



# Invasive Methicillin-Sensitive Staphylococcus aureus Healthcare-Associated Infections Community Interface (HAIC) Case Report – 2021

Form Approved  
OMB No. 0920-0978  
Expires xx/xx/xxxx

Patient's Name:		Phone No.: ( )	
Address:		MRN:	
City:	State:	ZIP:	Hospital:

— PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC —

1. STATE:	2. COUNTY:	3. STATE ID:	4. PATIENT ID:	5. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED:	6. FACILITY ID WHERE PATIENT TREATED:
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7. SEX AT BIRTH: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Check if transgendered	8. DATE OF BIRTH: ____ - ____ - ____ 9. AGE ____ 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Mos. 3 <input type="checkbox"/> Years	10. RACE: (Check all that apply) 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Unknown	13. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 9 <input type="checkbox"/> Unknown
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12. WEIGHT: ____ lbs. ____ oz. OR ____ kg. 1 <input type="checkbox"/> Unknown	13. HEIGHT: ____ ft. ____ in. OR ____ cm. 1 1 <input type="checkbox"/> Unknown	14. BMI (record only if ht. and/or wt. is not available) ____ 1 <input type="checkbox"/> Unknown	15. DATE OF INCIDENT SPECIMEN COLLECTION (DISC): ____ - ____ - ____
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16. WAS THE PATIENT HOSPITALIZED AT THE TIME OF OR IN THE 29 CALENDAR DAYS AFTER, THE DISC? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown IF YES, date of admission: ____ - ____ - ____	17. WAS INCIDENT SPECIMEN COLLECTED 3 OR MORE CALENDAR DAYS AFTER HOSPITAL ADMISSION? 1 <input type="checkbox"/> Yes (HO-MRSA case) 2 <input type="checkbox"/> No (CA-MRSA or HACO-MRSA case)
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18. INCIDENT SPECIMEN COLLECTION SITE: (Check all that apply)

1  Blood 1  Bone 1  CSF 1  Internal body site (specify): \_\_\_\_\_ 1  Joint/Synovial fluid 1  Muscle

1  Pericardial fluid 1  Peritoneal fluid 1  Pleural fluid 1  Other normally sterile site (specify): \_\_\_\_\_

<p>19. LOCATION OF SPECIMEN COLLECTION:</p> <p>1 <input type="checkbox"/> Outpatient 1 <input type="checkbox"/> Inpatient 5 <input type="checkbox"/> LTCF</p> <p>Facility ID: _____ Facility ID: _____ Facility ID: _____</p> <p>3 <input type="checkbox"/> Emergency room 1 <input type="checkbox"/> ICU 13 <input type="checkbox"/> LTACH</p> <p>8 <input type="checkbox"/> Clinic/doctor's office 6 <input type="checkbox"/> OR Facility ID: _____</p> <p>15 <input type="checkbox"/> Dialysis center 7 <input type="checkbox"/> Radiology 14 <input type="checkbox"/> Autopsy</p> <p>11 <input type="checkbox"/> Surgery 2 <input type="checkbox"/> Other Inpatient 10 <input type="checkbox"/> Other (specify): _____</p> <p>16 <input type="checkbox"/> Observation/Clinical decision unit 9 <input type="checkbox"/> Unknown</p> <p>4 <input type="checkbox"/> Other outpatient</p>	<p>20. WERE CULTURES OS THE SAME OR OTHER STERILE SITES(S) POSITIVE WITHIN 29 DAYS AFTER DISC?</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>IF YES, INDICATE SITE AND DATE OF LAST POSITIVE CULTURE:</p> <p>1 <input type="checkbox"/> Blood 1 <input type="checkbox"/> Bone 1 <input type="checkbox"/> CSF Date: _____ Date: _____ Date: _____</p> <p>1 <input type="checkbox"/> Internal body site 1 <input type="checkbox"/> Joint/Synovial fluid 1 <input type="checkbox"/> Muscle Date: _____ Date: _____ Date: _____</p> <p>1 <input type="checkbox"/> Peritoneal fluid 1 <input type="checkbox"/> Pericardial fluid 1 <input type="checkbox"/> Pleural fluid Date: _____ Date: _____ Date: _____</p> <p>1 <input type="checkbox"/> Other normally sterile site (specify): _____ Date: _____</p>
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21. DATE OF FIRST SA BLOOD CULTURE AFTER WHICH SA NOT ISOLATED FOR 14 DAYS: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

