HEALTHCARE-ASSOCIATED INFECTION (HAI) OUTBREAK INVESTIGATION ABSTRACTION FORM

Name: _____

Medical Record Number: _____

ID Number: _____

Facility Name: _____

ID Number: _____
Chart Abstraction Dates (Exposure Period): _____to _____

Today's Date:	**Abstractor Initials:**

Date of Illness Onset: _____/_____/_____

For Case/Control Study

Patient is a: ☐ Case ☐ Control – Linked to Case ID#: (_____)

Demographics

Gender: ☐ Male ☐ Female	**DOB:** _____/_____/_____

Race/Ethnicity:

☐ African American
☐ White
☐ Asian/PI
☐ Native American
☐ Hispanic
☐ Non-Hispanic
☐ Other:

Inpatient Admission Information

Admit Date: _____/_____/_____	**Admit Room #:**

Facility Room (Entire Admission)

Unit	Room #	Date In	Date Out

Admit Service:	**Admit Unit:** ☐ ICU – Type of ICU: MICU_____ CCU_____ SICU_____ ☐ Med/Surg Floor ☐ Step-down/Telemetry ☐ Other _____

Admit Diagnoses:

Admit Source:
☐ Home
☐ Long-term Acute Care Hospital (LTACH)
☐ Nursing Home
☐ Rehabilitation Facility
☐ Other Facility – In any ICU prior to this ICU admit?: ☐ Y ☐ N
☐ Other _____

Admit to this facility in last 30 days: ☐ Yes ☐ No	**Admit to other facility in last 30 days:** ☐ Yes ☐ No **Date:** _____/_____/_____ **Facility Name:** _____

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Status of Hospitalization:

☐ Still Inpatient

☐ Discharged Home: _____/_____/_____

☐ Transfer to other facility – Name: _____ Date: _____/_____/_____

☐ Deceased – Date of Death: _____/_____/_____ Cause of Death: _____

If deceased, was autopsy performed? ☐ Yes ☐ No If yes, Autopsy Date: _____/_____/_____

Autopsy Findings:_____
_____
_____
_____

Diagnoses at Discharge: (List all diagnoses appearing in the chart)

_____
_____
_____
_____
_____

Outpatient

Date started in clinic: _____/_____/_____

Date	Procedure or Infusion	Additional Visit Information
		☐ Neutropenia ☐ Vascular access Site/Type: _____
		☐ Neutropenia ☐ Vascular access Site/Type: _____
		☐ Neutropenia ☐ Vascular access Site/Type: _____
		☐ Neutropenia ☐ Vascular access Site/Type: _____

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Clinical History

History of Present Illness (Give a brief summary of the patient's illness and include any other relevant information not otherwise collected on this form):

_____
_____
_____
_____
_____

Past Medical History:

☐ Chronic Lung Disease
☐ Coronary Artery Disease
☐ Congestive Heart Failure (EF_____)
☐ Diabetes (AIC_____)
☐ Peripheral Vascular Disease
☐ Gastrointestinal disease/bleeding
☐ Liver Disease/Cirrhosis
☐ Chronic kidney disease (creatinine _____)
☐ Dialysis Dependent
☐ Other Immunosuppression (specify: _____)

☐ HIV/AIDS (CD4 _____)
☐ Major Trauma (30d PTA)
☐ Previous Surgery (30d PTA)
☐ Obesity
☐ Malignancy (type_____)
☐ Cerebrovascular Disease
☐ Hypertension
☐ Other: _____
☐ Other: _____

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Clinical Course

Site of Infection (check all that apply): ☐ Respiratory ☐ Blood ☐ Surgical/Wound ☐ Urine ☐
Other:_____

Date of Illness Onset: _____/_____/_____ | **Date of positive culture (if applicable):** _____/_____/_____

Previous history of this infection in last 30 days? (Specify:_____)

