Washington State Department of Health

Highly antibiotic resistant organism

(CRE, other gram negative, Staph, Strep and Candida)

County

Case name (last, first) _____

Birth date ___/___/___ Sex at birth ☐ F ☐ M ☐ Other Alternate name _____

Phone _____ Email _____

Address type ☐ Home ☐ Mailing ☐ Other ☐ Temporary ☐ Work

Street address _____

City/State/Zip/County _____

Residence type (incl. Homeless) _____ WA resident ☐ Yes ☐ No

ADMINISTRATIVE

Investigator _____

LHJ Case ID (optional) _____

LHJ notification date ___/___/___

Classification ☐ Classification pending ☐ Confirmed
☐ Not reportable ☐ Probable ☐ Ruled out ☐ Suspect

Investigation status
☐ In progress
☐ Complete
☐ Complete – not reportable to DOH
☐ Unable to complete Reason _____

Investigation start date ___/___/___

Investigation complete date ___/___/___

Case complete date ___/___/___

Outbreak related ☐ Yes ☐ No
LHJ Cluster ID _____Cluster Name _____

DEMOGRAPHICS

Age at symptom onset _____ ☐ Years ☐ Months

Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unk

Race (check all that apply) ☐ Unk ☐ Amer Ind/AK Native
☐ Asian ☐ Black/African Amer ☐ Native HI/other PI
☐ White ☐ Other _____

Primary language _____

Interpreter needed ☐ Yes ☐ No ☐ Unk

Employed ☐ Yes ☐ No ☐ Unk Occupation _____
Industry _____ Employer _____
Work site _____ City _____

Student/Day care ☐ Yes ☐ No ☐ Unk
Type of school ☐ Preschool/day care ☐ K-12 ☐ College
☐ Graduate School ☐ Vocational ☐ Online ☐ Other
School name _____
School address _____
City/State/County _____ Zip _____
Phone number _____ Teacher's name _____

REPORT SOURCE

Initial report source _____
LHJ _____
Reporter organization _____
Reporter name _____
Reporter phone _____

All reporting sources (list all that apply)
_____
_____
_____

COMMUNICATIONS

Primary HCP name _____
Phone _____

OK to talk to patient (If Later, provide date)
☐ Yes ☐ Later ___/___/___ ☐ Never

Date of interview attempt ___/___/___
☐ Complete ☐ Partial ☐ Unable to reach
☐ Patient could not be interviewed

Alternate contact ☐ Parent/Guardian ☐ Spouse/Partner
☐ Friend ☐ Other _____
Name _____ Phone _____

CLINICAL INFORMATION

Complainant ill ☐ Yes ☐ No ☐ Unk Symptom Onset ___/___/___ ☐ Derived
Diagnosis date ___/___/___ Date of first positive case defining lab ___/___/___
Illness duration _____ ☐ Days ☐ Weeks ☐ Months ☐ Years Illness is still ongoing ☐ Yes ☐ No ☐ Unk

Organism type/Genus/Species
☐ Candida auris
☐ CRA ☐ Acinetobacter ☐ Baumannii
☐ CRE ☐ Escherichia ☐ Coli
☐ Klebsiella ☐ Oxytoca ☐ Pneumoniae ☐ Aerogenes ☐ Other _____
☐ Enterobacter ☐ Aerogenes ☐ Cloacae ☐ Other _____
☐ Citrobacter ☐ Brakkii ☐ Freundi ☐ Other _____
☐ Serratia ☐ Marcescens ☐ Other _____
☐ Proteus ☐ Mirabilis ☐ Penneri ☐ Other _____
☐ CRP ☐ Pseudomonas ☐ Aeruginosa
☐ MRSA
☐ Other _____

