



Multidrug-Resistant Organism (MDRO) Case Report Form

New Jersey Department of Health

NJDOH USE ONLY
Received date: _____
NJDOH ID: _____

REPORTING FACILITY INFORMATION	
Date completed: _____	Facility Name: _____
Facility Street Address: _____	City: _____ State: _____ Zip: _____
Facility POC: _____	Email: _____ Phone: (____) ____ - ____ ext. ____
Facility type: <input type="checkbox"/> Acute care <input type="checkbox"/> Long-term acute care <input type="checkbox"/> Long-term care/skilled nursing with ventilator beds <input type="checkbox"/> Short-term rehabilitation	
<input type="checkbox"/> Long-term care/skilled nursing without ventilator beds <input type="checkbox"/> Other: _____	

CASE INFORMATION		
Patient First Name: _____	Patient Last Name: _____	Date of Birth: _____
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Ethnicity: <input type="checkbox"/> Hispanic and/or Latino <input type="checkbox"/> Not Hispanic and/or Latino <input type="checkbox"/> Unknown	
Race (select all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian		
<input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown		
Patient Street Address: _____		City: _____ State: _____ Zip: _____
Is the patient living? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If no, date of death: _____ Cause of death: _____ <input type="checkbox"/> Unknown	

LABORATORY INFORMATION	
Laboratory name: _____	Date of specimen collection: _____
Specimen site/source: _____	Clinical or Surveillance Specimen? <input type="checkbox"/> Clinical <input type="checkbox"/> Surveillance
MDRO organism (<i>Genus species</i>): _____	Date of laboratory confirmation: _____
Lab Street Address: _____	
City: _____ State: _____ Zip: _____	
Lab POC: _____	
Email: _____ Phone: (____) ____ - ____ ext. ____	

PATIENT MOVEMENT IN INQUIRED HEALTHCARE FACILITY <small>(List rooms/units in which the patient resided within your facility in the 30 days prior to specimen collection)</small>												
Admission/Move date	Unit	Room	Contact Precautions or EBP			Roommates			Shared Bathroom			Discharge/Move date
			Yes	No	Unk	Yes	No	Unk	Yes	No	Unk	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

PATIENT ADMISSION/DISCHARGE IN OTHER HEALTHCARE FACILITIES <small>(List all admissions and discharges from your facility in the 30 days prior to specimen collection)</small>			
Location from which the patient was sent to your facility <small>(Each row represents a different admission to your facility)</small>		Location to which the patient was sent to your facility <small>(Each row represents a different discharge from your facility)</small>	
Facility Name or "Home"	Date Received	Facility Name, "Home", or "Still Admitted"	Date Discharged

ROOMMATES <small>(List all known roommates of the patient at your facility unless otherwise specified)</small>			
Roommate First Name	Roommate Last Name	Roommate Date of Birth	Notes (include dates in common, transfers, etc.)

HEALTHCARE SERVICES <small>(Select all healthcare services provided to the patient within the 30 days prior to specimen collection unless otherwise specified)</small>			
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> ECMO	<input type="checkbox"/> Imaging	<input type="checkbox"/> Inpatient dialysis
<input type="checkbox"/> Respiratory therapy	<input type="checkbox"/> Wound care	<input type="checkbox"/> Ultrasound	<input type="checkbox"/> Other: _____
<input type="checkbox"/> IVIG	<input type="checkbox"/> Outpatient dialysis	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> None
MEDICAL CONDITIONS <small>(Select all of the patient's present medical conditions and those existing 14 days prior to the date of specimen collection unless otherwise specified)</small>			
<input type="checkbox"/> Autoimmune disorder	<input type="checkbox"/> Bacteremia	<input type="checkbox"/> Bone marrow transplant	<input type="checkbox"/> Cancer (hematogenous)
<input type="checkbox"/> Cardiovascular disease	<input type="checkbox"/> Chronic kidney disease	<input type="checkbox"/> Chronic wounds	<input type="checkbox"/> COVID-19
<input type="checkbox"/> History of MDR infection and/or colonization*	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Kidney failure	<input type="checkbox"/> Liver disease
<input type="checkbox"/> Non-ambulatory	<input type="checkbox"/> Obesity	<input type="checkbox"/> Respiratory disease (non-COVID)	<input type="checkbox"/> Sepsis
<input type="checkbox"/> Ventilator dependent	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Solid organ transplant	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Cancer (solid)	<input type="checkbox"/> History of COVID-19	<input type="checkbox"/> Neurologic disease	<input type="checkbox"/> None
MEDICAL DEVICES <small>(Select all of the patient's present medical devices unless a timeframe is otherwise specified)</small>			
<input type="checkbox"/> Abdominal feeding tube	<input type="checkbox"/> Central venous catheter	<input type="checkbox"/> Colostomy	<input type="checkbox"/> Hemodialysis catheter
<input type="checkbox"/> Mechanical ventilator	<input type="checkbox"/> Nephrostomy	<input type="checkbox"/> Port(s)	<input type="checkbox"/> Surgical drain
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Tracheostomy/tracheostomy collar	<input type="checkbox"/> Urinary catheter	<input type="checkbox"/> None
MEDICAL PROCEDURES <small>(List all of the patient's medical procedures conducted at your facility or host site in the past 30 days unless otherwise specified)</small>			
Did the patient undergo medical procedures in the past 30 days (if yes, list the procedures below)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Date	Procedure	Location	Facility
ANTIMICROBIAL EXPOSURES <small>(Select all of the patient's present antimicrobials and those administered 14 days prior to the specimen collection date unless otherwise specified)</small>			
Which (if any) of the following classes of antimicrobials was the patient exposed to? <input type="checkbox"/> Unknown <input type="checkbox"/> None			
<input type="checkbox"/> Aminoglycosides:	<input type="checkbox"/> Oxazolidinones:		
<input type="checkbox"/> Carbapenems:	<input type="checkbox"/> Penicillins:		
<input type="checkbox"/> Cephalosporins:	<input type="checkbox"/> Polypeptides:		
<input type="checkbox"/> Fluoroquinolones:	<input type="checkbox"/> Rifamycins:		
<input type="checkbox"/> Glycopeptides:	<input type="checkbox"/> Sulfonamides:		
<input type="checkbox"/> Macrolides:	<input type="checkbox"/> Tetracyclines:		
<input type="checkbox"/> Monobactams:	<input type="checkbox"/> Other: _____		
TRAVEL HISTORY			
Did the patient receive any international healthcare during travel in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
If yes, in which country? _____		Start Date: _____	End Date: _____
COMMENTS <small>(If no comments, please include a brief H&P)</small>			
<small>*if the patient has a history of MDR infection and/or colonization, please indicate organism here</small>			
FOR NJDOH USE ONLY			
MDRO: _____		Resistance Mechanism: _____	
Collection date: _____		Alert date: _____	
Testing date: _____		PHEL Submission date: _____	
		<input type="checkbox"/> Facility Report <input type="checkbox"/> AR Surveillance	



