 1 ☐ Chronic Liver Disease | 1 ☐ Dementia | 1 ☐ Obesity | |
| 1 ☐ Chronic Pulmonary Disease | 1 ☐ Diabetes | 1 ☐ Other Drug Use | |
| 1 ☐ Chronic Kidney Disease | 1 ☐ Hematologic Malignancy | 1 ☐ Peptic Ulcer Disease | |
| 1 ☐ Chronic Skin Breakdown | 1 ☐ Hemiplegia/Paraplegia | 1 ☐ Peripheral Vascular Disease (PVD/PAD) | |
| 1 ☐ Congestive Heart Failure | 1 ☐ HIV | 1 ☐ Premature Birth | |
| 1 ☐ Connective Tissue Disease | 1 ☐ Influenza (within 10 days of initial culture) | Birth Weight _____lb _____oz OR _____g | |
| 1 ☐ Current Smoker | | Estimated gestational age _____ weeks | |

**21. PRIOR HEALTHCARE EXPOSURE – Healthcare-associated and Community-associated:** (Check all that apply) 1 ☐ None 1 ☐ Unknown

1 ☐ Previous documented MRSA infection or colonization
Month Year OR previous STATE I.D.:
**IF YES:** ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐

1 ☐ Previous documented MSSA infection or colonization
Month Year OR previous STATE I.D.:
**IF YES:** ☐☐ ☐☐☐☐ ☐☐☐☐☐☐☐

1 ☐ Hospitalized within year before initial culture date.
**Date of discharge**
Mo. Day Year 1 ☐ Unknown
**IF YES:** ☐☐ ☐☐ ☐☐☐☐

If known, Facility: _____

1 ☐ Surgery within year before initial culture date.

If yes, list the surgeries and dates of surgery that occurred within 90 days prior to the initial culture:

| Surgery | Date |
|---|---|
| 1. _____ | ___/___/___ |
| 2. _____ | ___/___/___ |
| 3. _____ | ___/___/___ |
| 4. _____ | ___/___/___ |

1 ☐ Dialysis within year before initial culture date. *(Hemodialysis or Peritonial dialysis)*

1 ☐ Current chronic dialysis
Type ☐ Peritoneal ☐ Unknown
☐ Hemodialysis
Type of vascular access
☐ AV fistula/graft
☐ Hemodialysis CVC
☐ Unknown

1 ☐ Residence in a long-term care facility within year before initial culture date. If known, Facility: _____

1 ☐ Admitted to a LTACH within year before initial culture date. If known, Facility: _____

1 ☐ Central vascular catheter in place at at any time in the 2 calendar days prior to initial culture.

**22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]**

| | | | |
|---|---|---|---|
| Cefoxitin ☐ S ☐ I ☐ R ☐ U | Oxacillin ☐ S ☐ I ☐ R ☐ U | Vancomycin ☐ S ☐ I ☐ R ☐ U |
| Clindamycin ☐ S ☐ I ☐ R ☐ U | Trimethoprim-Sulfamethoxazole ☐ S ☐ I ☐ R ☐ U | |

## – THIS SHADED AREA FOR OFFICE USE ONLY –

| 23. Was case first identified through audit? | 24. CRF Status: | 25. Does this case have recurrent MSSA/MRSA disease? | If YES, previous: (1st) STATE I.D.: | 26. Date reported to EIP site: | 27. Initials of S.O.: |
|---|---|---|---|---|---|
| 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | 1 ☐ Complete 2 ☐ Incomplete 3 ☐ Edited & Correct 4 ☐ Chart unavailable after 3 requests | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown | ☐☐☐☐☐☐☐ | Mo. Day Year ☐☐ ☐☐ ☐☐☐☐ | _____ |

**28. COMMENTS:** _____