Vermont Department of Health

CARBEPENUM RESISTANT ENTEROBACTERIACEAE (CRE) WORKSHEET

Instructions: When a case of CRE is identified in a Vermont Healthcare Facility, the facility should conduct a single round of active surveillance testing of patients who have shared the same room, via rectal /peri-rectal swab. All cases of Carbepenum resistant enterobacteriaceae are reportable to the Vermont Department of Health (VDH). **Attach copy of culture and sensitivity results**

MR # _____ Facility _____ Date _____

Patient Demographics

Last Name _____ First Name _____ MI _____ DOB _____/_____/_____ Age _____ Sex _____ M/F

Street Address _____ Town _____ State _____Zip _____ Phone (____)_____-_____

Primary Care Provider _____ Town _____ State _____ Phone (____)_____-_____

Date VDH contacted the PCP _____/_____/_____ **Did this patient have an ERCP?** ☐ Yes ☐ No **If yes date ___/____/_____where** _____

Clinical Information ☐ Inpatient ☐ Outpatient Diagnosis _____

Date of admission _____/_____/_____ Date of Discharge _____/_____/_____ Admitted to ICU? ☐ Yes ☐ No Pregnant ? ☐ Yes ☐ No ☐ Unknown

Underlying high-risk medical condition? ☐ Yes ☐ No ☐ Unknown _____
Specify (include chronic pulmonary, cardiovascular, hepatic, hematological, neurological, neuromuscular, or metabolic disorders, or compromised immune systems)

_____

Specimen source: ☐ blood ☐ Urine ☐ CSF ☐ wound (wound location: _____) ☐ other source (specify _____)

Isolate sent to VDH lab? ☐ Yes ☐ No Date____/_____/_____ Isolate sent to CDC lab? ☐ Yes ☐ No Date _____/_____/_____

Primary Patient Discharge Information

Referral on discharge to LTCF? ☐ Yes ☐ No If yes, name of LTCF _____

Referral on discharge to HHCA? ☐ Yes ☐ No If yes, name of HHCA _____

Contact at facility _____ Phone _____ Date _____/_____/_____ Time _____

History of previous hospitalization, resident of LTCF, or patient of Home Health

Facility _____ Room # _____ Unit _____ Admission Date ____/____/____ Discharge Date ____/____/____

Town _____ State _____ Facility Contact _____ Phone # _____

History of previous hospitalization, resident of LTCF, or patient of Home Health, con't

Care Provider at previous facility _____ Phone # _____

Diagnosis on admission _____ Diagnosis at transfer _____

Results of notification _____

Roommate Information

Did the patient have a Roommate? ☐ Yes ☐ No **If NO: Stop Here If YES: Continue**

1. Name _____ DOB ____/____/____ Age _____ Admission Date ____/____/____ Discharge Date ____/____/____

   Room # _____ Dates shared room with Case ____/____/____ - ____/____/____

   Town _____ State _____ Contact _____

   Primary Care Provider _____ Phone # _____

   Referral on discharge to LTCF? ☐ Yes ☐ No If yes, name of LTCF _____

   Referral on discharge to HHCA? ☐ Yes ☐ No If yes, name of HHCA _____

   Results of notification _____

2. Name _____ DOB ____/____/____ Age _____ Admission Date ____/____/____ Discharge Date ____/____/____

   Room # _____ Dates shared room with Case ____/____/____ - ____/____/____

   Town _____ State _____ Contact _____

   Primary Care Provider _____ Phone # _____

   Referral on discharge to LTCF? ☐ Yes ☐ No If yes, name of LTCF _____

   Referral on discharge to HHCA? ☐ Yes ☐ No If yes, name of HHCA _____

   Results of notification _____

If more than 2 contacts, use another page and number the contacts 3,4,5, etc

Case entered into NDS ☐ Yes ☐ No DATE _____