CP-CRE Case Investigation

Patient Information

General Information

Date: _____

Comments:

Name Information

First Name: _____

Middle Name: _____

Last Name: _____

Other Personal Details

Date of Birth: _____

Reported Age: _____

Reported Age Units: _____

Country of Birth _____

Current Sex : ☐ Male ☐ Female

Is the patient deceased? ☐ Yes ☐ No ☐ Unknown

Deceased Date: _____

Marital Status: _____

Reporting Address for Case Counting

Street Address 1: _____

Street Address 2: _____

City: _____

State: _____

Zip: _____

County: _____

Telephone Information

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email: _____

Ethnicity and Race Information

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic or Latino

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

Clinical

Condition

Diagnosis Date: _____

Illness Onset Date: _____

Age at Onset: _____

Did the patient die from this illness?: ☐ Yes ☐ No ☐ Unknown

Outcome: ☐ Survived ☐ Death Due to Condition ☐ Death Unrelated ☐ Unknown

Deceased Date: _____

Hospital

Was patient seen at an emergency department?: ☐ Yes ☐ No ☐ Unknown

Date Seen: _____

Visit MRN: _____

Was the patient hospitalized for this illness?: ☐ Yes ☐ No ☐ Unknown

Hospital: _____

Admission Date: _____

From where was the admitted patient transferred:

☐ Acute Care Hospital ☐ Home ☐ Long Term Acute Care Hospital
☐ Long Term Care Facility ☐ Other: _____

Was a transfer form used on admit?: ☐ Yes ☐ No ☐ Unknown

Ward type during stay: ☐ ICU ☐ Non-ICU ☐ Other: _____

Was patient on contact precautions?: ☐ Yes ☐ No ☐ Unknown

Start Date: _____

Was the patient in a single room setting/isolation?: ☐ Yes ☐ No ☐ Unknown

Was patient discharged from hospital?: ☐ Yes ☐ No ☐ Unknown

Discharge Date: _____

To where was the discharged patient transferred?:

☐ Acute Care Hospital ☐ Home ☐ Long Term Acute Care Hospital
☐ Long Term Care Facility ☐ Other: _____
☐ Unknown

Was a transfer form used on discharge?: ☐ Yes ☐ No ☐ Unknown

Treatment

Was the patient treated with antibiotics after onset of this illness?: ☐ Yes ☐ No ☐ Unknown

Antibiotic(s): _____

Start Date: _____

End Date: _____

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?: ☐ Yes ☐ No ☐ Unknown

Specimen Collection Date: _____

Specimen Type: ☐ Clinical Specimen ☐ Screening Specimen

Specimen Source: _____

Organism: _____

Was phenotypic testing conducted?: ☐ Yes ☐ No ☐ Unknown

Phenotypic Test: ☐ CarbaNP ☐ MBL test ☐ CIM ☐ mCIM
☐ Modified Hodge test ☐ Other: _____

Phenotypic Test Result: ☐ Positive ☐ Negative

Was molecular testing performed?: ☐ Yes ☐ No ☐ Unknown

Mechanism: ☐ KPC ☐ NDM ☐ VIM ☐ OXA-48 ☐ IMP
☐ Other: _____ ☐ Unknown

Was antibiotic susceptibility testing performed for this organism?: ☐ Yes ☐ No ☐ Unknown

☐ Amikacin: MIC _____ ☐ Amoxicillin-clavulanate: MIC _____
☐ Ampicillin: MIC _____ ☐ Ampicillin-sulbactam: MIC _____
☐ Aztreonam: MIC _____ ☐ Cefazolin: MIC _____
☐ Cefepime: MIC _____ ☐ Cefotaxime: MIC _____
☐ Cefoxitin: MIC _____ ☐ Ceftazidime: MIC _____
☐ Ceftolozane-tazobactam: MIC _____
‘ ☐ Ceftriaxone: MIC _____ ☐ Cefuroxime: MIC _____
☐ Ciprofloxacin: MIC _____ ☐ Colistin: MIC _____
☐ Doripenem: MIC _____ ☐ Ertapenem: MIC _____
☐ Gentamicin: MIC _____ ☐ Imipenem: MIC _____
☐ Levofloxacin: MIC _____ ☐ Meropenem: MIC _____
☐ Nitrofurantoin: MIC _____ ☐ Tobramycin: MIC _____
☐ Piperacillin-tazobactam: MIC _____
☐ Trimethoprim-sulfamethoxazole: MIC _____

Epidemiologic

Medical History

Does the patient have a history of drug-resistant infection/colonization?: ☐ Yes ☐ No ☐ Unknown

☐ MRSA ☐ VRE ☐ VRSA ☐ CRE ☐ ESBL

☐ Drug-resistant *Acinetobacter baumannii* complex

☐ Drug-resistant *Pseudomonas aeruginosa*

Does this patient have underlying conditions?: ☐ Yes ☐ No ☐ Unknown

☐ 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: _____

Prior Antibiotic Use

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

☐ Yes ☐ No ☐ Unknown

Antibiotic: _____ Antibiotic: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Antibiotic: _____ Antibiotic: _____

Start Date: _____ Start Date: _____

End Date: _____ End Date: _____

Medical Procedure

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

☐ Yes ☐ No ☐ Unknown

Procedure(s): _____

Procedure Date: _____

Procedure Location: _____

Invasive Devices

Did the patient have any invasive devices within two days of specimen collection?:

☐ Yes ☐ No ☐ Unknown

Type: ☐ 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?:

☐ Yes ☐ No ☐ Unknown

Facility Name: _____

Facility Address: _____

Facility Contact Name: _____

Facility Contact Phone Number: _____

Long Term Acute Care Hospitalization Information

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

☐ Yes ☐ No ☐ Unknown

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?:

☐ Yes ☐ No ☐ Unknown

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?:

☐ Yes ☐ No ☐ Unknown

Did the patient receive medical treatment while outside of the United States?

☐ Yes ☐ No ☐ Unknown

Travel Out of Indiana

Travel outside the state of Indiana 6 months prior to illness onset?:

☐ Yes ☐ No ☐ Unknown

Did the patient have exposure to healthcare outside the state of Indiana within the past six months?:

☐ Yes ☐ No ☐ Unknown

Location	*Reason for Travel*	*Arrived at Location*	*Left from Location*

Close Contact Travel

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

☐ Yes ☐ No ☐ Unknown

Travel location of close contact: _____

Date of departure: _____

Date of return: _____

Case Status

Case Status:

Transmission Mode: _____

Detection Method: _____

Confirmation Method: _____

Confirmation Date: _____

Case Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a Case ☐ Unknown

MMWR Week: _____

MMWR Year: _____

Immediate National Notifiable Condition: ☐ Yes ☐ No ☐ Unknown

Supplemental Demographic Information

Demographic Questions

What is the highest grade or year of school you completed?: _____

What is the patient's current employment status?: _____

Type of Insurance: _____

What is the patient's current housing status?: _____

In the past 12 months, have you delayed receiving health care?: ☐ Yes ☐ No ☐ Unknown

Specify: _____

Annual household income from all sources in past 12 months: _____

General Comments