



CARBAPENEMASE-PRODUCING ORGANISM (CPO) REPORTING

State Form 9900428
INDIANA DEPARTMENT OF HEALTH



Indiana
Department
of
Health

INSTRUCTIONS:

Please submit one report per patient per case within one working day receiving lab result. Attach laboratory results, recent History and Physical and Infectious Disease Consult. If faxing, include Confidential Report of Communicable disease form and send to Indiana Department of Health (317)-234-2812 or upload to NBS Morbidity Report.

Reporting Facility: _____

Reporter's Name: _____

Address: _____

Reporter's Phone Number: _____

Patient Information

Patient name:	NBS ID (if known):
DOB:	Phone:
Address:	County:
Did the patient die? ☐ Yes ☐ No	Date of death:

Laboratory Information

Organism:	Collection date:
Specimen site:	☐ Clinical culture ☐ Screening culture
Mechanism: ☐ IMP ☐ KPC ☐ NDM ☐ OXA-48 ☐ OXA-24/40 ☐ VIM ☐ OXA-23 ☐ Other	

Clinical information

Admission date:		Discharge date:	
Facility admitted from: _____		Facility discharged to: _____	
☐ Transfer form used upon admission		☐ Transfer form used upon discharge	
Admitted to ICU during stay? ☐ Yes ☐ No			
Contact or EBP start date:		Roommates: ☐ Yes ☐ No Dates:	
History of MDRO:	Invasive devices:	Conditions:	
☐ MRSA ☐ VRE ☐ CPO ☐ CRE ☐ VRSA ☐ ESBL ☐ Drug-resistant PA ☐ Drug-resistant AB ☐ C. diff ☐ Other: ☐ None	☐ Central or PICC line ☐ G and/or J Tube ☐ Hemodialysis Port ☐ Mechanical Ventilator ☐ PEG Tube ☐ Urinary Catheter ☐ Wound Vac ☐ Tracheostomy ☐ Other: ☐ None	☐ Renal disease ☐ Diabetes mellitus ☐ Emphysema/COPD ☐ Heart failure/CHF ☐ Hypertension ☐ Respiratory failure ☐ Peri/Hemi/Quadriplegia ☐ Obesity (BMI > 30) ☐ Wound/Ulcer/Abscess ☐ Chronic/Recurring UTI ☐ Cancer/Malignancy ☐ CVA/TBI ☐ Hyperlipidemia ☐ Other: ☐ None	

Hospitalized or LTC in the last 3 months? ☐ Yes ☐ No Facility name:	Resident of a long-term care facility? ☐ Yes ☐ No Facility name:	Antimicrobial (abx) use 30 days prior to diagnosis: ☐ Yes ☐ No ☐ Unknown	Treatment with abx after diagnosis: ☐ Yes ☐ No ☐ Unknown
Invasive procedures in the past 6 months:	Reason for hospital admission:	Out of state/country travel in past 12 months? ☐ Yes ☐ No ☐ Unknown Where: Dates:	Room number(s) and unit(s) during admission:

Recommendations:

We recommend placing the patient in contact precautions or Enhanced Barrier Precautions (EBP) (if applicable).

We recommend flagging the patient chart in case the patient is readmitted to limit transmission. We recommend utilizing a transfer form if patient is transferred.

If the patient had a roommate, we have a concern of transmission. Screening may be recommended.

If you would like additional resources, please visit the [HAI/AR Website](#).