HARO required variables are in **bold.** Answers are: Yes, No, Unknown to case

Case Name _____ LHJ Case ID _____

Specimen Information

Types of infection associated with specimen(s) ☐ None (colonized) ☐ Abscess, not skin ☐ AV fistula/graft infection
☐ Bacteremia ☐ Bursitis ☐ Catheter site infection (CVC) ☐ Cellulitis/skin ☐ Decubitus/pressure ulcer
☐ Empyema ☐ Endocarditis ☐ Meningitis ☐ Osteomyelitis ☐ Peritonitis ☐ Pneumonia ☐ Pyelonephritis
☐ Septic arthritis ☐ Septic emboli ☐ Sepsis ☐ Skin abscess ☐ Surgical incision infection
☐ Surgical site infection (internal) ☐ Traumatic wound ☐ Ulcer/wound (not decubitus)
☐ Urinary tract infection (lower tract) ☐ Unk ☐ Other _____

County/State of facility where specimen collected _____

Type of Specimen ☐ Clinical ☐ Screening ☐ Unk

Physical location type of the patient when the specimen was collected ☐ Morgue ☐ Hospital ☐ Long-term acute care hospital
☐ Long-term care facility ☐ Outpatient ☐ Unknown ☐ Other _____

Y N Unk

☐ ☐ ☐ Was this patient EVER positive for the SAME organism and resistance mechanism
Earliest known date ___/___/___

☐ ☐ ☐ Does this patient have a history of infection or colonization with another MDRO (select all that apply)
☐ CRAB ☐ CRE ☐ CRPA ☐ C. difficile ☐ MRSA ☐ VRE ☐ Other _____

Predisposing Conditions

No known predisposing conditions (previously healthy) ☐ True ☐ False ☐ Unk

Y N Unk

☐ ☐ ☐ AIDS (CD4 count <200)
☐ ☐ ☐ HIV (not AIDS)
☐ ☐ ☐ Alcohol abuse
☐ ☐ ☐ Cancer Type (select all that apply) ☐ Solid tumor (metastatic) ☐ Solid tumor (non-metastatic) ☐ Hematologic
☐ ☐ ☐ Chronic GI disease Type (select all that apply) ☐ Hepatic ☐ Biliary ☐ Other _____
☐ ☐ ☐ Chronic lung disease (e.g., COPD, emphysema)
☐ ☐ ☐ Chronic kidney disease
☐ ☐ ☐ Chronic skin breakdown
☐ ☐ ☐ Congestive heart failure (pre-existing)
☐ ☐ ☐ Connective tissue disorder
☐ ☐ ☐ Current tobacco smoker
☐ ☐ ☐ CVA/stroke
☐ ☐ ☐ Cystic fibrosis
☐ ☐ ☐ Decubitus/pressure ulcer
☐ ☐ ☐ Dementia/chronic cognitive defect
☐ ☐ ☐ Diabetes mellitus
☐ ☐ ☐ Heart attack
☐ ☐ ☐ Hemiplegia/paraplegia
☐ ☐ ☐ Immunosuppressive therapy (past 6 months)
☐ ☐ ☐ Injection drug use, e.g. heroin
☐ ☐ ☐ Neurological problems
☐ ☐ ☐ Obesity Height (in inches) _____ Weight (in pounds) _____
☐ ☐ ☐ Peripheral vascular disease
☐ ☐ ☐ Premature at birth Specify gestational age in weeks _____
☐ ☐ ☐ Spina bifida
☐ ☐ ☐ Transplant recipient
☐ ☐ ☐ Urinary tract abnormality
☐ ☐ ☐ Other underlying medical condition _____

Hospitalization

Y N Unk

☐ ☐ ☐ Hospitalized at least overnight for this illness Facility name _____
Facility location _____
Hospital admission date ___/___/___ Discharge ___/___/___ HRN _____
Disposition ☐ Another acute care hospital Facility name/location _____
☐ Died in hospital
☐ Long term acute care facility Facility name/location _____
☐ Long term care facility Facility name/location _____
☐ Non-health care (home) ☐ Unk ☐ Other _____

