MARION COUNTY PUBLIC HEALTH DEPARTMENT
Prevent. Promote. Protect.

# Carbapenem-resistant Enterobacteriaceae

**Please submit one report per patient per admission within 72 hours**
**Fax form to MCPHD Infectious Disease (317) 221-2076**

Reporter name _____
Facility/Address _____
Phone _____

MCPHD # _____

## Patient Information

Name (Last, First, MI) | MRN

If child, name of parent (Last, First, MI)

Address (number and street) | Telephone number

City, Zip code

Date of birth (month, date, year)

Admitted from: ☐ Home ☐ LTCF ☐ LTACH ☐ Acute care hospital ☐ Other/Unknown_____
Facility name _____
Address _____
Phone _____

**SEX**
☐ Male ☐ Female ☐ Other _____

**RACE**
☐ Amer Ind/AK Native ☐ White ☐ Asian ☐ Other_____ ☐ Black/Afr American ☐ Unknown ☐ Nat Hawaiian/ Other Pac Islander

**ETHNICITY**
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other_____ ☐ Unknown

## Clinical Information

**Infection associated with CRE** Diagnosis date: ___ /___/___ ☐ None ☐ Unknown ☐ Abscess, not skin

☐ AV fistula/graft ☐ Bacteremia ☐ Catheter site ☐ Cellulitis/Skin ☐ Decubitus ☐ Empyema ☐ Endocarditis

☐ Meningitis ☐ Osteomyelitis ☐ Peritonitis ☐ Pneumonia ☐ Pyelonephritis ☐ Septic arthritis/Bursitis

☐ Sepsis ☐ Skin abscess ☐ Surgical incision infection ☐ Surgical site infection (internal) ☐ Traumatic wound

☐ Urinary tract infection ☐ Ulcer/wound, not decubitus ☐ Other

## Laboratory *Please attach all susceptibility testing for this culture

☐ **Clinical culture** ☐ **Surveillance Culture/Screen** Collection date ___ /___ /___

Facility where specimen obtained_____

**Specimen site:** ☐ Abscess ☐ BAL ☐ Blood ☐ Bone ☐ CSF ☐ Endotracheal aspirate ☐ Joint/Synovial Fluid ☐ Pericardial fluid ☐ Peritoneal fluid ☐ Pleural fluid ☐ Rectal swab ☐ Skin ☐ Sputum ☐ Urine ☐ Wound ☐ Other _____

☐ **PCR** ☐ **Culture** **Organism (Genus/Species):** _____

| **Susceptibility Results:** | **Susceptible** | **Intermediate** | **Resistant** | **Not tested** |
|---|---|---|---|---|
| Ceftriaxone | ☐ | ☐ | ☐ | ☐ |
| Cefotaxime | ☐ | ☐ | ☐ | ☐ |
| Cefazidime | ☐ | ☐ | ☐ | ☐ |
| Doripenem | ☐ | ☐ | ☐ | ☐ |
| Ertapenem | ☐ | ☐ | ☐ | ☐ |
| Imipenem | ☐ | ☐ | ☐ | ☐ |
| Meropenem | ☐ | ☐ | ☐ | ☐ |
| Amikacin | ☐ | ☐ | ☐ | ☐ |
| Colistin | ☐ | ☐ | ☐ | ☐ |
| Gentamicin | ☐ | ☐ | ☐ | ☐ |
| Tigecycline | ☐ | ☐ | ☐ | ☐ |
| Tobramycin | ☐ | ☐ | ☐ | ☐ |

**Mechanism of resistance:**
☐ Klebsiella pneumoniae carbapenemase (KPC)
☐ New Delhi Metallo-beta-lactamase (NDM)
☐ Verona Integron-Encoded Metallo-beta-lactamase (VIM)
☐ Imipenemase Metallo-beta-lactamase (IMP)
☐ Unknown
☐ Other (specify) _____

**Preexisting Conditions (check all that apply)** ☐ None ☐ Unknown ☐ AIDS/CD4 count < 200

☐ Central venous line ☐ Chronic liver disease ☐ Chronic lung disease ☐ Chronic renal insufficiency

☐ Cystic fibrosis ☐ Decubitis/Pressure ulcer ☐ Diabetes mellitus ☐ Heart failure/CHF

☐ Immunosuppressive therapy (past 6 months) ☐ Malignancy– hematologic ☐ Malignancy—solid organ

☐ Para/Hemi/Quadra-plegia ☐ Transplant recipient ☐ Urinary catheter ☐ Other _____

**Hospitalization**

| Yes | No | Unknown | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Hospitalized for this infection, If yes, facility name _____ Admit date ___ / ___ / ___ Discharge date ___ / ___ / ___ |
| ☐ | ☐ | ☐ | Admitted to intensive care unit |
| ☐ | ☐ | ☐ | Died from infection Death date ___ / ___ / ___ |
| ☐ | ☐ | ☐ | Autopsy performed |

**Disposition** ☐ Home ☐ LTCF ☐ LTACH ☐ Acute care hospital ☐ Not discharged at this time ☐ Other/Unknown

☐ Receiving facility notified of CRE colonization or infection
Facility name _____
Address _____
Phone _____

## Risk Factors

☐ Hospitalized within the past 3 months in acute care facility or long term care facility?
If yes, facility name _____

☐ Residence in a long term care facility?
If yes, facility name_____

☐ Past medical history of CRE infection or colonization?
If yes, specify _____

☐ History of multidrug-resistant organism infection or colonization within the past 3 months?
If yes, specify _____

☐ Invasive medical procedures in the past 6 months?
If yes, procedure(s) _____

☐ Endoscopic procedure in the past 6 months?
If yes, specify _____

Invasive devices at time of specimen collection?
☐ Central Venous Line ☐ Mechanical ventilator
☐ Urinary catheter ☐ Wound V.A.C
☐ Other (specify): _____

## Infection Prevention Concerns

During period patient was likely colonized/infected:

☐ Not on contact isolation
☐ Shared a room
☐ Shared a bathroom

Date contact isolation initiated ___/___/___
☐ Contact isolation not initiated and reason:
_____
☐ Pt currently in a healthcare facility
☐ Other: _____

## Public Health Actions

☐ Facility infection preventionist aware
☐ Emailed CRE Toolkit to facility
☐ Surveillance cultures of appropriate contacts

If yes, who was cultured?

☐ Roommates
☐ Patients who shared staff
☐ Other (specify) _____

**Comments:**