

Carbapenemase-Producing Organism (CPO) /Carbapenem-Resistant Organism (CRO) Report Form



Department of
Public Health
CITY OF PHILADELPHIA

Philadelphia Department of Public Health

Division of Disease Control

1101 Market St., 12th Floor

Philadelphia, PA 19107

Telephone: (215) 685-6748

Fax: (215) 238-6947

Form available at hip.phila.gov

PATIENT DEMOGRAPHIC INFORMATION

PATIENT'S NAME (LAST, FIRST)	D.O.B. ____/____/____	AGE (years) _____	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
RACE <input type="checkbox"/> African-American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native-American <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	HISPANIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK		
CURRENT ADDRESS <input type="checkbox"/> Private Residence <input type="checkbox"/> Healthcare/Assisted Living Facility	ZIP CODE ____-____	PATIENT TELEPHONE <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home	
FACILITY NAME, if residing in a healthcare/assisted living facility	WAS FACILITY NOTIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	PART OF OUTBREAK/CLUSTER <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	

CLINICAL DATA

HOSPITALIZED <input type="checkbox"/> Yes <input type="checkbox"/> No	HOSPITAL NAME _____	ADMIT DATE ____/____/____	DISCHARGE DATE ____/____/____	Admitted to Intensive Care Unit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK Fatal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of Death: ____/____/____
REASON FOR TESTING <input type="checkbox"/> Screening/Surveillance <input type="checkbox"/> Signs/Symptoms of Infection		SIGNS/SYMPTOMS ONSET DATE, if infection ____/____/____		HISTORY OF CPO/CRO <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK DATE OF FIRST POSITIVE: ____/____/____
INFECTION(S) ASSOCIATED WITH CULTURE(S) (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Blood <input type="checkbox"/> Respiratory Tract Infection <input type="checkbox"/> Urinary Tract Infection (UTI) <input type="checkbox"/> Organ Space/Abscess <input type="checkbox"/> Skin/Soft Tissue Infection or Wound <input type="checkbox"/> Other: _____				
UNDERLYING MEDICAL CONDITIONS (Check all that apply or attach problems list or pertinent sections of medical record) <input type="checkbox"/> Chronic Heart/Cardiovascular Disease <input type="checkbox"/> Kidney Disease; <input type="checkbox"/> Dialysis in Past Year <input type="checkbox"/> Wound(s), specify: _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Neurological, specify: _____ <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> COPD <input type="checkbox"/> Immunosuppression, specify: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown				

RISK FACTORS

IF AVAILABLE, HISTORY OF HEALTHCARE STAYS IN THE UNITED STATES IN THE PREVIOUS YEAR (List where the patient was transferred from first)

Facility: _____ Admission/Discharge Dates: ____/____/____ - ____/____/____

Facility: _____ Admission/Discharge Dates: ____/____/____ - ____/____/____

Facility: _____ Admission/Discharge Dates: ____/____/____ - ____/____/____

HISTORY OF INTERNATIONAL TRAVEL and/or MEDICAL CARE ABROAD IN PREVIOUS YEAR (Check all that apply)

☐ International Travel ☐ Medical Care Abroad ☐ No ☐ Unknown Dates of travel: ____/____/____ - ____/____/____

If yes, location(s): _____

SURGERY/PROCEDURE INVOLVING A SCOPING DEVICE IN THE PAST YEAR? ☐ Yes ☐ No ☐ Unknown If yes, date: ____/____/____

CURRENT INDWELLING / INVASIVE DEVICE(S)? ☐ Yes ☐ No ☐ Unknown If yes, specify: _____

LABORATORY (Please attach culture and sensitivity results and any other applicable test results available)

