CDC Case Report Form: Serious Adverse Events Following Ceftriaxone Injection in Healthcare Settings

Form Approved
OMB Control No. 0920-1011
Expiration Date: 12/31/2025

This form is intended to be completed by a healthcare provider or a healthcare facility staff member, coroner, medical examiner, or public health professional in conjunction with a healthcare provider. The purpose of this form is to report a serious adverse event after administration of ceftriaxone injection. If you are a patient and want to report an adverse event related to ceftriaxone injection, please speak with your medical provider.

A serious adverse event is defined by the Food and Drug Administration as any undesirable experience associated with the use of a medical product in a patient, including:

- Death
- Life-threatening outcome
- Hospitalization (initial or prolonged)
- Outcomes which required intervention to prevent permanent impairment or damage
- Other serious events (including allergic bronchospasm or serious problems with breathing)

For additional information from the Food and Drug Administration on the definition of serious adverse events, please view: https://www.fda.gov/safety/reporting-serious-problems-fda/what-serious-adverse-event

Please note that completing this form does not replace reporting adverse events to FDA's MedWatch or to the manufacturer directly. The online form to file a MedWatch report can be found here: https://www.accessdata.fda.gov/scripts/medwatch/index.cfm?action=reporting.home

Reporter Information

Reporter name _____

Reporter phone number _____

Reporter email _____

Reporter fax number _____

Name of reporter's workplace _____

Reporter work address _____

Reporter city

Reporter zip code

Reporter county

Reporter state or territory	◯ Alabama ◯ Alaska ◯ Arizona ◯ Arkansas ◯ California ◯ Colorado ◯ Connecticut ◯ Delaware ◯ Florida ◯ Georgia ◯ Hawaii ◯ Idaho ◯ Illinois ◯ Indiana ◯ Iowa ◯ Kansas ◯ Kentucky ◯ Louisiana ◯ Maine ◯ Maryland ◯ Massachusetts ◯ Michigan ◯ Minnesota ◯ Mississippi ◯ Missouri ◯ Montana ◯ Nebraska ◯ Nevada ◯ New Hampshire ◯ New Jersey ◯ New Mexico ◯ New York ◯ North Carolina ◯ North Dakota ◯ Ohio ◯ Oklahoma ◯ Oregon ◯ Pennsylvania ◯ Rhode Island ◯ South Carolina ◯ South Dakota ◯ Tennessee ◯ Texas ◯ Utah ◯ Vermont ◯ Virginia ◯ Washington ◯ West Virginia ◯ Wisconsin ◯ Wyoming ◯ District of Columbia ◯ American Samoa ◯ Federated States of Micronesia ◯ Guam ◯ Marshall Islands ◯ Commonwealth of the Northern Mariana Islands ◯ Palau ◯ Puerto Rico ◯ U.S. Minor Outlying Islands ◯ U.S. Virgin Islands

Reporter type	◯ Coroner ◯ Hospital ◯ Outpatient facility ◯ Health department ◯ Other
If other, please specify	_____

Patient Demographics

Patient age	_____
Patient sex	◯ Male ◯ Female
Patient county of residence	_____

Patient state or territory of residence

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ District of Columbia
- ◯ American Samoa
- ◯ Federated States of Micronesia
- ◯ Guam
- ◯ Marshall Islands
- ◯ Commonwealth of the Northern Mariana Islands
- ◯ Palau
- ◯ Puerto Rico
- ◯ U.S. Minor Outlying Islands
- ◯ U.S. Virgin Islands

Serious Adverse Event Information

Please use the following information to help guide selection of the particular serious event type:

- Death: Check if the patient died after receiving the medical product.

- Life-threatening outcome: Check if you suspect that the patient was at substantial risk of dying at the time of the adverse event, or if continued use of the medical product might have resulted in the death of the patient.

- Hospitalization (initial or prolonged): Check if admission to the hospital or prolongation of hospitalization was a result of the adverse event.

- Outcomes which required intervention to prevent permanent impairment or damage: Check if you believe that medical or surgical intervention was delivered to prevent permanent impairment of a body function or prevent permanent damage to a body structure due to the use of a medical product.

- Other serious or important medical events: Check when the event does not fit the other outcomes, but the event could have jeopardized the patient and could have required medical or surgical intervention (treatment) to prevent one of the other outcomes. Examples include allergic bronchospasm (a serious problem with breathing) requiring treatment in an emergency room.

Please choose the type of serious adverse event (Note: Please choose the most serious adverse event type applicable)	◯ Death ◯ Life-threatening outcome ◯ Hospitalization (initial or prolonged) ◯ Outcomes which required intervention to prevent permanent impairment or damage ◯ Other serious or important medical events
DATE of most recent dose of ceftriaxone received?	_____
TIME of most recent dose of ceftriaxone if known (please enter in 24-hour time format) Note: For outpatient facilities, if the timing of administration is not documented, please record estimated time of ceftriaxone administration from the treating provider.	_____
Healthcare facility type where ceftriaxone was administered	◯ Outpatient clinic (including primary care clinics) ◯ Urgent care clinic ◯ Ambulatory surgery center ◯ Emergency department ◯ Acute care hospital, excluding emergency department and ICU ◯ Acute care hospital ICU ◯ Long term acute care hospital ◯ Skilled nursing facility ◯ Assisted living facility ◯ Rehab facility ◯ Other
If other, please specify	_____

DATE of adverse event onset (Note: Please specify date when new or worsening symptoms occurred after ceftriaxone administration)	_____
TIME of adverse event onset (Note: please enter in 24-hour time format) (Note: Please specify time when new or worsening symptoms occurred after ceftriaxone administration)	_____
Did the onset of the serious adverse event within 6 hours of receiving ceftriaxone?	◯ Yes ◯ No ◯ Unknown
In which setting did the adverse event occur?	◯ Community setting (ex: home, store, restaurant, etc.) ◯ Outpatient clinic (including primary care clinics) ◯ Urgent care clinic ◯ Ambulatory surgery center ◯ Emergency department ◯ Acute care hospital, excluding emergency department and ICU ◯ Acute care hospital ICU ◯ Long term acute care hospital ◯ Skilled nursing facility ◯ Assisted living facility ◯ Rehab facility ◯ Other
If other setting of adverse event, please specify	_____
Did EMS evaluate the patient?	◯ Yes ◯ No ◯ Unknown
Was the patient transferred to a higher level of care as a result of this severe adverse event? (If "No" or "Unknown", please skip to question about signs and symptoms of serious adverse event)	◯ Yes ◯ No ◯ Unknown
If patient transferred to a higher level of care, what was the highest level of care the patient received for management of the adverse event?	◯ Treatment in urgent care or outpatient clinic ◯ Treatment in emergency department (for cases where patient was not admitted to hospital after emergency department evaluation) ◯ Treatment in acute care hospital (excluding emergency department or ICU) ◯ Treatment in ICU ◯ Other (specify)
If "other" selected for highest level of care, please specify	_____
If the patient was evaluated in an outpatient setting or in emergency department, what was the disposition after care?	◯ Discharged home ◯ Transferred to another facility ◯ Death ◯ Other
If "other" selected for question above, please specify	_____

If the patient was hospitalized or if "other" selected for higher level of care, what was the disposition after care?

- ◯ Discharged home
- ◯ Discharged or transferred to another facility
- ◯ Still receiving care inpatient
- ◯ Death
- ◯ Other

If "other" selected for question above, please specify

_____

Signs and symptoms of serious adverse event (select all that apply)

- ☐ Abdominal pain
- ☐ Blurred vision
- ☐ Bradycardia
- ☐ Chest pain
- ☐ Chills
- ☐ Confusion
- ☐ Cough/choke
- ☐ Diaphoresis
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Facial swelling
- ☐ Fever
- ☐ Flushing
- ☐ Found unresponsive
- ☐ Headache
- ☐ Hypoxia
- ☐ Lacrimation (tearing from eyes)
- ☐ Lethargy
- ☐ Loss of consciousness
- ☐ Low blood pressure
- ☐ Nausea
- ☐ Numbness
- ☐ Palpitations
- ☐ Rash (other than hives or skin redness)
- ☐ Seizure
- ☐ Shortness of breath
- ☐ Skin redness (other than hives)
- ☐ Strange smell
- ☐ Strange taste
- ☐ Swelling of legs, feet, or ankles
- ☐ Tachycardia
- ☐ Throat closing
- ☐ Tingling
- ☐ Tongue itching
- ☐ Urticaria (hives)
- ☐ Vomiting
- ☐ Wheezing
- ☐ Other

If other sign or symptom of serious adverse event, please list here

_____

Was the adverse event suspected to be an allergic (immunologically-mediated) reaction? (Select yes if an allergic reaction is suspected OR if event clinically managed as an allergic reaction)

- ◯ Yes
- ◯ No

Did the patient receive cardiopulmonary resuscitation (CPR) as a result of the serious adverse event? Note: For the purpose of this form, CPR is defined as cardiopulmonary resuscitation defined as the use of chest compressions and mechanical ventilation or provision of rescue breaths to maintain circulatory flow and oxygenation during cardiac arrest.	◯ Yes ◯ No
If CPR selected, enter DATE CPR was initiated	_____
If CPR selected, enter TIME CPR was initiated (Note: please enter in 24-hour time format)	_____
Does the treating provider attribute the adverse event to a cause OTHER than ceftriaxone administration?	◯ Adverse event attributed to a cause other than ceftriaxone administration (such as known infection, other underlying medical condition, or exposure to a medication or medical product other than ceftriaxone) ◯ Adverse event NOT attributed to a cause other than ceftriaxone administration
Does the treating provider attribute the adverse event to ceftriaxone administration?	◯ Yes ◯ No ◯ Provider not sure
If the adverse event is suspected to be from ceftriaxone, is it a known adverse effect of ceftriaxone? Note: Major known adverse effects of ceftriaxone are listed below. For other known adverse events of ceftriaxone, please refer to the ceftriaxone product label corresponding to the NDC number and manufacturer administered to this patient here: https://dailymed.nlm.nih.gov/dailymed/search.cfm?labeltype=all&query=ceftriaxone	◯ Yes ◯ No ◯ Adverse event not suspected to be from ceftriaxone
If the adverse event is a known adverse effect of ceftriaxone, please name the adverse effect(s) here	_____

Major known adverse effects of ceftriaxone include:

- Local reactions: Pain, induration and tenderness was 1% overall. Phlebitis was reported in < 1% after IV administration.
- Hypersensitivity: Rash (1.7%). Less frequently reported (< 1%) were pruritus, fever or chills.
- Infections and infestations: Genital fungal infection (0.1%).
- Hematologic: Eosinophilia (6%), thrombocytosis (5.1%) and leukopenia (2.1%). Less frequently reported (< 1%) were anemia, hemolytic anemia, neutropenia, lymphopenia, thrombocytopenia and prolongation of the prothrombin time.
- Blood and lymphatic disorders: Granulocytopenia (0.9%), coagulopathy (0.4%).
- Gastrointestinal: Diarrhea/loose stools (2.7%). Less frequently reported (< 1%) were nausea or vomiting, and dysgeusia. The onset of pseudomembranous colitis symptoms may occur during or after antibacterial treatment.
- Hepatic: Elevations of aspartate aminotransferase (AST) (3.1%) or alanine aminotransferase (ALT) (3.3%). Less frequently reported (< 1%) were elevations of alkaline phosphatase and bilirubin.
- Renal: Elevations of the BUN (1.2%). Less frequently reported (< 1%) were elevations of creatinine and the presence of casts in the urine.
- Central nervous system: Headache or dizziness were reported occasionally (< 1%).
- Genitourinary: Moniliasis or vaginitis were reported occasionally (< 1%).
- Miscellaneous: Diaphoresis and flushing were reported occasionally (< 1%).
- Investigations: Blood creatinine increased (0.6%).

Post-market adverse experiences reported:

- Gastrointestinal: Pancreatitis, stomatitis and glossitis.
- Genitourinary: Oliguria, ureteric obstruction, post-renal acute renal failure.
- Dermatologic: Exanthema, allergic dermatitis, urticaria, edema; acute generalized exanthematous pustulosis (AGEP) and isolated cases of severe cutaneous adverse reactions (erythema multiforme, Stevens-Johnson syndrome or Lyell's syndrome/toxic epidermal necrolysis) have been reported.
- Hematological changes: Isolated cases of agranulocytosis (< 500/mm) have been reported, most of them after 10 days of treatment and following total doses of 20 g or more.
- Nervous system disorders: Convulsion
- Other: Symptomatic precipitation of ceftriaxone calcium salt in the gallbladder, kernicterus, oliguria, and anaphylactic or anaphylactoid reactions. Source: https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=8351aa37-552d-471d-b293-c564dcb6ec29

Other:

- The combination of lansoprazole and ceftriaxone has been associated with prologed corrected QT (QTc) intervals. Citations: Bai AD, Wilkinson A, Almufleh A, et al. Ceftriaxone and the Risk of Ventricular Arrhythmia, Cardiac Arrest, and Death Among Patients Receiving Lansoprazole. JAMA Netw Open. 2023;6(10):e2339893. doi:10.1001/jamanetworkopen.2023.39893;

Lorberbaum T, Sampson KJ, Chang JB, Iyer V, Woosley RL, Kass RS, Tatonetti NP. Coupling Data Mining and Laboratory Experiments to Discover Drug Interactions Causing QT Prolongation. J Am Coll Cardiol. 2016 Oct 18;68(16):1756-1764. doi: 10.1016/j.jacc.2016.07.761. PMID: 27737742; PMCID: PMC5082283.

If the adverse event was attributed to a cause other than ceftriaxone administration, what was the suspected cause of the adverse event?	◯ Adverse event secondary to another medication other than ceftriaxone (please specify below) ◯ Active infection (please specify below) ◯ Other medical diagnosis (please specify below)
If the primary cause of the adverse event is suspected to be a medication other than ceftriaxone, please specify that medication here	_____

If the primary cause of the adverse event is suspected to be an active infection, please specify the infection here	_____
If the primary cause of the adverse event is suspected to be another medical diagnosis, please specify the medical diagnosis here	_____
Is patient deceased? (If no, please skip to next section on EKG information)	◯ Yes ◯ No
DATE of death	_____
TIME of death if known (Note: please enter in 24-hour time format)	_____
Recorded cause of death in medical record or death certificate	_____
Per treating provider or clinician, was this death in an apparently healthy patient or patient whose disease is not so severe that a fatal outcome would be expected?	◯ Yes ◯ No
Was autopsy performed? Please note that autopsy findings are critical to evaluate unexpected deaths which are suspected to be related to a medical product exposure. Please reach out to CDC at haioutbreak@cdc.gov with any questions regarding autopsy.	◯ Yes ◯ No ◯ Unknown
If autopsy was performed, what were significant findings?	_____
Was a toxicology screen performed?	◯ Yes ◯ No ◯ Unknown
If toxicology screen was performed, what were significant findings?	_____

Vital Signs Information

What were the patient's vital signs BEFORE the onset of the adverse event? (If vital signs are documented more than once before adverse event, please report those recorded most recently before onset)

Heart rate (beats per minute) _____
Respiratory rate (breaths per minute) _____
Systolic blood pressure (mmHg) _____
Diastolic blood pressure (mmHg) _____
Oxygen saturation (%) _____
Temperature (degrees Fahrenheit) _____

What were the patient's vital signs AFTER the onset of the adverse event? (If vital signs are documented more than once after adverse event, please report those recorded most recently after onset)

Heart rate (beats per minute) _____
Respiratory rate (breaths per minute) _____
Systolic blood pressure (mmHg) _____
Diastolic blood pressure (mmHg) _____
Oxygen saturation (%) _____
Temperature (degrees Fahrenheit) _____

EKG, Rhythm Strip, or Defibrillator Recording Information

Was an EKG, rhythm strip, or defibrillator recording collected during the severe adverse event? (If "No" or "Unknown", please skip to next section on patient medical information)

- ◯ Yes
- ◯ No
- ◯ Unknown

What was the heart rate?

_____

If computerized reading available, what was the PR interval?

_____

If computerized reading available, what was the QRS duration?

_____

If computerized reading available, what was the QT interval?

_____

If computerized reading available, what was the QTc interval?

_____

Please select any EKG, rhythm strip, or defibrillator recording findings that apply

- ☐ Normal sinus rhythm
- ☐ Sinus tachycardia
- ☐ Sinus bradycardia
- ☐ Atrial fibrillation
- ☐ Atrial flutter
- ☐ Supraventricular tachycardia
- ☐ Ventricular fibrillation
- ☐ Ventricular tachycardia
- ☐ ST elevation
- ☐ Right bundle branch block
- ☐ Left bundle branch block
- ☐ QT prolongation
- ☐ Other

If other EKG findings (or to elaborate on previous selected findings), please list here

_____

Patient Medical Information

Patient's medical history (select all that apply)

- ☐ COPD/emphysema/chronic lung disease
- ☐ Asthma
- ☐ Diabetes
- ☐ Congestive heart failure
- ☐ Coronary arterial disease (including history of myocardial infarction, coronary stents, or coronary artery bypass graft [CABG] surgery)
- ☐ Chronic renal insufficiency (CRI/CKD) or end-stage renal disease (ESRD)
- ☐ Cirrhosis/liver disease
- ☐ History of stroke/CVA
- ☐ Dementia
- ☐ HIV/AIDS
- ☐ Cancer (specify in next question)
- ☐ Allergy to penicillin
- ☐ Hypothyroidism
- ☐ Psychiatric illness
- ☐ Hypertension
- ☐ Hyperlipidemia
- ☐ Tobacco use
- ☐ Alcohol use disorder
- ☐ Hyperthyroidism
- ☐ Arrhythmia (ex: atrial fibrillation)
- ☐ Gastroesophageal reflux disease (GERD
- ☐ Other

If other medical history, please list here:

_____

List all the medications that the patient was taking at the time of the serious adverse event. Please use generic names of medications. Please separate medications by a semi-colon (ex: aspirin; atorvastatin; metoprolol). If no other medications, please state "none".

_____

List all allergies of the patient at the time of the serious adverse event. Please use generic names of medications if possible. Please separate medications by a semi-colon (ex: amoxicillin; trimethoprim/sulfamethoxazole). If no known allergies, please state "none".

_____

Ceftriaxone Information

Manufacturer of most recent dose of ceftriaxone received

_____

NDC (National Drug Code) number of ceftriaxone received
Note: This is a 10-digit number found on the medication vial.

_____

Lot number of most recent dose of ceftriaxone received

_____

Was this lot number documented as administered to the patient or present in the facility at the time of ceftriaxone administration (but not documented in the medical record as administered to patient)?	◯ Documented as administered to the patient ◯ Present in facility at time of administration ◯ Other
If other selected for above question, please specify	_____
If lot number was present in the facility at time of administration (but not documented in the medical record as administered to patient), please list any other manufacturers and lot numbers of ceftriaxone present in the facility at the time of administration	_____
Expiration date of most recent dose of ceftriaxone received	_____
Name of distributor or supplier of ceftriaxone for healthcare facility	_____
Dose of most recent ceftriaxone injection	◯ 250 mg ◯ 500 mg ◯ 1 g ◯ 2 g ◯ Other (please specify)
For other dose of ceftriaxone, please specify	_____
Route of administration of ceftriaxone	◯ Intramuscular (IM) ◯ Intravenous (IV) infusion ◯ Intravenous (IV) push ◯ Intravenous unknown ◯ Unknown
Which diluent was used to prepare the ceftriaxone injection?	◯ Sterile water ◯ 0.9% Sodium chloride ◯ 1% Lidocaine solution without epinephrine ◯ Bacteriostatic water + 0.9% benzyl alcohol ◯ 5% Dextrose ◯ 10% Dextrose ◯ 5% Dextrose + 0.9% Sodium Chloride Solution ◯ 5% Dextrose + 0.45% Sodium Chloride Solution ◯ Sodium lactate ◯ 10% Invert sugar ◯ 5% Sodium bicarbonate ◯ Freamine III ◯ Normosol-M in 5% dextrose ◯ Ionosol-B in 5% dextrose ◯ 5% Mannitol ◯ 10% Mannitol ◯ No other diluent used ◯ Unknown ◯ Other (specify)
If other diluent used, please specify	_____

Reason for ceftriaxone treatment	◯ Pneumonia ◯ COPD exacerbation ◯ Other respiratory illness (please specify) ◯ Urinary tract infection ◯ Sexually transmitted infection ◯ Skin and soft tissue infection ◯ Bloodstream infection ◯ Intra-abdominal infection ◯ Other (please specify)
If "other respiratory illness" or "other" chosen for reason for ceftriaxone treatment, please specify	_____
List any other medications and route of administration provided at the same time as ceftriaxone (ex: dexamethasone intramuscular, etc.).	_____
Has this patient received ceftriaxone before this incident?	◯ Yes ◯ No ◯ Unknown
If this patient has received ceftriaxone prior to current administration, did the patient experience any adverse events with previous receipt of ceftriaxone?	◯ Yes ◯ No ◯ Unknown

Respiratory Testing Information

Please answer the following questions if the reason for ceftriaxone administration was for a respiratory illness (pneumonia, COPD exacerbation, or other respiratory illness). If another reason for treatment with ceftriaxone was chosen, please skip to the next section on microbiology test information.

Did the patient have a flu test performed?	◯ Yes ◯ No ◯ Unknown
If the patient had a flu test performed, what was the result?	◯ Flu A positive ◯ Flu B positive ◯ Flu negative
Did the patient have a covid test performed?	◯ Yes ◯ No ◯ Unknown
If the patient had a covid test performed, what were the results?	◯ Covid test positive ◯ Covid test negative

Note: The following four questions are to be completed for patients who received ceftriaxone for pneumonia, COPD exacerbation, or other respiratory illness.

CURB-65 Pneumonia Severity Score Questions

The following four questions are derived from the CURB-65 Pneumonia Severity Score tool which helps stratify risk for more severe outcomes from community-acquired pneumonia.

Citation: Lim WS, van der Eerden MM, Laing R, Boersma WG, Karalus N, Town GI, Lewis SA, Macfarlane JT. Defining community acquired pneumonia severity on presentation to hospital: an international derivation and validation study. Thorax. 2003 May;58(5):377-82. doi: 10.1136/thorax.58.5.377. PMID: 12728155; PMCID: PMC1746657.

	Yes	No	Unknown
Was the patient confused (e.g., disoriented to time, place, or person) prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	◯	◯	◯
Was the patient's blood urea nitrogen (BUN) level 20 mg/dL or higher prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	◯	◯	◯
Was the patient's respiratory rate 30 breaths per minute or higher prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	◯	◯	◯
Was the patient's systolic blood pressure less than 90 mmHg, or diastolic blood pressure less than 60 mmHg prior to receiving ceftriaxone? (Note: if inpatient, this question applies to the 24 hours prior to receiving ceftriaxone)	◯	◯	◯

Microbiology Test Information

Please answer the following questions about any positive microbiology results within 2 days of the adverse event.

If there are no microbiology results to report, please skip to the next section on picture upload.

Microbiology test #1 name (ex: respiratory viral panel, stool culture, etc.) _____

Microbiology test #1 specimen source

- ◯ Nasal or oropharyngeal
- ◯ Sputum
- ◯ Blood
- ◯ Urine
- ◯ Stool
- ◯ Wound
- ◯ Other

If other specimen for microbiology test #1, please specify _____

Microbiology test #1 type	◯ Culture ◯ Gram stain ◯ NAAT (including PCR) ◯ Other
If other test type for microbiology test #1, please specify	_____
Microbiology test #1 result	_____
Microbiology test #2 name (ex: respiratory viral panel, stool culture, etc.)	_____
Microbiology test #2 specimen source	◯ Nasal or oropharyngeal ◯ Sputum ◯ Blood ◯ Urine ◯ Stool ◯ Wound ◯ Other
If other specimen for microbiology test #2, please specify	_____
Microbiology test #2 type	◯ Culture ◯ Gram stain ◯ NAAT (including PCR) ◯ Other
If other test type for microbiology test #2, please specify	_____
Microbiology test #2 result	_____
Microbiology test #3 name (ex: respiratory viral panel, stool culture, etc.)	_____
Microbiology test #3 specimen source	◯ Nasal or oropharyngeal ◯ Sputum ◯ Blood ◯ Urine ◯ Stool ◯ Wound ◯ Other
If other specimen for microbiology test #3, please specify	_____
Microbiology test #3 type	◯ Culture ◯ Gram stain ◯ NAAT (including PCR) ◯ Other
If other test type for microbiology test #3, please specify	_____

Microbiology test #3 result	
If additional microbiology tests, please list with name, specimen source, test type, and result	

Picture Upload

Upload pictures of ceftriaxone vial of most recent dose if available. Ideally include front label of bottle and lot number.

Ceftriaxone vial picture #1

Ceftriaxone vial picture #2

Ceftriaxone vial picture #3

Upload picture of medication vials/containers coadministered with ceftriaxone if available (ex: lidocaine, saline). Ideally include front label and lot number.

Other medical vials/containers picture #1

Other medical vials/containers picture #2

Other medical vials/containers picture #3

Healthcare Facility Information

Healthcare facility name where ceftriaxone was administered	
Street address of healthcare facility where ceftriaxone was administered	
City of healthcare facility where ceftriaxone was administered	

State or territory of healthcare facility where ceftriaxone was administered

- ◯ Alabama
- ◯ Alaska
- ◯ Arizona
- ◯ Arkansas
- ◯ California
- ◯ Colorado
- ◯ Connecticut
- ◯ Delaware
- ◯ Florida
- ◯ Georgia
- ◯ Hawaii
- ◯ Idaho
- ◯ Illinois
- ◯ Indiana
- ◯ Iowa
- ◯ Kansas
- ◯ Kentucky
- ◯ Louisiana
- ◯ Maine
- ◯ Maryland
- ◯ Massachusetts
- ◯ Michigan
- ◯ Minnesota
- ◯ Mississippi
- ◯ Missouri
- ◯ Montana
- ◯ Nebraska
- ◯ Nevada
- ◯ New Hampshire
- ◯ New Jersey
- ◯ New Mexico
- ◯ New York
- ◯ North Carolina
- ◯ North Dakota
- ◯ Ohio
- ◯ Oklahoma
- ◯ Oregon
- ◯ Pennsylvania
- ◯ Rhode Island
- ◯ South Carolina
- ◯ South Dakota
- ◯ Tennessee
- ◯ Texas
- ◯ Utah
- ◯ Vermont
- ◯ Virginia
- ◯ Washington
- ◯ West Virginia
- ◯ Wisconsin
- ◯ Wyoming
- ◯ District of Columbia
- ◯ American Samoa
- ◯ Federated States of Micronesia
- ◯ Guam
- ◯ Marshall Islands
- ◯ Commonwealth of the Northern Mariana Islands
- ◯ Palau
- ◯ Puerto Rico
- ◯ U.S. Minor Outlying Islands
- ◯ U.S. Virgin Islands

Zip code of healthcare facility where ceftriaxone was administered

_____

If the patient received higher level of care at a different facility than where ceftriaxone was administered, please provide the name and complete address of the facility here: _____