Manage Pages: View Page

View Page

TEST_MDRO

Patient Information

General Information

* Information As of Date:
Comments:

Name Information

Name Information As Of Date:
First Name:
Middle Name:
Last Name:
Suffix:

Other Personal Details

Other Personal Details As Of Date:
Date of Birth:
Reported Age:
Reported Age Units:
Country of Birth:
Current Sex:
Mortality Information As Of Date:
Is the patient deceased?:
Deceased Date:
Marital Status As Of Date:
Marital Status:

Reporting Address for Case Counting

Address Information As Of Date:
Street Address 1:
Street Address 2:
City:
State:
Zip:
County:
Country:

Telephone Information

Telephone Information As Of Date:
Home Phone:
Work Phone:
Ext.:
Cell Phone:
Email:

Ethnicity and Race Information

Ethnicity Information As Of Date:
Ethnicity:
Race Information As Of Date:
Race: American Indian or Alaska Native
Asian
Black or African American
Native Hawaiian or Other Pacific Islander
White
Other
Refused to answer
Not Asked
Unknown

Investigation Information

Investigation Details

Investigation Details

* Jurisdiction:
* Program Area:
Investigation Start Date:
* Investigation Status:
* Shared Indicator:
State Case ID:
Legacy Case ID:

Investigator

Investigator: - OR -
Investigator Selected:
Date Assigned to Investigation:

Reporting Information

Key Report Dates

Date of Report:
Reference Date:

Reporting Organization

Reporting Source Type:
Reporting Organization: - OR -
Reporting Organization Selected:

Reporting Provider

Reporting Provider: - OR -
Reporting Provider Selected:

Reporting County

Reporting County:

Clinical

Condition

Diagnosis Date:
Illness Onset Date:
Age at Onset:
Age at Onset Units:
Did the patient die from this illness?:
Outcome:
Date of Death:

Hospital

Was patient seen at an Emergency Department?:
Date Seen:
Visit MRN:
Was the patient hospitalized for this illness?:
Hospital: - OR -
Hospital Selected:
Admission Date:
From where was the admitted patient transferred?:
Was a transfer form used on admit?:
Ward type during stay:
Was patient on contact precautions?:
Start Date of contact precautions:
Was the patient in a single room setting/isolation?:
Was patient discharged from hospital?:
Discharge Date:
To where was the discharged patient transferred?:
Was a transfer form used on discharge?:
Does this patient live in a long-term care facility?:

Treatment

Was the patient treated with antibiotics after onset of this illness?:
What antibiotic was prescribed?:
Prescription Start date:
Prescription End Date:

Patient Location

Patient Location

Provide the facility information where the patient was treated:

Facility Name:
Facility Address:
Facility Contact Name:
Facility Contact Phone Number:

Laboratory

Laboratory Test Information

Was lab testing done?:
Specimen Collection Date:
Specimen Type:
Specimen Source:
Organism:
Was phenotypic testing conducted?:
Phenotypic test:
Phenotypic test result:
Was molecular testing performed?:
Mechanism:
Other Mechanism:
Was antibiotic susceptibility testing performed for this organism?:

Antibiotic Susceptibility

	Antibiotic	MIC	Susceptibility Interpretation
No Data has been entered.			

Antibiotic:
MIC:
Susceptibility Interpretation:

Epidemiologic

Medical History

Does the patient have a history of drug-resistant infection(s) or colonization?:
MRSA:
VRE:
VRSA:
CRE:
ESBL:
Drug-resistant Acinetobacter baumannii:
Drug-resistant Pseudomonas aeruginosa:
Does this patient have underlying conditions?:
Chronic renal insufficiency/Chronic Kidney Disease:
Diabetes mellitus:
Emphysema/COPD:
Heart Failure/CHF:
Acute/Chronic Respiratory failure:
Para/Hemi/Quadri-plegia:
Obesity:
Wound/Ulcer/Abscess:
Chronic/Recurring UTI:
Cancer/Malignancy:
Other, please specify:
Has the patient received vancomycin in the past year?:

Prior Antibiotic Use

Was patient taking antibiotics in the last 30 days prior to diagnosis?:

Prior Antibiotic Use Information

	Antibiotic	Prescription start date	Prescription end date
No Data has been entered.			

Antibiotic:
Prescription start date:
Prescription end date:

Medical Procedure

Did the patient have any invasive medical procedures within the past six months?:

Medical Procedure Information

	Procedure Type	Procedure Date	Procedure Location
No Data has been entered.			

Procedure Type:
Procedure Date:
Procedure Location:

Invasive Devices

Did the patient have any invasive devices within two days of specimen collection?:
Central venous/PICC line:
Urinary Catheter:
Mechanical Ventilator:
Gastrojejunostomy tube (G/J Tube):
Wound V.A.C.:
Percutaneous Endoscopic Gastrostomy (PEG):
Hemodialysis port:

Acute Care Hospitalization

Was the patient hospitalized within the past six months in an Acute Care Facility?:

Acute Care Hospitalization Information

	Facility Name	Facility Address	Facility Contact Name	Facility Contact Phone Number
No Data has been entered.				

