CARBAPENEM-RESISTANT ENTEROBACTERIACEAE REPORT FORM

Philadelphia Department of Public Health
Division of Disease Control
Acute Communicable Disease Program
500 South Broad St, Philadelphia, 19146
Telephone (215) 685-6740 Fax (215) 238-6947
Form available at hip.phila.gov

REPORT DATE: _____/_____/____ GENUS AND SPECIES:

PATIENT DEMOGRAPHIC INFORMATION

LAST NAME	FIRST NAME	D.O.B	AGE (yr)	SEX	RACE
		___/___/____			

ADDRESS	ZIP CODE	PHONE

RESIDES IN FACILITY	FACILITY NAME	WAS FACILITY NOTIFIED?	PART OF CLUSTER?
Y ☐ N ☐		Y ☐ N ☐	Y ☐ N ☐ DK ☐

HISTORY OF INTERNATIONAL HEALTHCARE STAY IN PREVIOUS 6 MONTHS

Y ☐ N ☐ DK ☐ If yes, Location: Dates of Travel: ____/_____/____ - ____/_____/____

CLINICAL DATA

SYMPTOM ONSET DATE	HOSPITALIZED	HOSPITAL NAME	ADMIT DATE	DISCHARGE DATE
_____/_____/____	Y ☐ N ☐		____/_____/____	____/_____/____

Y	N	DK	*(Y=Yes; N=No; DK=Don't Know)*
☐	☐	☐	Admitted to Intensive Care Unit
☐	☐	☐	Fatal, Date of Death: ___/____/_____

PATIENT LOCATION ON 4th CALENDAR DATE PRIOR TO INITIAL CULTURE DATE

☐ Inpatient at reporting location ☐ LTCF/SNF ☐ LTACH ☐ Private Residence
☐ Inpatient at _____ ☐ Unknown ☐ Other, Specify : _____

INFECTIONS ASSOCIATED WITH CULTURE(S) *(Check all that apply)*

☐ None ☐ Pneumonia (X-ray confirmed) ☐ Urinary Tract Infection (UTI) ☐ Abscess ☐ Ulcer/wound
☐ Bacteremia ☐ Other, specify:_____

UNDERLYING CONDITIONS

☐ None ☐ Chronic Heart Disease/Cardiovascular Disease ☐ Kidney Disease
☐ Unknown ☐ Neurological, specify_____ ☐ Invasive Devices, Specify: _____
☐ Dialysis in past year ☐ Diabetes ☐ Other, Specify: _____
☐ COPD ☐ Immunosuppression, Specify : _____

LABORATORY (Please attach drug susceptibility and test method or document below)

SPECIMEN COLLECTION DATE: _____/_____/____ RESULT DATE: _____/_____/____

SPECIMEN TYPE

☐ Blood ☐ Urine
☐ Sputum ☐ Endotracheal aspirate
☐ Wound ☐ CSF
☐ Rectal Swab ☐ Abcess
☐ Other, Specify_____

RESISTANT/INTERMEDIATE TO:

☐ Doripenem
☐ Ertapenem
☐ Imipenem
☐ Meropenem
☐ 3rd Generation Cephalosporins

TESTING FOR CARBAPENEMASES

Pos.	Neg.	NT	DK	*(NT= Not Tested, DK=Don't Know)*
☐	☐	☐	☐	Hodge Test
☐	☐	☐	☐	KPC PCR
☐	☐	☐	☐	NDM PCR
☐	☐	☐	☐	Other, please specify: _____

REPORTER INFORMATION

REPORTER NAME	FACILITY NAME:	REPORTER PHONE #:	TYPE: ☐ DO/MD ☐ ICP ☐ PA/NP ☐ RN ☐ Other_____

Please fax report to 215-238-6947 upon completion. Retain CRE isolates from patients who have a history of overnight healthcare treatment outside of the U.S. during the preceding 6 months. Contact PDPH at (215) 685-6742 to coordinate resistance mechanism testing at CDC.