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: _____

CRE 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 ☐ NA ☐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 ☐NA

Discharged to: ☐Home ☐ Acute care hospital ☐LTAC ☐LTCF/NH ☐Rehab ☐Hospice ☐UNK ☐NA ☐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 ☐NA

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: ☐CRE-E.coli ☐CRE-K.pneumoniae ☐CRE-K.oxytoca ☐Other: CRE-K._____

Specimen source: _____ Specimen site (specific): _____

Test Method: ☐Culture ☐PCR ☐MHT ☐Other

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

CRE Confirmed: A *Klebsiella* species or *E.coli* from any body site/ source that is laboratory confirmed.

Klebsiella species and *E. coli* that are **resistant** to any carbapenem, including meropenem, imipenem, doripenem, or ertapenem,
OR
Production of a carbapenemase (i.e. KPC, NDM, VIM, IMP, OXA-48) demonstrated by a recognized test (i.e. polymerase chain reaction, metallo-B-lactamase test, modified Hodge test, Carba NP).

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.