



Carbapenem-resistant Enterobacteriaceae (CRE) Report Form

Date of Report: / /	Reporting Facility:
Phone:	Person Preparing Report:

Bacteria Identified

Organism (Genus and Species):

Patient Information

Patient Name (Last, First):		DOB: / /	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Is patient deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death: / /	Died from this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Address (Street):		City:	State: Zip:
Usual Housing: <input type="checkbox"/> Homeless <input type="checkbox"/> Prison/Jail <input type="checkbox"/> Foster Home <input type="checkbox"/> Hospital <input type="checkbox"/> Assisted Living <input type="checkbox"/> Nursing Home <input type="checkbox"/> Other:			
Phone Number (Home):		Phone Number (Cell):	Next of Kin Name:
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			Next of Kin Number:
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown			

Laboratory Data

Admission Date: / /	Collection Date: / /	Initial Culture Site:	Testing Facility:
Were the positive cultures collected within 2 days of admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Antibiotic Resistance to: <input type="checkbox"/> Imipenem <input type="checkbox"/> Meropenem <input type="checkbox"/> Ertapenem <input type="checkbox"/> Doripenem			
Any Carbapenemase Testing Performed: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If Yes, Test Performed: <input type="checkbox"/> MHT <input type="checkbox"/> E-test <input type="checkbox"/> KPC <input type="checkbox"/> NDM <input type="checkbox"/> VIM <input type="checkbox"/> IMP <input type="checkbox"/> OXA-48 <input type="checkbox"/> Carba-NP <input type="checkbox"/> Other: _____			
Which, if any, were positive: <input type="checkbox"/> MHT <input type="checkbox"/> E-test <input type="checkbox"/> KPC <input type="checkbox"/> NDM <input type="checkbox"/> VIM <input type="checkbox"/> IMP <input type="checkbox"/> OXA-48 <input type="checkbox"/> Carba-NP <input type="checkbox"/> Other: _____			
Which, if any, were negative: <input type="checkbox"/> MHT <input type="checkbox"/> E-test <input type="checkbox"/> KPC <input type="checkbox"/> NDM <input type="checkbox"/> VIM <input type="checkbox"/> IMP <input type="checkbox"/> OXA-48 <input type="checkbox"/> Carba-NP <input type="checkbox"/> Other: _____			
Which, if any, were inconclusive: <input type="checkbox"/> MHT <input type="checkbox"/> E-test <input type="checkbox"/> KPC <input type="checkbox"/> NDM <input type="checkbox"/> VIM <input type="checkbox"/> IMP <input type="checkbox"/> OXA-48 <input type="checkbox"/> Carba-NP <input type="checkbox"/> Other: _____			

Epi-Linkage

During the 6 weeks prior to onset was the patient:

Associated with a known outbreak: Yes No Unknown

In close contact with a confirmed or presumptive case: Yes No Unknown

If yes, confirmed or presumptive case's name:

Please fax this form with a copy of relevant medical records and lab reports to 505-827-0013

Additional Information

Is this patient on a device? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, which device? <input type="checkbox"/> Ventilator <input type="checkbox"/> Central Line <input type="checkbox"/> Urinary Catheter <input type="checkbox"/> Tracheotomy
Does this patient have a history of CRE infection or colonization? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Is this patient isolated or cohorted with other CRE patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is this patient under contact precautions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Was this patient transferred <u>FROM</u> another healthcare facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, which facility?
Was your facility notified of patient's CRE status at time of transfer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Was this patient transferred <u>TO</u> another healthcare facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, which facility?
Did you notify receiving healthcare facility as well as transport organization of patient's CRE status? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
If yes, whom did you contact?	
If yes, how did you notify them?	

Comments

Fax report to: Infectious Disease Epidemiology Bureau, Attn: Surveillance Team, Fax: (505) 827-0013, Phone: (505) 827-0006