22. SUSCEPTIBILITY RESULTS [S=Sensitive (1), I=Intermediate (2), R=Resistant (3), U=Unknown/Not Reported (9)]

Cefazolin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Cefoxitin 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Clindamycin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U
Nafcillin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Oxacillin 1 <input type="checkbox"/> S 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U	Trimethoprim-Sulfamethoxazole 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U
Vancomycin 1 <input type="checkbox"/> S 2 <input type="checkbox"/> I 3 <input type="checkbox"/> R 9 <input type="checkbox"/> U		

<p>23. WHERE WAS THE PATIENT LOCATED ON THE 3RD CALENDAR DAY BEFORE THE DISC?</p> <p>1 <input type="checkbox"/> Private residence 1 <input type="checkbox"/> LTACH Facility ID: _____</p> <p>1 <input type="checkbox"/> LTCF Facility ID: _____ 1 <input type="checkbox"/> Homeless</p> <p>1 <input type="checkbox"/> Hospital Inpatient Facility ID: _____ 1 <input type="checkbox"/> Incarcerated</p> <p>1 <input type="checkbox"/> Other (specify): _____</p> <p>Was patient transferred from this hospital? _____</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Unknown</p>	<p>24. IF CASE IS ≤12 MONTHS OF AGE, TYPE OF BIRTH HOSPITALIZATION: 1 <input type="checkbox"/> NICU/SCN 2 <input type="checkbox"/> Well Baby Nursery 9 <input type="checkbox"/> Unknown</p> <p>25. IF PATIENT &lt;2 YEARS OF AGE WERE THEY BORN PREMATURE (&lt;37 WEEKS GESTATION)? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown</p> <p>IF YES, birth weight: ____ lbs. ____ oz. OR ____ g. OR 1 <input type="checkbox"/> Unknown birth weight</p> <p>IF YES, estimated gestational age: ____ weeks OR 1 <input type="checkbox"/> Unknown gestational age</p>
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Public reporting burden of this collection of information is estimated to average 28 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

<b>26. WAS THE PATIENT IN AN ICU IN THE 2 DAYS BEFORE THE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, date of ICU admission:</b> ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown	<b>27. WAS THE PATIENT IN AN ICU ON THE DISC OR IN THE 2 DAYS AFTER THE DISC?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown <b>IF YES, date of ICU admission:</b> ____ - ____ - ____ OR 1 <input type="checkbox"/> Date Unknown
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**28. TYPES OF MRSA INFECTION ASSOCIATED WITH CULTURE(S):** (Check all that apply) 1  None 1  Unknown

1 <input type="checkbox"/> Abscess (not skin)	1 <input type="checkbox"/> Cellulitis	1 <input type="checkbox"/> Epidural Abscess	1 <input type="checkbox"/> Septic Arthritis
1 <input type="checkbox"/> AV Fistula/Graft Infection	1 <input type="checkbox"/> Chronic Ulcer/Wound (non-decubitus)	1 <input type="checkbox"/> Meningitis	1 <input type="checkbox"/> Septic Emboli
1 <input type="checkbox"/> Bacteremia	1 <input type="checkbox"/> Decubitus/Pressure Ulcer	1 <input type="checkbox"/> Peritonitis	1 <input type="checkbox"/> Septic Shock
1 <input type="checkbox"/> Bursitis	1 <input type="checkbox"/> Empyema	1 <input type="checkbox"/> Pneumonia	1 <input type="checkbox"/> Skin Abscess
1 <input type="checkbox"/> Catheter Site Infection	1 <input type="checkbox"/> Endocarditis	1 <input type="checkbox"/> Osteomyelitis	1 <input type="checkbox"/> Surgical Incision
			1 <input type="checkbox"/> Surgical Site (Internal)
			1 <input type="checkbox"/> Traumatic Wound
			1 <input type="checkbox"/> Urinary Tract
			1 <input type="checkbox"/> Other: (specify) _____
			_____