Facility Name:
Facility Address:
Facility Contact Name:
Facility Contact Phone Number:

Long Term Acute Care Hospitalization

Was the patient hospitalized within the past six months in a Long Term Acute Care Facility?:

Long Term Acute Care Hospitalization Information

	Facility Name	Facility Address	Facility Contact Name	Facility Contact Phone Number
No Data has been entered.				

Facility Name:
Facility Address:
Facility Contact Name:
Facility Contact Phone Number:

Long Term Care Residency

Was the patient a resident in a Long Term Care facility within the past six months?:

Long Term Care Residency Information

	Facility Name	Facility Address	Facility Contact Name	Facility Contact Phone Number
No Data has been entered.				

Facility Name:
Facility Address:
Facility Contact Name:
Facility Contact Phone Number:

Travel History

Travel Out of United States

Travel outside of the United States 6 months prior to illness onset?:
Did the patient receive medical treatment or hospitalization while outside of the United States?:

Travel Out of United States Information

Travel Out of United States Information

	Other country patient traveled to	Date of departure	Date of return	Reason for travel
No Data has been entered.				

Other country patient traveled to:
Date of departure:
Date of return:
Reason for travel:
Other Reason for travel:

Travel Out of Indiana

Travel outside the state of Indiana 6 months prior to illness onset?:
Did the patient have exposure to healthcare outside the state of Indiana within the past six months?:

Travel Out of Indiana Information

	Other state patient traveled to	Date of departure	Date of return	Reason for travel
No Data has been entered.				

Other state patient traveled to:
Date of departure:
Date of return:
Reason for travel:
Other Reason for travel:

Close Contact Travel

Has the patient had contact with anyone recently returning from travel outside the country?:

Close Contact Travel Information

	Travel location of close contact	Date of departure	Date of return
No Data has been entered.			

Travel location of close contact:
Date of departure:
Date of return:

Case Status

Case Status

Transmission Mode:
Detection Method:
Confirmation Method: *(Use Ctrl to select more than one)*
Selected Values:
Confirmation Date:
Case Status:
MMWR Week:
MMWR Year:
Immediate National Notifiable Condition:
If yes, describe:
Date CDC Was First Verbally Notified of This Case:
Notification Comments to CDC:

General Comments

General Comments

General Comments:

Supplemental Demographic Information

Demographic Information

Id like to finish up by asking you a series of questions about your background. These questions provide us with highly useful information about how different illnesses affect different groups of people.

We are asking these questions so we can target our efforts to prevent infectious diseases [or insert disease name] in Indiana.

You can choose not to answer a question at any point. Any information you give me will be confidential and will not be released to outside of public health, including your medical care team and insurance provider. Do you have any questions?

Demographic Information

If no: Okay, feel free to ask questions at any time. [Proceed to questions]

What is the highest grade or year of school you completed?:
What is the patient's current employment status?:
Type of Insurance: *(Use Ctrl to select more than one)*
Selected Values:
Other Type of Insurance:
What is the patient's current housing status?:
Other What is the patient's current housing status?:
Household Size:
In the past 12 months, have you delayed receiving healthcare for any of the following reasons?: *(Use Ctrl to select more than one)*
Selected Values:
Annual household income from all sources in past 12 months:

Contact Investigation

Risk Assessment

Contact Investigation Priority:
Infectious Period From:
Infectious Period To:

Administrative Information

Contact Investigation Status:
Contact Investigation Comments:

Contact Records

Contacts Named By Patient

The following contacts were named within Walter White's investigation:

Date Named	Contact Record ID	Name	Priority	Disposition	Investigation ID
Nothing found to display.					

Patient Named By Contacts

The following contacts named Walter White within their investigation and have been associated to Walter White's investigation:

Date Named	Contact Record ID	Named By	Priority	Disposition	Investigation ID
Nothing found to display.					

Associations

Associated Lab Reports

Ordered Test	Resulted Test(s)
Nothing found to display.	

Associated Morbidity Reports

Date Received	Condition	Report Date	Type	Observation ID
Nothing found to display.				

Associated Treatments

Date	Treatment	Treatment ID
Nothing found to display.		

Associated Vaccinations

Date Administered	Vaccine Administered	Vaccination ID
Nothing found to display.		

Associated Documents

Date Received	Type	Purpose	Description	Document ID
Nothing found to display.				

Notes And Attachments

Notes

Date Added	Added By	Note	Private
Nothing found to display.			

Attachments

Date Added	Added By	File Name	Description
Nothing found to display.			

History

Investigation History

No history found to display.

Notification History

No Notification History found.