MDRO Case Report Form Appendix New Jersey Department of Health

Please submit this completed form, with final microbiology reports as a separate attachment, via the secure portal, linked here:
<http://healthsurveys.nj.gov/NoviSurvey/n/zz2g8.aspx>

If you have any questions, please email the AR team at DOH.CDS.HAIAR.EPI@doh.nj.gov.

Clarification of Medical Conditions and Devices:

When completing this form, please reference the table below for certain options listed in sections regarding Medical Conditions, Medical Devices, and Medications (antibiotics and antifungals) to limit redundancy. If you have any additional comments, please list them in the box on the last page of the form.

MEDICAL CONDITIONS <i>(These examples are not exhaustive but provide an idea of the conditions included in each category)</i>
Autoimmune disorder: anemia, celiac disease, lupus, psoriasis, rheumatoid arthritis, scleroderma, vasculitis, etc.
Cancer (hematogenous): leukemia, lymphoma, myeloma, etc.
Cardiovascular disease: arrhythmias, coronary artery disease, cardiomyopathy, congestive heart failure, hypertension, etc.
History of MDR infection: Vancomycin-resistant <i>Enterococci</i> (VRE), Methicillin-resistant <i>Staphylococcus aureus</i> (MRSA), etc.
Liver disease: cirrhosis, fatty liver disease, hemochromatosis, hepatitis, etc.
Neurologic disease: Alzheimer’s disease, ataxia, epilepsy, meningitis, multiple sclerosis, Parkinson’s disease, etc.
Respiratory disease: asthma, bronchitis, chronic obstructive pulmonary disease, emphysema, pneumonia, etc.

MEDICAL DEVICES <i>(These examples are not exhaustive but provide an idea of the devices included in each category)</i>
Abdominal feeding tube: nasogastric (NG) tube, orogastric (OG) tube, gastric (G) tube, jejunostomy (J) tube, etc.
Central venous catheter: central line (tunneled central venous catheter), peripherally inserted central catheter (PICC), etc.
Urinary catheter: Foley (indwelling) catheter, suprapubic catheter, etc.

MEDICATION EXPOSURES <i>(These examples are not exhaustive but provide an idea of the drugs included in each category)</i>
Aminoglycosides: Amikacin, Gentamicin, Kanamycin, Neomycin, Plazomicin, Streptomycin, Tobramycin, etc.
Carbapenems: Doripenem, Ertapenem, Imipenem, Meropenem, etc.
Cephalosporins: Ceftobiprole, Ceftriaxone, Ceftazidime, Cephalexin, Cefotaxime, Cefuroxime, Cefazolin, Cefepime, etc.
Fluoroquinolones: Ciprofloxacin, Delafloxacin, Gemifloxacin, Levofloxacin, Moxifloxacin, Norfloxacin, Ofloxacin, etc.
Glycopeptides: Dalbavancin, Oritavancin, Teicoplanin, Telavancin, Vancomycin, etc.
Macrolides: Azithromycin, Clarithromycin, Erythromycin, Fidaxomicin, etc.
Monobactams: Aztreonam
Oxazolidinones: Linezolid, Tedizolid, etc.
Penicillins: Amoxicillin, Ampicillin, Carbenicillin, Dicloxacillin, Nafcillin, Oxacillin, Penicillin G or V, Piperacillin, Ticarcillin, etc.
Polypeptides: Bacitracin, Colistin, Polymyxin B, etc.
Rifamycins: Rifabutin, Rifampin, Rifapentine, Rifaximin, etc.
Sulfonamides: Mafenide, Sulfacetamide, Sulfadiazine, Sulfadoxine, Sulfamethizole, Sulfamethoxazole, Sulfasalazine, etc.
Tetracyclines: Doxycycline, Eravacycline, Minocycline, Omadacycline, Tetracycline, etc.