UTAH DEPARTMENT OF HEALTH

Carbapenem-resistant *Enterobacteriaceae* (CRE), Carbapenem-resistant *Acinetobacter* (CRA) and Carbapenem-resistant *Pseudomonas aeruginosa* (CRPA) Investigation Form

Patient Demographics

First Name:		Middle Name:	
Last Name:			
Date of Birth:			
Parent/Guardian:			
Address:			
City:	State:	Zip:	
Is this address for a long-term care hospital or nursing home?	Yes ☐	No ☐	
Name of Facility:	Facility Type:		
Phone Number:	Sex: M ☐ F ☐		
Email Address:			
Primary Language:			

Ethnicity		Race	
Not Hispanic or Latino ☐	Hispanic or Latino ☐	White ☐	Black or African American ☐
		American Indian or Alaska Native ☐	Asian ☐
		Native Hawaiian or Other Pacific Islander ☐	Unknown ☐

Reporting Facility Information

Facility Name:			Facility Type:			
Facility Address:			Was the patient in contact precautions for the duration, or part of their stay?		Was this infection health care facility acquired? (In a facility 2 days prior to culture collection and no previous positive culture)	
Facility City:	Facility State:	Facility ZIP:	Duration ☐	Part of stay ☐	Yes ☐	No ☐
Was the patient admitted to the facility?	Yes ☐	No ☐	Did the patient have a history of infection with a carbapenem resistant organism?		Yes ☐	No ☐
			Was the patient's carbapenem resistant status communicated to the facility?		Yes ☐	No ☐

Admit Date:	Discharge Date:	Died from illness?	Yes ☐	No ☐	Date of death:

Risk Factors

Was the patient admitted to an intensive care unit in the past 6 months?	Yes ☐	No ☐	Facility Name: Month/year:
Was the patient transferred to any other facility from the reporting facility?	Yes ☐	No ☐	Facility Name: Month/year:

Acute care hospital ☐	Long-term care facility ☐	Long-term acute care hospital ☐
Was CRE status communicated to receiving facility?	Yes ☐	No ☐
Has the patient had any surgical procedures in the past year?	Yes ☐	No ☐
List Surgical Procedures:		
Has the patient had any out-patient procedures in the past year?	Yes ☐	No ☐
List Out-Patient Procedures:		
Is the patient bed-bound?	Yes ☐	No ☐
Is the patient incontinent?	Yes ☐	No ☐
Has the patient been on a ventilator in the past year?	Yes ☐	No ☐

Has the patient had exposure to any of the following devices in place in the past 6 months? (check all that apply)

Duodenoscope ☐	Central venous catheter ☐	Peripheral IV ☐	Dialysis catheter ☐
Urinary catheter ☐	ET/NT tube ☐	Gastrostomy tube ☐	NG Tube ☐
Tracheostomy ☐	Nephrostomy tube ☐	Surgical drain ☐	Other (please specify):

Travel History

Has the patient traveled outside of the country in the past year?		Location:	Date:
Yes ☐	No ☐	Location:	Date:
Did the patient receive medical care outside of the U.S.?		Location:	Date:
Yes ☐	No ☐	Location:	Date:

Contacts

Please list all contacts below and indicate if they are a familial contact, healthcare worker contact, or facility roommate.

Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:

Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Name:	Phone Number:	Contact type:
Additional Notes:		