Did patient receive antimicrobial therapy for this illness? ☐ Yes ☐ No ☐ N/A Date: _____ /_____/ _____

Abnormal Vital Signs (within 48 hours of illness onset):

☐ Fever >38℃ or 100.4℉ ☐ Hypoxia (O2Sat < 92% on room air) ☐ Hypotension (BP <(90/60))
☐ Tachypnea (RR > 25) ☐ Tachycardia (HR > 100)

Clinical signs and symptoms (within 48 hours of illness onset)

General:
☐ Altered Mental Status ☐ Loss of appetite
☐ Chills ☐ Weight Loss

Respiratory:
☐ Dyspnea (i.e., difficulty breathing) ☐ Rales/Crackles
☐ Hemoptysis (i.e., coughing up blood) ☐ Rhinorrhea (i.e., runny nose)
☐ New Increased Sputum: ☐ Sore throat
☐ Purulent ☐ Wheezing
☐ Change in character (e.g., color, quantity, etc.) ☐ Worsening gas exchange (e.g., increased O2, PEEP, TV)
☐ New onset cough

GI:
☐ Abdominal Pain ☐ Diarrhea ☐ Nausea/Vomiting
☐ Bloating ☐ Hematochezia (i.e., red blood in stool)
☐ Constipation ☐ Melena (i.e., black, tarry stool)

Urinary:
☐ Dysuria
☐ Suprapubic Tenderness
☐ Urinary urgency

Skin:
☐ Abscess
☐ Cellulitis
☐ Furuncle (i.e., skin boil)
☐ Rash
☐ Wound – Description (include # of wounds, sites, draining and other characteristics)

_____
_____

Laboratory: List abnormal labs within 48 hours of illness onset (if more than one, list the value closest to illness onset)

1. Creatinine _____
2. HCO3 _____
3. Hematocrit _____
4. INR _____
5. pH _____
6. Platelets _____
7. PTT _____
8. WBC _____

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Microbiology: (7 days prior to illness onset until end of abstraction period)

Date	Specimen Source (e.g., blood, urine)	Site (e.g., catheter, peripheral)	Result (e.g., organism)
			`

Radiology (e.g., X rays, CTs, U/S, etc.): (7 days prior to illness onset until end of abstraction period)

Date	Type of Study	Location (e.g., bedside, radiology)	Result

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ANTIMICROBIALS

Name	Dose/Route	Start Date	End Date

IV MEDICATIONS

Name	Dose/Route	Start Date	End Date

OTHER MEDICATIONS (e.g., immunosuppressives or inhaled/nebulized medications)

Name	Dose/Route	Start Date	End Date

Blood Products (7 days prior to end of abstraction period)

Type of Blood Product	Volume Transfused	Date

Mechanical Ventilation (7 days prior to end of abstraction period)

Type: (Endotracheal, Tracheostomy)	Start Date	End Date
CPAP/BIPAP: ☐ Yes ☐ No	Start Date: _____/_____/_____	End Date: _____/_____/_____

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Devices (7 days prior to end of abstraction period)

Device	Site	Date Inserted	Date Removed
☐ Central Venous Catheter			
☐ Central Venous Catheter			
☐ Central Venous Catheter			
☐ Condom Catheter			
☐ Foley Catheter			
Feeding Tube: ☐ Nasogastric/Nasoduodenal ☐ PEG/PEJ (stomach)			
☐ Other			

Point of care testing/injections/infusions (7 days prior to end of abstraction period)

Procedure	Dates
☐ Blood Glucose Monitoring	

Invasive Procedures (7 days prior to end of abstraction period)

Date	Type of procedure	Location (e.g., Bedside, OR, Radiology)

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Consult Services (7 days prior to end of abstraction period): ☐ Yes ☐ No		
Service	**Start Date**	**End Date**
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Speech Therapy/Language		
☐ Respiratory Therapy		
☐ Wound Care Team		
☐ Other: _____		
☐ Other: _____		
☐ Other: _____		