**29. UNDERLYING CONDITIONS:** (Check all that apply) 1  None 1  Unknown

<b>CHRONIC LUNG DISEASE</b> 1 <input type="checkbox"/> Cystic fibrosis 1 <input type="checkbox"/> Chronic pulmonary disease  <b>CHRONIC METABOLIC DISEASE</b> 1 <input type="checkbox"/> Diabetes mellitus 1 <input type="checkbox"/> With chronic complications  <b>CARDIOVASCULAR DISEASE</b> 1 <input type="checkbox"/> CVA/Stroke/TIA 1 <input type="checkbox"/> Congenital heart disease 1 <input type="checkbox"/> Congestive heart failure 1 <input type="checkbox"/> Myocardial infarction 1 <input type="checkbox"/> Peripheral vascular disease (PVD)  <b>GASTROINTESTINAL DISEASE</b> 1 <input type="checkbox"/> Diverticular disease 1 <input type="checkbox"/> Inflammatory bowel disease 1 <input type="checkbox"/> Peptic ulcer disease 1 <input type="checkbox"/> Short gut syndrome	<b>IMMUNOCOMPROMISED CONDITION</b> 1 <input type="checkbox"/> HIV infection 1 <input type="checkbox"/> AIDS/CD4 count <200 1 <input type="checkbox"/> Primary immunodeficiency 1 <input type="checkbox"/> Transplant, hematopoietic stem cell 1 <input type="checkbox"/> Transplant, solid organ  <b>LIVER DISEASE</b> 1 <input type="checkbox"/> Chronic liver disease 1 <input type="checkbox"/> Ascites 1 <input type="checkbox"/> Cirrhosis 1 <input type="checkbox"/> Hepatic encephalopathy 1 <input type="checkbox"/> Variceal bleeding 1 <input type="checkbox"/> Hepatitis C 1 <input type="checkbox"/> Treated, in SVR 1 <input type="checkbox"/> Current, chronic	<b>MALIGNANCY</b> 1 <input type="checkbox"/> Malignancy, hematologic 1 <input type="checkbox"/> Malignancy, solid organ (non-metastatic) 1 <input type="checkbox"/> Malignancy, solid organ (metastatic)  <b>NEUROLOGIC CONDITION</b> 1 <input type="checkbox"/> Cerebral palsy 1 <input type="checkbox"/> Chronic cognitive deficit 1 <input type="checkbox"/> Dementia 1 <input type="checkbox"/> Epilepsy/seizure/seizure disorder 1 <input type="checkbox"/> Multiple sclerosis 1 <input type="checkbox"/> Neuropathy 1 <input type="checkbox"/> Parkinson's Disease 1 <input type="checkbox"/> Other (specify): _____ _____ _____  <b>PLEGIAS/PARALYSIS</b> 1 <input type="checkbox"/> Hemiplegia 1 <input type="checkbox"/> Paraplegia 1 <input type="checkbox"/> Quadriplegia	<b>RENAL DISEASE</b> 1 <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____mg/DL 1 <input type="checkbox"/> Unknown or not done  <b>SKIN CONDITION</b> 1 <input type="checkbox"/> Burn 1 <input type="checkbox"/> Decubitus/pressure ulcer 1 <input type="checkbox"/> Surgical wound 1 <input type="checkbox"/> Other chronic ulcer or chronic wound 1 <input type="checkbox"/> Other skin condition (specify): _____ _____ _____  <b>OTHER</b> 1 <input type="checkbox"/> Connective tissue disease 1 <input type="checkbox"/> Obesity or morbid obesity 1 <input type="checkbox"/> Pregnant 1 <input type="checkbox"/> Other (specify only for cases ≤12 months of age): _____ _____ _____
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**30. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE DISC?** 1  Yes 2  No 9  Unknown

**31. SUBSTANCE USE:**

<b>SMOKING:</b> 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Tobacco 1 <input type="checkbox"/> E-nicotine delivery system 1 <input type="checkbox"/> Marijuana	<b>ALCOHOL ABUSE:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
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**OTHER SUBSTANCES (CHECK ALL THAT APPLY):** 1  None 1  Unknown

	<b>DOCUMENTED USE DISORDER (DUD/ABUSE):</b>	<b>MODE OF DELIVERY (Check all that apply):</b>
1 <input type="checkbox"/> Marijuana, cannabinoid (other than smoking)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Opioid, NOS	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Cocaine	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Methamphetamine	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
1 <input type="checkbox"/> Other (specify): _____	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown
_____		
1 <input type="checkbox"/> Unknown substance	1 <input type="checkbox"/> DUD or abuse	1 <input type="checkbox"/> IDU 1 <input type="checkbox"/> Skin popping 1 <input type="checkbox"/> Non-IDU 1 <input type="checkbox"/> Unknown

**DURING THE CURRENT HOSPITALIZATION DID THE PATIENT RECEIVE MEDICATION ASSISTED TREATMENT (MAT) FOR OPIOID USE DISORDER?** 1  Yes 2  No 9  N/A (patient not hospitalized or did not have DUD)

