West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH

# Carbapenem-Resistant *Enterobacteriaceae* (CRE)

## PATIENT DEMOGRAPHICS

**Name** (last, first): _____
**Address**: _____ **Homeless:** _____
**City/State/Zip**: _____
**Phone** (home): _____ **Phone** (work) : _____
**Occupation/grade**: _____ **Employer/School**: _____

*Alternate contact:* ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
*Name:* _____ *Phone:* _____

**Birth date**: ___/___/_____ **Age**: _____
**Sex**: ☐Male ☐Female ☐Unk

**Ethnicity**: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk

**Race**: ☐White ☐Black/Afr. Amer. ☐Am. Ind/AK Native ☐Native HI/Other PI ☐Asian ☐ Unk

## INVESTIGATION SUMMARY

**Local Health Department** (Jurisdiction): _____
**Investigation Start Date**: ___/___/_____
**Earliest date reported to LHD**: ___/___/_____
**Earliest date reported to DIDE**: ___/___/_____

**Entered in WVEDSS?** ☐Yes ☐No ☐Unk
**Case Classification**:
☐ Confirmed ☐ Not a case ☐ Unknown

## REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

**Report Source**: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other
**Reporter Name:** _____ **Reporter Phone:** _____
**Primary HCP Name:** _____ **Phone Number**: _____

## LABORATORY

**Organism**: _____
**Culture type**: ☐ Surveillance ☐ Clinical **Specimen Source**: _____ **Collection date**: ___/___/_____

| Carbapenem Interpretations : | S | I | R | Not tested |
|---|---|---|---|---|
| **Ertapenem:** | ☐ | ☐ | ☐ | ☐ |
| **Meropenem:** | ☐ | ☐ | ☐ | ☐ |
| **Imipenem:** | ☐ | ☐ | ☐ | ☐ |
| **Doripenem:** | ☐ | ☐ | ☐ | ☐ |

Detection of carbapenemase production by a recognized test (e.g. positive modified Hodge test (MHT), PCR, etc.)?
**Y** ☐ **N** ☐ **Not tested** ☐

## EPIDEMIOLOGIC

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Was the patient hospitalized at the time of specimen collection? If YES: Hospital Name: _____ Date of Admission: ___/___/_____ |
| ☐ | ☐ | ☐ | Was the patient in the ICU? If YES: Date of Admission: ___/___/_____ Date of Discharge: / / |
| ☐ | ☐ | ☐ | Does patient reside in (or will be discharged to) a nursing home or other long-term care facility? If YES: LTCF Name: _____ LTCF Address: _____ |
| ☐ | ☐ | ☐ | Has the patient utilized home health services in the last 6 months? If YES: Agency Name: _____ |
| ☐ | ☐ | ☐ | Did patient die? If YES, date of death: ___________ |
| ☐ | ☐ | ☐ | Did patient visit any other healthcare facilities in the 6 months before their CRE diagnosis (physician offices, dialysis clinics, etc)? If YES: Provider/Clinic Name: _____ Address: _____ Provider/Clinic Name: _____ Address: _____ Provider/Clinic Name: _____ Address: _____ |

## PUBLIC HEALTH ISSUES

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | Epi-linked to another confirmed case of CRE |
| ☐ | ☐ | ☐ | Case is part of an outbreak |
| ☐ | ☐ | ☐ | Other: |

## PUBLIC HEALTH ACTIONS

| Y | N | U | |
|---|---|---|---|
| ☐ | ☐ | ☐ | CRE initial assessment conducted with LTCF |
| ☐ | ☐ | ☐ | CDC CRE Toolkit provided to & discussed with LTCF |
| ☐ | ☐ | ☐ | Patient and/or family interviewed and given education |
| ☐ | ☐ | ☐ | Outpatient healthcare provider given education |
| ☐ | ☐ | ☐ | Patient is lost to follow-up |
| ☐ | ☐ | ☐ | Other: |

## EXPOSURE

Y N U

☐ ☐ ☐ Any indwelling device in place at any time in the 2 calendar days prior to initial culture?

If YES, check all that apply: ☐ Peripheral IV ☐ Central venous catheter ☐ Dialysis catheter
☐ Urinary catheter ☐ ET/NT tube ☐ Gastrostomy tube ☐ NG tube
☐ Tracheostomy ☐ Nephrostomy tube ☐ Surgical drain
☐ Other (specify): _____

☐ ☐ ☐ Was the patient prescribed antibiotics more than two times in six months?

## NOTES