Section 1: Demographics		
	First:	
	Middle:	
	Last:	
	Suffix:	
	Healthcare Worker:	
	Maiden Name:	
	Mothers' Maiden:	
	Address:	
		City:
		State: [Loading states]
		Zip:
		Please select a county
	Telephone Number:	
	Date of Birth:	
	or	
	Age:	Years
	Multiple Birth:	
	Gender:	
	Race(s):	American Indian or Alaska Native
		Asian
		Black or African American
		\Box Native Hawaiian or Other Pacific Islander
		Other/Multiracial
		Unknown
		□ White
	Ethnicity:	
	Physician's Name:	
	Phone Number:	
	Face North and	
	Fax Number:	
	Street Address:	
	City:	[Loading states]
	Zip:	
	Occupation:	
Employer Name:		
Phone Number:		
Street Address:		
City:		
	[Loading states]	
County:	Please select a county	
Zip:		
ection 2: Clinical		
nfection resulted in hospitalization?		
	🗌 Yes 🗌 No 🗌 Ui	
	Admission Date:	
	Discharge Date:	•

Case Investigation - Carbapenemase-producing Carbapenem-resistant Enterobacteriaceae (CP-CRE)

Yes No Unknown Type: Start Date: End Date:			Facility Type:		
Pone: Section: Section: Section: Section: Section: Section: Determine: Section: Determine: Section: Determine: Section: Determine: Determine: <th>Fac</th> <th>cility:</th> <th></th> <th></th> <th></th>	Fac	cility:			
Pine: section: section: imple room setting: ''''''''''''''''''''''''''''''''''''					
search: ingle room setting: 'rea control Procedures within the past 6 months?: 'reacting condition(2) at the time of specimen collection: 'control Venous Line 'control Ven					
<pre>sectiv:</pre>					
<pre></pre>					
<pre></pre>					
<pre></pre>					
tart Date of Contact Precaution:					
het of illues onset:			!n		
<pre>rvs:vs device() at the time of specimen collection:</pre>	tart Date of Contact Precautions:	:			
Image:	Date of illness onset:				
Urge: Location: Date: Type: Location: Date: Cantral Venous Line Date: Date: Date: Date: Date:					
Type: Location: Type: Location: Type: Location: Type: Location: Type: Location: Type: Location: Location: Location: Type: Location: Location:	NVasive medical procedures withi	in the past 6 months?:			
		Location:	Date:		
Central Venous Line Central Insufficiency Central Insufficien					
Central Venous Line Central Insufficiency					
Central Venous Line Central Insufficiency Central Insufficien					
Central Venous Line Central Insufficiency					
<pre>ultinary Catheter Bridoscope Specify: Comparison of the time of specimen collection: Comparison of the time of spe</pre>		pecimen collection:			
specify:					
Mechanical Ventilator Wound V.A.C. None Unknown Other specify: reexisting condition(s) at the time of specimen collection: Chronic renal insufficiency Diabetes mellitus Emphysema/COPD Heart Failure/CHF Malignancy-solid organ Para/Hem/Quadri-plegia None Unknown Other Specify: wtbiotic use within the past 6 months?: Type: Start Date: End Date: Type: Start Date: End Date: End Date: Type: Start Date: End Date: End Date: Type: Start Date: End	L Endoscope				
Wound V.A.C. Wone Wound V.A.C. Wone Wound V.A.C. Wone Wound V.A.C. Wou	Speen y.				
Wound V.A.C. Wone Wound V.A.C. Wone Wound V.A.C. Wone Wound V.A.C. Wou	Mechanical Ventilator				
None □ Unknown □ Other Specify: reexisting condition(s) at the time of specimen collection: □ orbit on is null fictioncy □ blabetes mellitus □ blabetes me					
Unknown Other Specify: <td></td> <td></td> <td></td> <td></td> <td></td>					
Other Specify: reexisting condition(s) at the time of specimen collection: Chronic renal insufficiency Diabetes mellitus Emphysema/COPD Heart Failure/CHF Malignancy-hematologic Para/Hemi/Quadri-plegia Other Specify: Antibiotic use within the past 6 months?: Type: Start Date: End Date:					
Specify: reexisting condition(s) at the time of specimen collection: Chronic renal insufficiency Diabetes mellitus Emphysema/COPD Heart Failure/CHF Malignancy-hematologic Malignancy-hematologic Malignancy-solid organ Para/Hemi/Quadri-plegia None Other Specify: Antibiotic use within the past 6 months?: Type: Yes No Unknown Unknown Type: Start Date: End Date:					
Chronic renal insufficiency Diabetes mellitus Emphysema/COPD Heart Failure/CHF Malignancy-hematologic Malignancy-solid organ Para/Hemi/Quadri-plegia None Unknown Other Specify: Type: Yes No Unknown Type: End Date:					
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Chronic renal insufficiency Diabetes mellitus Emphysema/COPD Heart Failure/CHF Malignancy-hematologic Para/Hemi/Quadri-plegia None Unknown Other Specify: Type: Start Date: End Date: Type: Start Date: End Date:					
□ Diabetes mellitus □ Emphysema/COPD □ Heart Failure/CHF □ Malignancy-hematologic □ Malignancy-solid organ □ Para/Hemi/Quadri-plegia □ None □ Unknown □ Other Specify: □		ne of specimen collection:			
Heart Failure/CHF Malignancy-hematologic Malignancy-solid organ Para/Hemi/Quadri-plegia None Unknown Other Specify: Antibiotic use within the past 6 months?:	Diabetes mellitus				
Malignancy-hematologic Malignancy-solid organ Para/Hemi/Quadri-plegia Unknown Other Specify: Antibiotic use within the past 6 months?:	Emphysema/COPD				
Malignancy-solid organ Para/Hemi/Quadri-plegia Unknown Other Specify: Antibiotic use within the past 6 months?:	Heart Failure/CHF				
□ Para/Hemi/Quadri-plegia □ None □ Unknown □ Other Specify: Antibiotic use within the past 6 months?:	□ Malignancy-hematologic				
□ None □ Unknown □ Other Specify: Antibiotic use within the past 6 months?: Type: Yes No □ Unknown Type: End Date: □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	🗌 Malignancy-solid organ				
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Specify: Antibiotic use within the past 6 months?: Type: Start Date: End Date: 	Unknown				
Specify: Antibiotic use within the past 6 months?: Type: Start Date: End Date: 					
Yes No Unknown Type: Start Date: End Date:					
Yes No Unknown Type: Start Date: End Date:	Antibiotic use within the past 6 m	onths?:			
			🗆 Yes 🛽	🗌 No 🔲 Unknown	
Section 3: Diagnostic Tests		Type:	Start Da	te: End Date:	
Section 3: Diagnostic Tests					
Section 3: Diagnostic Tests					
Section 3: Diagnostic Tests					
Section 3: Diagnostic Tests					
	Section 3: Diagnostic Tests				