**32. PRIOR HEALTHCARE EXPOSURE(S):**

**PREVIOUS DOCUMENTED MSSA INFECTION OR COLONIZATION**

1  Yes 2  No 9  Unknown

If YES: \_\_\_\_\_ OR previous STATE I.D.: \_\_\_\_\_  
Month Year

**OVERNIGHT STAY IN LTACH IN THE YEAR BEFORE DISC**

1  Yes 2  No 9  Unknown

Facility ID: \_\_\_\_\_

**PREVIOUS HOSPITALIZATION IN THE YEAR BEFORE DISC**

1  Yes 2  No 9  Unknown

If YES, DATE OF DISCHARGE CLOSEST TO DISC: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

OR, 1  Date unknown

Facility ID: \_\_\_\_\_

**OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE DISC**

1  Yes 2  No 9  Unknown

Facility ID: \_\_\_\_\_

**SURGERY IN THE YEAR BEFORE DISC** 1  Yes 2  No 9  Unknown

**IF YES**, list the surgeries and dates of surgery that occurred within 90 days prior to the DISC:

Surgery Date

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**CENTRAL LINE IN PLACE ON THE DISC (UP TO THE TIME OF COLLECTION), OR AT ANY TIME IN THE 2 CALENDAR DAYS BEFORE DISC**

1  Yes 2  No 9  Unknown

CHECK HERE if central line in place for >2 calendar days 1

**DIALYSIS IN THE YEAR BEFORE DISC** (Hemodialysis or Peritoneal dialysis)

1  Yes 2  No 9  Unknown

**CURRENT CHRONIC DIALYSIS** 1  Yes 2  No 9  Unknown

TYPE: 1  Hemodialysis 1  Peritoneal 1  Unknown

**IF HEMODIALYSIS**, type of vascular access:

1  AV fistula/graft 2  Hemodialysis central line 9  Unknown

**33. PATIENT OUTCOME** 1  Survived

2  Died

2  Unknown

DATE OF DISCHARGE: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ OR 1  Date Unknown

DATE OF DEATH: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ OR 1  Date Unknown

1  Left against medical advice (AMA)

ON THE DAY OF OR IN THE 6 CALENDAR DAYS BEFORE DEATH, WAS THE PATHOGEN OF INTEREST ISOLATED FROM A SITE THAT MEETS THE CASE DEFINITION?

IF SURVIVED, DISCHARGED TO:

- 1  Private Residence 4  Other (specify): \_\_\_\_\_
- 2  LTCF Facility ID: \_\_\_\_\_
- 3  LTACH Facility ID: \_\_\_\_\_ 9  Unknown

**34a. DID THE PATIENT HAVE A POSITIVE TEST FOR SARS-CoV-2 (MOLECULAR ASSAY, SEROLOGY OR OTHER CONFIRMATORY TEST) ON OR BEFORE THE DISC?** 1  Yes 2  No 9  Unknown

COVID-NET CASE ID \_\_\_\_\_

NNDSS IDs (please provide at least one of the following when applicable):

CDC 2019 NCOV ID: \_\_\_\_\_

Local case ID: \_\_\_\_\_

Local record ID: \_\_\_\_\_

State case identifier: \_\_\_\_\_

Legacy case identifier: \_\_\_\_\_

IF YES, COMPLETE TABLE BELOW

IF YES, COMPLETE TABLE BELOW	Specimen collection date	Test Type
FIRST positive test for SARS-CoV-2 on or before the DISC:	____ - ____ - ____ 1 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Molecular assay 1 <input type="checkbox"/> Serology 1 <input type="checkbox"/> Method unknown 1 <input type="checkbox"/> Other (specify): _____
MOST RECENT positive test for SARS-CoV-2 on or before the DISC:	____ - ____ - ____ 1 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Molecular assay 1 <input type="checkbox"/> Serology 1 <input type="checkbox"/> Method unknown 1 <input type="checkbox"/> Other (specify): _____

**34. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?**

1  Yes 2  No  
9  Unknown

**35. CRF STATUS:**

- 1  Complete  
 2  Incomplete  
 3  Edited & Correct  
 4  Chart unavailable after 3 requests

**36. DOES THIS CASE HAVE RECURRENT MRSA DISEASE?**

1  Yes 2  No  
9  Unknown

**IF YES, PREVIOUS (1ST) STATE I.D.**

\_\_\_\_\_

**37. DATE REPORTED TO EIP SITE:**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**38. DATE ABSTRACTION:**

\_\_\_\_ - \_\_\_\_ - \_\_\_\_

**39. S.O. INITIALS:**

\_\_\_\_\_

**40. COMMENTS:**