☐ ☐ ☐ Admitted to ICU Date admitted to ICU ___/___/___ Date discharged from ICU ___/___/___
☐ ☐ ☐ Mechanical ventilation or intubation required
☐ ☐ ☐ Still hospitalized As of ___/___/___

Y N Unk

☐ ☐ ☐ Died of this illness Death date ___/___/___ *Please fill in the death date information on the Person Screen*
☐ ☐ ☐ Autopsy performed
☐ ☐ ☐ Death certificate lists disease as a cause of death or a significant contributing condition

RISK AND RESPONSE (Ask about exposures 12 months prior to specimen collection date unless otherwise specified)

Travel – *Make sure to list all international travel within 12 months of specimen collection date*

	Setting 1	Setting 2	Setting 3

Case Name _____ LHJ Case ID _____

Travel out of:	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____	☐ County/City _____ ☐ State _____ ☐ Country _____ ☐ Other _____
Destination name			
Start and end dates	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Patient was hospitalized while visiting state/country	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Patient received any health care while visiting state/country	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

Risk and Exposure Information

Y N Unk

☐ ☐ ☐ Is case a recent foreign arrival (e.g., immigrant, refugee, adoptee, visitor) Country _____

☐ ☐ ☐ Case first identified through surveillance screen

☐ ☐ ☐ Specimen collected >3 calendar days after hospital admission

☐ ☐ ☐ Central venous catheter in place at any time in the 2 calendar days prior to the specimen collection date

☐ ☐ ☐ Urinary catheter in place at any time in the 2 calendar days prior to the specimen collection date

Type ☐ Indwelling urethral catheter ☐ Suprapubic catheter ☐ Condom catheter

☐ Other _____

☐ ☐ ☐ Any OTHER indwelling device in place at any time in the 2 calendar days prior to the specimen collection date

Type ☐ Dialysis catheter ☐ ET/NT Tube ☐ Gastrostomy tube ☐ NG tube ☐ Nephrostomy tube

☐ Peripheral IV catheter ☐ Tracheostomy ☐ Other _____

Was tracheostomy tube in place at the time of specimen collection *(C. auris only)* ☐ Yes ☐ No ☐ Unk

☐ ☐ ☐ Was the patient on a ventilator at the time of specimen collection *(C. auris only)*

☐ ☐ ☐ Hospitalized within 12 months before the specimen collection date

Date admitted ___/___/___ Prior HRN _____

Facility name _____ Facility location _____

☐ ☐ ☐ Did hospitalization include ICU stay

☐ ☐ ☐ Surgery within 12 months before the specimen collection date Date of surgery ___/___/___

Facility name _____ Facility location _____

☐ ☐ ☐ Admitted to a long term care facility within 12 months before the specimen collection date

Admit date ___/___/___ Discharge date ___/___/___

Facility name _____ Facility location _____

☐ ☐ ☐ Admitted to a long term care facility within 90 days before the specimen collection date *(C. auris only)*

Type of facility ☐ Assisted living facility ☐ Group home ☐ Inpatient rehabilitation facility

☐ Long-term acute care hospital ☐ Nursing home/skilled nursing facility with ventilator beds

☐ Nursing home/Skilled nursing facility without ventilator beds or ventilator bed status unknown

☐ Other _____

☐ ☐ ☐ Admitted to a long term acute care hospital within 12 months before the specimen collection date

Admit date ___/___/___ Discharge date ___/___/___

Facility name _____ Facility location _____

☐ ☐ ☐ On dialysis within 12 months of the specimen collection date

Facility name _____ Facility location _____

☐ ☐ ☐ Current chronic dialysis

Facility name _____ Facility Location _____

Type of dialysis ☐ Peritoneal ☐ Hemodialysis ☐ Unk

Hemodialysis access ☐ AV fistula/graft ☐ CVC ☐ None ☐ Unk

Exposure and Transmission Summary

Likely geographic region of exposure ☐ In Washington – county _____ ☐ Other state _____

☐ Not in US - country _____ ☐ Unk

International travel related ☐ During entire exposure period ☐ During part of exposure period ☐ No international travel

