



# Carbapenem-resistant Enterobacteriaceae

County: \_\_\_\_\_

LHJ Use ID \_\_\_\_\_  
 Reported to DOH Date \_\_\_/\_\_\_/\_\_\_  
 LHJ Classification  Confirmed  
 Suspect  
 By:  Lab  Clinical  
 Epi Link: \_\_\_\_\_

Outbreak-related  
 LHJ Cluster# \_\_\_\_\_  
 LHJ Cluster Name: \_\_\_\_\_  
 DOH Outbreak # \_\_\_\_\_

Genus and species: \_\_\_\_\_  
 (Enterobacteriaceae include *E. coli*, *Klebsiella*, *Enterobacter*, *Morganella*, *Proteus*, *Providencia*, *Serratia*, and *Yersinia*.)

## REPORT SOURCE

LHJ notified  Yes  No  
 LHJ notification date \_\_\_/\_\_\_/\_\_\_ Investigation start date \_\_\_/\_\_\_/\_\_\_  
 Reporter (check all that apply)  Lab  Hospital  HCP  
 Public health agency  Other  
 OK to talk to case?  Yes  No  DK Date of interview \_\_\_/\_\_\_/\_\_\_  
 Reporter name \_\_\_\_\_  
 Reporter phone \_\_\_\_\_  
 Primary HCP name \_\_\_\_\_  
 Primary HCP phone \_\_\_\_\_

## PATIENT INFORMATION

Name (last, first) \_\_\_\_\_ Birth date \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_  Homeless Gender  F  M  Other  Unk  
 City/State/Zip \_\_\_\_\_ Ethnicity  Hispanic or Latino  
 Not Hispanic or Latino  Unk  
 Phone(s)/Email \_\_\_\_\_  
 Alt. contact  Parent/guardian  Spouse  Other Name: \_\_\_\_\_  
 Zip code (school or occupation): \_\_\_\_\_ Phone: \_\_\_\_\_  
 Occupation/grade \_\_\_\_\_  
 Employer/worksite \_\_\_\_\_ School/child care name \_\_\_\_\_  
 Race  Amer Ind/AK Native  Asian  
 Native HI/other PI  Black/Afr Amer  
 White  Other  Unk

## CLINICAL INFORMATION

Onset date: \_\_\_/\_\_\_/\_\_\_  Derived Diagnosis date: \_\_\_/\_\_\_/\_\_\_ Illness duration: \_\_\_\_\_ days

### Infections associated with culture (check all that apply)

- 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 \_\_\_\_\_

### Hospitalization

Y= Yes DN= Don't know  
 N= No NA= Not asked

- Y N DK NA**
- Hospitalized at least overnight for this illness  
 If yes, Hospital name \_\_\_\_\_  
 Admit date \_\_\_/\_\_\_/\_\_\_  
 Discharge date \_\_\_/\_\_\_/\_\_\_  Still hospitalized
  - Admitted to intensive care unit
  - Died from illness Death date \_\_\_/\_\_\_/\_\_\_
  - Autopsy Place of death \_\_\_\_\_
- Disposition**  Non-healthcare setting  LTCF  LTACH  
 Another acute care hospital  Unknown  
 Other: \_\_\_\_\_

### Underlying Conditions (check all that apply)

- None  Unknown  AIDS/CD4 count < 200
- Alcohol abuse  Chronic Liver Dz\*  Chronic Lung Dz\*
- Chronic Renal Dz\*  Chronic Skin Breakdown
- Congestive Heart Failure  Current Smoker
- CVA/Stroke  Cystic Fibrosis  Decubitus/Pressure Ulcer
- Dementia  Diabetes  Hemiplegia/Paraplegia
- HIV (not AIDS)  Active Hematologic Malignancy
- Immunosuppressive therapy ( past 6 months)  IVDU
- Myocardial Infarct  Neurological Problems
- Peripheral Vascular Dz\*  Premature Birth
- Solid Tumor (metastatic)  Solid Tumor (non metastatic)
- Transplant Recipient  Urinary Tract Abnormality
- Other \_\_\_\_\_

\*Dz=Disease

### Laboratory

Collection date: \_\_\_/\_\_\_/\_\_\_  
 Specimen type:  Blood  CSF  Bone  Pleural fluid  
 Peritoneal fluid  Pericardial fluid  Joint/Synovial Fluid  
 Urine  Normally sterile internal body site  
 Other normally sterile site  Wound  Abscess  Sputum  
 Endotracheal aspirate  BAL  Skin  Rectal swab  
 Other: \_\_\_\_\_  
 Resistant/Intermediate to  Doripenem  Ertapenem  
 Imipenem  Meropenem  
 Resistant to  3<sup>rd</sup> gen Cephalosporins

### Testing for carbapenemases

- P N NT DK**
- Hodge Test
  - KPC pcr
  - NDM pcr
  - VIM pcr
  - IMP pcr
  - OXA48-like pcr

P = Positive N= Negative  
 NT= Not Tested DK=Don't know

**EXPOSURE**

**Risk Factors of Interest (check all that apply)**

Culture collected > calendar day 3 after hospital admission  
 Hospitalized within 6 months of initial culture  
**If yes**, enter mo/yr \_\_\_/\_\_\_\_ OR  Unknown  
 Facility name(s)/location \_\_\_\_\_

**If yes**, hospitalization included ICU stay  
 Residence in LTCF within 6 months of initial culture  
**If yes**, enter mo/yr \_\_\_/\_\_\_\_ OR  Unknown  
 Facility name(s)/location \_\_\_\_\_

Surgery within 6 months of initial culture  
**If yes**, enter mo/yr \_\_\_/\_\_\_\_ OR  Unknown  
 Facility name(s)/location \_\_\_\_\_

Dialysis within 6 months of initial culture  
**If yes**, enter mo/yr \_\_\_/\_\_\_\_ OR  Unknown  
 Facility name(s)/location \_\_\_\_\_  
 Current chronic dialysis

**Risk Factors of Interest (cont.)**

Patient traveled internationally in 6 months prior to initial culture.  
 Country/(ies): \_\_\_\_\_  
 Patient was hospitalized while visiting country (ies) listed above  
 Any indwelling device in place at any time in the 2 calendar days prior to initial culture  
**If yes, check all that apply:**  Central venous catheter  
 Peripheral IV  Dialysis catheter  Urinary catheter  
 ET/NT Tube  Gastrostomy Tube  
 NG Tube  Tracheostomy  Nephrostomy Tube  
 Surgical drain  Other (please specify): \_\_\_\_\_

**PUBLIC HEALTH ISSUES**

Not on contact precautions during period patient was likely colonized or infected  
 Shared room during period patient was likely colonized or infected  
 Shared hospital staff during period patient was likely colonized or infected  
 Dates other patients potentially at risk:  
 from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_  
 Patient is currently in healthcare facility  
 Other: \_\_\_\_\_

**PUBLIC HEALTH ACTIONS**

Facility infection preventionist aware  
 Contact precautions in place  
 Emailed CRE Toolkit to facility  
**Y N DK NA**  
    Surveillance cultures of appropriate contacts  
**If yes**, who was cultured?  
 Roommates  Patients who shared staff  
 Other (specify): \_\_\_\_\_

**NOTES**

**If confirmed, enter case's name, demographics, dates of notification, birth and onset, and genus and species of organism identified into electronic PHIMS. Complete this supplemental CRE report form and fax along with antimicrobial susceptibility testing results (if not already sent) to CD-Epi at 206-418-5515**

Investigator _____ Phone/email: _____	Investigation complete date ___/___/___
Local health jurisdiction _____	Record complete date ___/___/___