WEST VIRGINIA Department of Health & Human Resources
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): _____

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

NOTES