TEXAS Department of State Health Services

For questions regarding this form, call 1-800-705-8868
www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

NBS pt. ID: _____

MDR-A Investigation Form

Public Health Use Only ☐Confirmed ☐Not a case ☐ Out of jurisdiction

Patient's name: _____
Last **First** **MI**

Address: _____ ☐ Homeless

City: _____ **State:** _____ **Zip:** _____

County: _____

Home #: ( ) _____ **Work #:** ( ) _____

Date of birth: ____/____/____ **Age:** _____ **Sex:** ☐Male ☐Female ☐UNK

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐UNK

Race: ☐Am.Indian/Alaskan Native ☐Asian ☐Black/African Am. ☐Native Hawaiian/ Pacific Isl. ☐White ☐UNK

Jurisdiction: _____

Investigation start date: _____/_____/_____

Investigated by: _____

Phone: ( ) _____

Email: _____

Reporting source type: _____

Reporting Organization: _____

Reporting Provider: _____

Reported by: _____

Phone: ( )_____ **Date reported:** ____/____/____

HOSPITAL/ FACILITY INFORMATION

Was the patient admitted to a healthcare facility (HCF)? ☐Yes, name of HCF: _____ ☐No

Was the patient visit due to an outpatient/ wound clinic/ ER, etc. visit only? ☐ Yes, name of facility: _____ ☐No

Date of HCF admission: _____/_____/_____ **Date of HCF discharge**: _____/_____/_____ **OR** **Date of Outpatient visit:** _____/_____/_____

Were control measures (per MDRO Guidance) implemented at the admitting HCF? ☐Yes ☐No ☐UNK ☐ NA

Facility patient came from: ☐Home ☐ Acute care hospital ☐LTAC ☐LTCF/NH ☐Rehab ☐Hospice ☐UNK ☐ N/A ☐Other

Name of facility: _____ **Was this facility notified of MDRO?** ☐Yes ☐No ☐UNK

Were control measures (per MDRO Guidance) implemented at the facility the patient came from? ☐Yes ☐No ☐UNK ☐N/A

Discharged to: ☐Home ☐ Acute care hospital ☐LTAC ☐LTCF/NH ☐Rehab ☐Hospice ☐UNK ☐N/A ☐Other ☐Patient still admitted ☐Patient expired

Name of facility: _____ **Was this facility notified of MDRO?** ☐Yes ☐No ☐UNK

Were control measures (per MDRO Guidance) implemented at the facility the patient was discharged to? ☐Yes ☐No ☐UNK ☐N/A

CLINICAL DATA

Date of symptom onset: ____/____/____ Earliest Date Suspected: _____/_____/____

Did patient die? ☐Yes, date of death: ____/____/____ ☐No ☐UNK

Did the MDRO contribute to death? ☐Yes ☐No ☐UNK

Was the patient admitted to an intensive care unit?
☐Yes, admitted to ICU date: ____/_____/____ ☐No ☐UNK

Did patient have indwelling/invasive devices at time of positive culture?
☐Yes ☐No ☐UNK
If yes, select all that apply: ☐Central line/ PICC ☐Hemodialysis Cath ☐Intubated/ Ventilator ☐Nasogastric/ PEG tube ☐Tracheostomy tube ☐Urinary Catheter ☐Other

OTHER INFORMATION

Was the patient previously in a HCF within past 6 months?
☐Yes ☐No ☐UNK
If yes, facility name:_____
Admit date: _____ Discharge date: _____
Facility name:_____
Admit date: _____ Discharge date: _____
Facility name:_____
Admit date: _____ Discharge date: _____

LABORATORY DATA

Date collected: ____/____/____ Pathogen: ☐MDR-Acinetobacter baumanii ☐Other MDR-A._____

Specimen source: _____ Specimen site (specific): _____

Test Method: ☐Culture ☐PCR ☐Other

Epi Case Criteria: (lab report should be attached to form and/or entered into NBS)

MDR-A Confirmed: *Acinetobacter* species from any body site/source that is laboratory confirmed.
Non-susceptible (i.e., resistant or intermediate) to at least one antibiotic in at least 3 antimicrobial classes of the following 6 antimicrobial classes:

	Antimicrobial Class	Antibiotics		
1.	Aminoglycosides	☐Amikacin	☐Gentamicin	☐Tobramycin
2.	Beta-Lactam	☐Piperacillin	☐Piperacillin/Tazobactam	
3.	Carbapenems	☐Imipenem	☐Meropenem	☐Doripenem
4.	Cephalosporins	☐Cefepime	☐Ceftazidime	
5.	Fluoroquinolones	☐Ciprofloxacin	☐Levofloxacin	
6.	Sulbactam	☐Ampicillin/Sulbactam		

Note: There is no requirement to submit isolates to the DSHS lab. Please contact a DSHS HAI Epidemiologist or the DSHS lab for additional information on available lab support.