Suspected exposure type ☐ Person to person ☐ Health care associated ☐ Unk ☐ Other _____

Describe _____

Suspected exposure setting ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER ☐ Hospital outpatient facility ☐ Home

☐ Long term care facility ☐ International travel ☐ Out of state travel ☐ Other _____

Describe _____

Exposure summary

Suspected transmission type (check all that apply) ☐ Person to person ☐ Health care associated ☐ Unk
☐ Other _____
Describe _____
Suspected transmission setting (check all that apply) ☐ Doctor's office ☐ Hospital ward ☐ Hospital ER
☐ Hospital outpatient facility ☐ Home ☐ Long term care facility ☐ International travel ☐ Out of state US travel
☐ Other _____
Describe _____

Public Health Issues

Y N Unk
☐ ☐ ☐ Patient currently in health care facility
Facility name _____ Facility location _____

Fill out the Transmission Tracking Section if concern for potential transmission to other patients. Focus particularly on 30 days prior to the specimen collection date.

Public Health Interventions/Actions

Y N Unk
☐ ☐ ☐ Contact precautions implemented Start date ___/___/___ End Date ___/___/___
Facility name _____ Facility location _____
☐ ☐ ☐ Contact investigation
☐ ☐ ☐ Surveillance specimens collected from appropriate patients
Who was tested ☐ Roommates ☐ Other epi-linked patients ☐ Point prevalence survey
☐ Other _____
How many patients tested _____
☐ ☐ ☐ Patient education provided Method ☐ Verbal ☐ Written ☐ Letter
Who provided ☐ Health care provider ☐ Local public health ☐ State public health
☐ ☐ ☐ Letter sent Date ___/___/___ Batch date ___/___/___
☐ ☐ ☐ Any other public health action _____

TRANSMISSION TRACKING

Visited, attended, employed, or volunteered at any public settings while contagious ☐ Yes ☐ No ☐ Unk

	Setting 1	Setting 2	Setting 3	Setting 4
Setting Type	Health care	Health care	Health care	Health care
Facility Name				
Details (floor, ward, wing, room number)				
Start (admit) Date	___/___/___	___/___/___	___/___/___	___/___/___
End (discharge) Date	___/___/___	___/___/___	___/___/___	___/___/___
Dates not on contact precautions	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Dates shared room	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Dates shared health care staff	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___	___/___/___ to ___/___/___
Number of people potentially exposed				
Facility Infection Preventionist aware	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Contact information available for setting (who will manage exposures or disease control for setting)	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk
Is a list of contacts known?	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk	☐ Y ☐ N ☐ Unk

If list of contacts is known, please fill out Contact Tracing Form Question Package

NOTES

LAB RESULTS

Lab report information
Lab report reviewed – LHJ ☐
WDRS user-entered lab report note

Submitter _____
Performing lab for entire report _____
Referring lab _____

Specimen
Specimen identifier/accession number _____
Specimen collection date ___/___/___ Specimen received date ___/___/___

WDRS specimen type _____
WDRS specimen source site _____
WDRS specimen reject reason _____
Test performed and result
WDRS test performed _____
WDRS test result, coded _____
WDRS test result, comparator _____
WDRS result, numeric only (enter only if given, including as necessary ***Comparator*** and ***Unit of measure***) _____
WDRS unit of measure _____
Test method _____
WDRS interpretation code _____
Test result – Other, specify _____
WDRS result summary ☐ Positive ☐ Negative ☐ Indeterminate ☐ Equivocal ☐ Test not performed ☐ Pending
Test result status ☐ Final results; Can only be changed with a corrected result
☐ Preliminary results
☐ Record coming over is a correction and thus replaces a final result
☐ Results cannot be obtained for this observation
☐ Specimen in lab; results pending
Result date ___/___/___
Upload document

Ordering Provider
WDRS ordering provider _____

Ordering facility
WDRS ordering facility name _____