SPECIMEN COLLECTION DATE: ____/____/____		RESULT DATE: ____/____/____		GENUS and SPECIES: _____			
SPECIMEN TYPE (Check all that apply) <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Rectal <input type="checkbox"/> Wound <input type="checkbox"/> CSF <input type="checkbox"/> Sputum <input type="checkbox"/> Abscess <input type="checkbox"/> Axilla/Groin <input type="checkbox"/> Other, specify: _____		RESISTANT/INTERMEDIATE TO: (Check all that apply) <input type="checkbox"/> Doripenem <input type="checkbox"/> Ertapenem <input type="checkbox"/> Imipenem <input type="checkbox"/> Meropenem <input type="checkbox"/> Pandrug-Resistant (PDR)		CARBAPENEMASE PRODUCTION <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Test Performed: <input type="checkbox"/> Modified Hodge Test <input type="checkbox"/> ICT <input type="checkbox"/> Metallo- β -lactamase Test <input type="checkbox"/> CIM <input type="checkbox"/> mCIM <input type="checkbox"/> eCIM <input type="checkbox"/> Carba-NP <input type="checkbox"/> Other: _____		CARBAPENEMASE MECHANISMS <input type="checkbox"/> KPC <input type="checkbox"/> NDM <input type="checkbox"/> VIM <input type="checkbox"/> IMP <input type="checkbox"/> OXA-48 <input type="checkbox"/> OXA-23 <input type="checkbox"/> Other: _____ Test Performed: <input type="checkbox"/> PCR <input type="checkbox"/> Xpert Carba-R <input type="checkbox"/> VERIGENE <input type="checkbox"/> Streck ARM-D <input type="checkbox"/> CEPHEID <input type="checkbox"/> Other: _____	

REPORTER INFORMATION

REPORT DATE ____/____/____	REPORTER NAME Role: <input type="checkbox"/> DO/MD <input type="checkbox"/> ICP <input type="checkbox"/> PA/NP <input type="checkbox"/> RN <input type="checkbox"/> Other: _____	FACILITY NAME _____	REPORTER PHONE # & EMAIL _____
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PLEASE FAX REPORT TO (215) 238-6947 UPON COMPLETION. **RETAIN CRO/CPO ISOLATE FOR ONE MONTH**

Reporting Guidelines for Carbapenemase-Producing Organisms (CPO) / Carbapenem-Resistant Organisms (CRO)

Report **all cases of CPO**, including any bacterial species and cases that were identified from diagnostic testing as well as surveillance/screening testing.

If carbapenemase-production testing is not conducted, report both diagnostic and surveillance/screening cases of CRO, as follows:

Report **all carbapenem-resistant *Enterobacterales***;
report **pan non-susceptible *Acinetobacter spp.* and *Pseudomonas spp.***

A case of **CPO** is defined as a culture yielding a bacterium that is in the order *Enterobacterales* (e.g. *Klebsiella*, *Enterobacter*, *Escherichia coli*, *Proteus*, *Serratia*, etc.), or *Acinetobacter spp.* or *Pseudomonas spp.*:

1. that is documented to produce a carbapenemase by means of a phenotypic or genotypic laboratory test. Tests include but are not limited to, MicroScan, E-test, disk diffusion test, Modified Hodge Test (MHT), Metallo- β -lactamase test, Carba NP, Carbapenem Inactivation Method (CIM), Modified CIM (mCIM), polymerase-chain reaction (PCR), and Gene Xpert CarbaR.

A case of **CRO** is defined as a culture yielding a bacterium that is in the order *Enterobacterales* (e.g. *Klebsiella*, *Enterobacter*, *Escherichia coli*, *Proteus*, *Serratia*, etc.), or *Acinetobacter spp.* or *Pseudomonas spp.*:

1. that is resistant to at least one carbapenem antibiotic (minimum inhibitory concentrations of ≥ 4 mcg/ml for meropenem, imipenem, and doripenem OR ≥ 2 mcg/ml for ertapenem)

All positive test results should be reported to the Philadelphia Department of Public Health (PDPH) **within 5 days**, with the exception of CPO/CRO clusters/outbreaks, which should be reported, via phone, within 24 hours.

A CPO/CRO Case Report Form should be filled out and faxed to PDPH at (215) 238-6947. Cases may be reported to PDPH via phone at (215) 685-6748.