inter all antibiotics tes	sted and the results. This inf	formation detern	nines the case de	efinition of CP-CRE.		
lote: Minimal Inhibito	ry Concentration (MIC)					
	I susceptibility information	provided for CR	E:			
□Yes □No □Un	known					
specimen Date:	Specimen Type:	Specimen	Source:	Organism:	Resistance Mechanism:	
Antibiotic:	MIC:	Susceptib	ility Result:			
Specimen Date:	Specimen Type:	Specimen	Source:	Organism:	Resistance Mechanism:	
Antibiotic:	MIC:	Susceptib	ility Result:			
Specimen Date:	Specimen Type:	Specimen	Source:	Organism:	Resistance Mechanism:	
Antibiotic:	MIC:	Susceptib	ility Result:			
ection 4: Epidemiolo	gic Information					
Was the specimen ob	tained?					
□Yes □No □Un	known					
Facility Name:	Facility Address:		Contact Name:	Contact Phone:		
-						
					-	
					_	
					_	
Was the patient hosp	italized within the past 3 m	nonths in Acute	Care Facility?		_	
Was the patient hosp		nonths in Acute	Care Facility?			
			Care Facility? Contact Name:	Contact Phone:		
□ _{Yes} □ _{No} □ _{Un}	known			Contact Phone:		
□ _{Yes} □ _{No} □ _{Un}	known			Contact Phone:		
□ _{Yes} □ _{No} □ _{Un}	known			Contact Phone:		
□ _{Yes} □ _{No} □ _{Un}	known			Contact Phone:		
Yes No Un Facility Name:	known Facility Address: table to the set 3 m italized within the past 3 m		Contact Name:			
Yes No Un Facility Name:	known Facility Address: table to the set 3 m italized within the past 3 m		Contact Name:		-	
Yes No Un Facility Name:	known Facility Address: table to the set 3 m italized within the past 3 m	nonths in Long T	Contact Name:			
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Yes No Un Facility Name:	known Facility Address: italized within the past 3 m known Facility Address: ident in a Long Term Care Fa known Facility Address: Interference factors for the factor of t	nonths in Long T acility (e.g. nurs	Contact Name:	Facility? Contact Phone:		

	nt receive medical treatr	nent or hospitalizatio	n outside the US in the past	6 months?	
Location:		Reas	on or procedure:		
Location.		Reasi	on or procedure.		
	history of CRE infection	or colonization?			
□Yes □No	Unknown				
Date:					
	itted patient transferred			Current admitted patie	
	Care Facility/Skilled Nursin	ng Facility			cility/Skilled Nursing Facility
Long Term /	Acute Care Facility			Long Term Acute C	are Facility
Acute Care I	Facility			Acute Care Facility	
Rehabilitatio	on Facility			Rehabilitation Facili	ty
Home				Home	
Other				Other	
Specify:				Specify:	
	101 · · · · · ·				
	ultidrug-resistant organisi	m (MDRO) infection or	colonization within the pas	st 3 months:	
MRSA					
VRE					
None(MDRO					
Unknown(M					
Other(MDRO))				
Specify:					
Section 5: Con	nments				
Comments:					
		Interviewee	Please Select		

Interviewe	e's Name:			
Submitted				
by Agency:				
Investigator:				
				Address:
				Phone: