Tables of Instructions

Table 1. Instructions for Completion of the Patient Safety Monthly Reporting Plan Form (CDC 57.106) (Tables of Instructions List)

Data Field	Instructions for Form Completion
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Month/Year	Required. Enter the month and year for the surveillance plan being recorded; use MM/YYYY format.
No NHSN Patient Safety Modules Followed this Month	Conditionally required. Check this box if you do not plan to follow any of the NHSN Patient Safety Modules during the month and year selected.
Device-Associated Module	
Locations	Conditionally required. If you plan to follow device-associated events, enter the location codes for those facility locations where patients are housed overnight and from which you will collect denominator data (i.e., inpatient locations). If you plan to follow CLIP (see below), any type of patient care location where central lines are inserted may be entered.
CLABSI	Conditionally required. If you plan to follow device-associated events, check this box if you will collect central line-associated bloodstream infection (CLABSI) data and corresponding summary (denominator) data for the location in the left column.
DE	Conditionally required. If you plan to follow device-associated events, check this box if you will collect dialysis event (DE) data and corresponding summary (denominator) data for the outpatient dialysis location in the left column.
VAP	Conditionally required. If you plan to follow device-associated events, check this box if you will collect ventilator-associated pneumonia (VAP) data and corresponding summary (denominator) data for the location in the left column.
CAUTI	Conditionally required. If you plan to follow device-associated events, check this box if you will collect catheter-associated urinary tract infection (CAUTI) data and corresponding summary (denominator) data for the location in the left column.
CLIP	Conditionally required. Check this box if you will collect central line insertion practice (CLIP) data for the location indicated in the left column. These locations may be any type of patient care area where central lines are inserted (e.g., ward, OR, ED, ICU, outpatient clinic, etc.).
Procedure-Associated Module	
Procedures	Conditionally required. If you plan to follow procedure-associated events, list the procedure codes for those NHSN operative procedures for which you will collect data about selected procedure-associated events and procedure-level denominator data.

Data Field	Instructions for Form Completion
SSI (Circle one setting)	Conditionally required. For each selected NHSN operative procedure in the left column, if you plan to follow SSIs, choose the patient population for which you will monitor this procedure. Circle "In" to follow only inpatients, circle "Out" to follow only outpatients, or circle "Both" to follow inpatients and outpatients. If SSIs will not be monitored for a listed procedure for this month, do not circle any of the choices.
Post-procedure PNEU	Conditionally required. For each selected NHSN operative procedure in the left column, if you plan to follow post-procedure pneumonia (PPP), circle "In". If you do not monitor PPP, leave this unmarked. **NOTE:** Inpatient ("In") is the only setting option for monitoring post-procedure pneumonia.
Medication-Associated Module: Antimicrobial Use and Resistance	
Locations	Conditionally required. If you plan to follow the antimicrobial use and resistance (AUR) option, enter the location codes for those facility locations from which you will collect data about antibiotic use and/or resistance. If you select this module, you must choose: 1) at least one intensive care unit (ICU) or specialty care area (SCA) location, 2) all non-ICU/SCA locations combined, and 3) all outpatient locations combined. EXCEPTION: Pharmacy data are not collected for outpatient locations.
Microbiology	Conditionally required. If you plan to follow the AUR option, check if you will submit microbiology data for the selected location.
Pharmacy	Conditionally required. If you plan to follow the AUR option, check if you will submit pharmacy data for the selected location. **NOTE:** Pharmacy data are not submitted from outpatient areas.
MDRO and CDAD Module	
Locations	Conditionally required. If you plan to perform LabID event surveillance overall facility-wide (using Method C as defined in the protocol), use Locations **ALL**. This will enable you to use total hospital admissions and patient days for your denominators on the *MDRO and CDAD Prevention Process and Outcome Measures Monthly Monitoring* form (rather than stratified by location). If you want to perform facility-wide by location (Method A), you must enter each specific facility location being monitored.
Setting	Conditionally required. If overall facility-wide surveillance is being performed, circle whether it includes only inpatient locations, only outpatient locations or both in and outpatient locations.
Specific Organism Type	Conditionally required. Enter each organism you will be following: MRSA, MRSA/MSSA, VRE, MDR-*Klebsiella* spp., MDR-*Acinetobacter* spp. and/or *C. difficile.*
LabID Event	Conditionally required. Check this on the top section of the form only

Data Field	Instructions for Form Completion
	if performing surveillance on the organism facility-wide but not by location (i.e., using only Method C).
Locations	Conditionally required. If you plan to perform MDRO or *C. difficile* infection surveillance, LabID Event reporting, or monitor process and/or outcome measures, list the individual location code on each line for the areas in your facility that you intend to monitor.
Specific Organism Type	Conditionally required. For the location(s) selected, enter the organism you will be following in each: MRSA, MRSA/MSSA, VRE, MDR-*Klebsiella* spp., MDR-*Acinetobacter* spp. and/or *C. difficile.*
Infection Surveillance	Conditionally required. Infection surveillance or LabID Event reporting in ≥ 1 patient care area is required for each MDRO your facility chooses to monitor (MRSA, MRSA/MSSA, VRE, MDR-*Klebsiella* spp., MDR-*Acinetobacter* spp., *or C. difficile*).
AST Timing	Conditionally required. For the given location and organism, If you plan to perform active surveillance testing (AST) for the organism, indicate whether testing will be done on admission (Adm) only or at admission and at discharge/transfer (Both).
AST Eligible	Conditionally required. For the given location and organism, circle All if **all** patients will be eligible for AST, OR, circle NHx to indicate that the only patients eligible for testing will be those with no history of MDRO colonization or infection in the past 12 months as documented by the admitting facility.
Incidence	Conditionally required. Check this box if you plan to report incidence of the organism at the location listed in the left column using AST and clinical positives.
Prevalence	Conditionally required. Check this box if you plan to report prevalence of the organism at the location listed in the left column using AST, clinical positive and known positive cases.
LabID Event	Conditionally required. For the given location and organism, indicate if you plan to monitor for Laboratory-identified (LabID). Infection Surveillance or LabID Event reporting in at least one patient care area is required for each organism your facility chooses to monitor (MDRO or *C. difficile*).
HH	Conditionally required. Check this if you plan to monitor Hand Hygiene adherence in the location specified. Ideally, this should be the patient care location(s) also selected for MDRO Infection or *C. difficile* surveillance.
GG	Conditionally required. Check this if you plan to monitor gown and gloves use adherence in the location specified. Ideally, this should be the patient care location(s) also selected for MDRO Infection or *C. difficile* surveillance.

Data Field	Instructions for Form Completion
High Risk Inpatient Influenza Vaccination Module	
Method A:/Method B:	Conditionally required. Select either Method A or Method B.

Table 2. Instructions for Completion of the Primary Bloodstream Infection (BSI) Form (CDC 57.108) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer.
Patient ID #	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of Birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. BSI.
Date of event	Required. The date when the first clinical evidence of the BSI appeared or the date the blood culture was collected, whichever comes first. Enter date of this event using this format: MM/DD/YYYY.
Post-procedure BSI	Optional. Check Y if this event occurred after an NHSN defined procedure but before discharge from the facility, otherwise check N.
NHSN procedure code	Conditionally required. If Post-procedure BSI = Y, enter the appropriate NHSN procedure code. **NOTE:** A BSI cannot be "linked" to an operative procedure unless that procedure has already been added to NHSN. If the procedure was previously added, and the "Link to Procedure" button is clicked, the fields pertaining to the operation will be auto-entered by the computer.
ICD-9-CM procedure code	Optional. The ICD-9-CM code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-9-CM code is entered, the NHSN code will be auto-entered by the computer. If the NHSN code is entered first, you will have the option to select the appropriate ICD-9-CM code. In either case, it is optional to select the ICD-9-CM code. Only those ICD-9-CM codes identified in Table 10 of the Procedure-associated Module section are allowed.
MDRO infection	Required. Enter "Yes", if the pathogen is being followed for the MDRO/CDAD Module and is part of your Monthly Reporting Plan:

Data Field	Instructions for Data Collection
	MRSA, MSSA (MRSA/MSSA), VRE, MDR-*Klebsiella*, MDR-*Acinetobacter* or *C. difficile*. If the pathogen for this event happens to be an MDRO but your facility is not following the MDRO/CDAD Module in your Monthly Reporting Plan, answer "No" to this question.
Location	Required. Enter the inpatient location to which the patient was assigned when the BSI was identified. If the BSI develops in a patient within 48 hours of transfer from a location, indicate the transferring location, not the current location of the patient.
Date admitted to facility	Required. Enter date patient admitted to facility using this format: MM/DD/YYYY.
Risk Factors: If ICU/Other locations, central line	Required. Answer this question if the location is an intensive care unit (ICU) or location other than a specialty care area (SCA) or neonatal intensive care unit (NICU). Check Y if patient had a central line during the 48 hour period before event date, otherwise check N. **NOTE:** If the patient has both a peripheral and a central line and the BSI can clearly be attributed to the peripheral line (e.g., pus at insertion site and matching pathogen from pus and blood), check N.
Risk Factors: If Specialty Care Area, Permanent central line	Required. Answer these questions if the location is an SCA: Check Y if patient had a tunneled or implanted central line during the 48-hour period before event date, otherwise check N.
Temporary central line	Check Y if patient had a non-tunneled central line during the 48-hour period before event date, otherwise check N.
Risk Factors: If NICU, Central line	Required. Answer these questions if the location is an NICU: Check Y if patient had a non-umbilical central line during the 48-hour period before event date, otherwise check N.
Umbilical catheter	Check Y if patient had an umbilical catheter during the 48-hour period before event date, otherwise check N.
Birthweight	Required. Enter patient's weight at the time of birth in grams, not the weight on the date of event.
Location of device insertion	Optional. Enter the patient location where the central line was inserted. • If the patient has more than one central line, enter the location where the first central line was inserted. • If the patient has both a permanent and a temporary central line, enter the location where the temporary line was inserted.

Data Field	Instructions for Data Collection
	• If the patient has both an umbilical and a non-umbilical central line, enter the location where the umbilical line was inserted.
Date of device insertion	Optional. Enter the date the central line was inserted. If the patient has more than one central line, enter the insertion date for the first line that was inserted.
Event Details: Specific event	Required. Check Laboratory-confirmed (LCBI).
Event Details Specify criteria used:	Required. Check each of the elements of the criterion that was used to identify this infection.
Event Details: Died	Required. Check Y if patient died during the hospitalization, otherwise check N.
Event Details: BSI contributed to death	Conditionally required if patient died. Check Y if the BSI contributed to death, otherwise check N.
Event Details: Discharge date	Optional. Date patient discharged from facility using this format: MM/DD/YYYY.
Event Details: Pathogen identified	Required. Enter Y if pathogen identified, otherwise check N. If Yes, specify pathogen(s) on reverse of form (see Table 2a for instructions). **NOTE:** If LCBI, this field will be autofilled by the computer as Y.
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. **NOTE:** Each custom field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information on the event.

Table 2a. Instructions for Completion of the Back of the Following Forms: Primary Bloodstream Infection (CDC 57.108); Pneumonia (CDC 57.111); Urinary Tract Infection (CDC 57.114); Surgical Site Infection (CDC 57.120); Dialysis Event (CDC 57.109); MDRO and CDAD Infection Event (CDC 57.126) (Tables of Instructions List)

Data Field	Instructions for Data Collection/Entry
For specified Gram-positive and Gram-negative organisms, Pathogen #	Up to three pathogens may be reported. If multiple pathogens are identified, enter the pathogen judged to be the most important cause of infection as #1, the next most as #2, and the least as #3 (usually this order will be indicated on the laboratory report).
Antimicrobial agent and susceptibility results	Conditionally required if Pathogen Identified = Y. • For those organisms shown on the back of an event form, susceptibility results are required only for the agents listed. • For organisms that are not listed on the back of an event form, enter a susceptibility result for at least one antimicrobial agent, even if that result is "Not Tested". Circle the pathogen's susceptibility result: S – Susceptible, I – Intermediate, R – Resistant, N – Not Tested. Additional antimicrobial agents and susceptibility results may be reported for up to a total of 20 agents.
For Other Organisms, Pathogen #	Up to three pathogens may be reported. If multiple pathogens are identified, enter the pathogen judged to be the most important cause of infection as #1, the next most as #2, and the least as #3 (usually this order will be indicated on the laboratory report).
Antimicrobial agent and susceptibility results	For each pathogen, up to 20 antimicrobial agents and susceptibility results may be reported. Values for susceptibility results are: S – Susceptible, I – Intermediate, R – Resistant, N – Not Tested.

Table 3. Instructions for Completion of the Central Line Insertion Practices Adherence Monitoring Form (CDC 57.125) (Tables of Instructions List)

Data Field	Instructions for Form Completion
Facility ID	The NHSN-assigned facility ID will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer.
Patient ID	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name: Last, first, middle	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of Birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race (specify)	Optional. Check all the boxes that apply to identify the patient's race.
Event Type	Required. CLIP.
Location	Required. Enter the location of the patient at the time of the central line insertion.
Insertion date	Required. Enter the date of central line insertion (MM/DD/YYYY).
Person recording insertion practice data	Required. Select inserter or observer.
Central line inserter ID	Optional. Enter the HCW ID# of the person inserting the central line.
Name, Last, First	Optional. Enter last name and first name of person inserting the central line.
Occupation of inserter	Required. Check the occupational category of the person inserting the central line Attending physician; Intern/Resident; Physician assistant; IV team; Fellow; Other medical staff; Medical student; Other student. If Other than these, please specify.
Reason for insertion	Required. Check the primary reason for inserting the central line: New indication; Replace malfunctioning central line; Suspected central line-associated infection. If Other, please specify.
Inserter performed hand hygiene prior to central line	Required. Check Y if the inserter appropriately performed hand hygiene prior to inserting central line; otherwise check N. Appropriate

Data Field	Instructions for Form Completion
insertion	hand hygiene includes the use of alcohol-based hand rub or soap and water hand wash.
Maximal sterile barrier precautions used	Required. Check each sterile barrier used during insertion: Mask, Sterile gown; Large sterile (full body) drape; Sterile gloves; Cap. **NOTE:** If inserter wore either a mask or a mask with eye shield, the Mask box should be checked
Skin preparation	Required. Check all that apply: Chlorhexidine gluconate; Povidone iodine; Alcohol.
Was skin preparation agent completely dry at time of first skin puncture?	Required. Check Y if the skin prep agent was allowed to dry completely at the time of first skin puncture; otherwise select N.
Insertion site	Required. Check the site of insertion of the central line: Jugular; Subclavian; Umbilical; Femoral; Upper extremity; Lower Extremity; Scalp.
Antimicrobial coated catheter used	Optional. Check Y if antimicrobial coated catheter was used; otherwise check N.
Central line catheter type	Required. Check the type of central line inserted: Non-tunneled catheter (other than dialysis); Tunneled catheter (other than dialysis); Dialysis catheter non-tunneled; Dialysis catheter tunneled; Umbilical; PICC. If other, please specify.
Number of lumens	Required. Circle the number of lumens in the device: 1, 2, 3 or $\geq$ 4.
Central line exchanged over a guidewire	Required. Check Y if the central line was exchanged over a guidewire; otherwise Check N.
Antiseptic ointment applied to site	Required. Check Y if antiseptic was applied to the insertion site following insertion but prior to application of the dressing; otherwise check N.
Custom Fields and Labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. **NOTE:** Each custom field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any additional information on the central line insertion.

Table 4. Instructions for Completion of Pneumonia (PNEU) Form (CDC 57.111) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto entered by the computer.
Event #	Event ID number will be auto entered by the computer.
Patient ID #	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. PNEU.
Date of event	Required. The date when the first clinical evidence of the PNEU appeared or the date the specimen used to make or confirm the diagnosis was collected, whichever comes first. Enter date of this event using this format: MM/DD/YYYY.
Post-procedure PNEU	Required. Check Y if this event occurred after an NHSN defined procedure but before discharge from the facility, otherwise check N.
Date of procedure	Conditionally required. If Post-procedure PNEU = Y, then enter the date the procedure was done.
NHSN procedure code	Conditionally required. Answer this question only if this patient developed the PNEU during the same admission as an operative procedure. Enter the appropriate NHSN procedure code. **NOTE:** A PNEU cannot be "linked" to an operative procedure unless that procedure has already been added to NHSN. If the procedure was previously added, and the "Link to Procedure" button is clicked, the fields pertaining to the operation will be auto entered

Data Field	Instructions for Data Collection
	by the computer.
ICD-9-CM procedure code	Optional. The ICD-9-CM code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-9-CM code is entered, the NHSN code will be auto entered by the computer. If the NHSN code is entered first, you will have the option to select the appropriate ICD-9-CM code. In either case, it is optional to select the ICD-9-CM code. Only those ICD-9-CM codes identified in Table 10 of the Procedure-associated Module section are allowed.
MDRO infection	Required. Enter "Yes", if the pathogen is being followed for the MDRO/CDAD Module and is part of your Monthly Reporting Plan: MRSA, MSSA (MRSA/MSSA), VRE, MDR-*Klebsiella*, MDR-*Acinetobacter* or *C. difficile*. If the pathogen for this event happens to be an MDRO but your facility is not following the MDRO/CDAD Module in your Monthly Reporting Plan, answer "No" to this question.
Location	Required. Enter the inpatient location to which the patient was assigned when the PNEU was identified. If the PNEU develops in a patient within 48 hours of transfer from a location, indicate the transferring location, not the current location of the patient.
Date admitted to facility	Required. Enter date patient admitted to facility using this format: MM/DD/YYYY.
Risk Factors Ventilator	Required. Check Y if the patient with PNEU had a device to assist or control respiration continuously through a tracheostomy or by endotracheal intubation, inclusive of the weaning period, within the 48-hour period before developing infection, otherwise check N.
Birth weight	Conditionally required. If the patient is a NICU patient, enter the patient's birth weight in grams.
Location of device insertion	Optional. Enter the patient location where the intubation and ventilation procedure was performed
Date of device insertion	Optional. Enter the date the intubation and ventilation procedure was performed.
Event Details: PNEU Specific event	Required. Check one: Clinically Defined Pneumonia (PNU1), Pneumonia with specific laboratory findings (PNU2), or Pneumonia in immunocompromised patients (PNU3), whichever criteria are met for this event.
Event Details: Specify criteria used	Required. Check each of the elements that were used to identify this infection.
Event Details: Secondary bloodstream infection	Required. Check Y if there is a culture-confirmed bloodstream infection (BSI) and a related pneumonia, otherwise check N.

Data Field	Instructions for Data Collection
Event Details: Died	Required. Check Y if patient died during the hospitalization, otherwise check N.
Event Details: PNEU contributed to death	Conditionally required. If the patient died, check Y if the PNEU contributed to death, otherwise check N.
Event Details: Discharge date	Optional. Date patient discharged from facility.
Event Details: Pathogen identified	Required. Enter Y if Pathogen Identified, N otherwise; if Yes, specify on reverse (See Table 2a for instructions)
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields that may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information on the event.

Table 5. Instructions for Completion of Urinary Tract Infection (UTI) Form (CDC 57.114) (Tables of Instructions List)

Data Field	Instructions for Data Collection/Entry
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer.
Patient ID #	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. UTI.
Date of event	Required. The date when the first clinical evidence of the UTI appeared or the date the specimen used to make or confirm the diagnosis was collected, whichever comes first. Enter date of this event using this format: MM/DD/YYYY.
Post-procedure UTI	Optional. Check Y if this event occurred after an NHSN defined procedure but before discharge from the facility, otherwise check N.
Date of procedure	Conditionally required. If Post-procedure UTI = Y, enter the date the procedure was done.
NHSN procedure code	Conditionally required. If Post-procedure UTI = Y, enter the appropriate NHSN procedure code. **NOTE:** A UTI cannot be "linked" to an operative procedure unless that procedure has already been added to NHSN. If the procedure was previously added, and the "Link to Procedure" button is clicked, the fields pertaining to the operation will be auto-entered by the computer.
ICD-9-CM procedure code	Optional. The ICD-9-CM code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-9-CM code is entered, the NHSN code will be auto-entered by the computer. If the NHSN code is entered first, you will have the option to select the

Data Field	Instructions for Data Collection/Entry
	appropriate ICD-9-CM code. In either case, it is optional to select the ICD-9-CM code. Only those ICD-9-CM codes identified in Table 10 of the Procedure-associated Module section are allowed.
MDRO infection	Required. Enter "Yes", if the pathogen is being followed for the MDRO/CDAD Module and is part of your Monthly Reporting Plan: MRSA, MSSA (MRSA/MSSA), VRE, MDR-*Klebsiella*, MDR-*Acinetobacter* or *C. difficile*. If the pathogen for this event happens to be an MDRO but your facility is not following the MDRO/CDAD Module in your Monthly Reporting Plan, answer "No" to this question.
Location	Required. Enter the inpatient location to which the patient was assigned when the UTI was identified. If the UTI develops in a patient within 48 hours of transfer from a location, indicate the transferring location, not the current location of the patient.
Date admitted to facility	Required. Enter date patient admitted to facility using this format: MM/DD/YYYY.
Risk factor: Urinary catheter status at time of specimen collection	Required. Check "In place" if urinary catheter was in place at time of urine specimen collection; Check "Removed within 48 hours prior " if a urinary catheter was removed within the 48 hours before urine specimen was collected; Check "Not in place nor within 48 hours prior" if no urinary catheter was in place at the time of or within the 48 hours prior to urine specimen collection.
Location of device insertion	Optional. Enter the patient location where the indwelling urethral catheter was inserted.
Date of device insertion	Optional. Enter the date the indwelling urethral catheter was inserted.
Event details: Specific event: UTI	Required. Check Symptomatic UTI (SUTI), Asymptomatic Bacteremic UTI (ABUTI), or Other UTI (OUTI), for the specific event type you are reporting.
Event details: UTI Specify criteria used	Required. Check each of the elements of the criteria that were used to identify the specific type of UTI being reported.
Event Details: Secondary bloodstream infection	Required. Check Y if there is a culture-confirmed bloodstream infection (BSI) and a related healthcare-associated UTI, otherwise check N.
Event Details: Died	Required. Check Y if patient died during the hospitalization, otherwise check N.
Event Details: UTI contributed to death	Conditionally required. If patient died, check Y if the UTI contributed to death, otherwise check N.
Event Details: Discharge date	Optional. Date patient discharged from facility.
Event Details: Pathogens identified	Required. Enter Y if pathogen identified, N if otherwise. If Y, specify organism name on reverse. For SUTI with secondary BSI and ABUTI, enter only the matching organism(s) identified in <u>both</u> urine and blood cultures (See Table 2a for instructions).
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric

Data Field	Instructions for Data Collection/Entry
	fields that may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information on the event.

Table 6. Instructions for the Completion of Denominators for Intensive Care Unit (ICU)/Other Locations (Not NICU or SCA) (CDC 57.118)

(Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Location code	Required. Enter the location code of the unit where you collect the data.
Month	Required. Record the 2-digit month during which the data were collected for this location.
Year	Required. Record the 4-digit year during which the data were collected for this location.
Number of patients	Required. For each day of the month selected, record the number of patients on the unit. Record this number at the same time each day.
Number of patients with 1 or more central lines	Conditionally required. Complete if you have chosen central line-associated bloodstream infection (CLABSI) as an event to follow in your Plan for this month. For each day of the month, at the same time each day, record the number of patients on the selected unit who have 1 or more central lines.
Number of patients with a urinary catheter	Conditionally required. Complete if you have chosen catheter-associated urinary tract infection (CAUTI) as an event to follow in your Plan for this month. For each day of the month, at the same time each day, record the number of patients on the selected unit who have an indwelling urinary catheter.
Number of patients on a ventilator	Conditionally required. Complete if you have chosen ventilator-associated pneumonia (VAP) as an event to follow in your Plan for this month. For each day of the month, at the same time each day, record the number of patients on the selected unit who are on a ventilator.
Total	Required. Totals for each column should be calculated. This is the number that will be entered into the NHSN application.
Label and data fields	Optional. Up to five numeric fields may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of NHSN before the field can be selected for use.

Table 7. Instructions for Completion of the Denominators for Specialty Care Area (SCA) (CDC 57.117) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer
Location code	Required. Enter the location code of the unit where you collect the data.
Month	Required. Record the 2-digit month during which the data were collected for this location.
Year	Required. Record the 4-digit year during which the data were collected for this location.
Number of patients	Required. For each day of the month selected, record the number of patients on the unit. Record this number at the same time each day.
Number of patients with 1 or more central lines	Conditionally required. Complete if you have chosen central line-associated bloodstream infection (CLABSI) as an event to follow in your Plan for this month.
Temporary	For each day of the month, at the same time each day, record the number of patients on the selected unit who have 1 or more non-tunneled central lines.
Permanent	For each day of the month, at the same time each day, record the number of patients on the selected unit who have 1 or more tunneled or implanted central lines beginning on the first day the permanent line was accessed and continuing through the entire stay. **NOTE:** If a patient has both a temporary and a permanent line in place, count only the temporary line.
Number of patients with a urinary catheter	Conditionally required. Complete if you have chosen catheter-associated urinary tract infection (CAUTI) as an event to follow in your Plan for this month. For each day of the month, at the same time each day, record the number of patients on the selected unit who have an indwelling urinary catheter.
Number of patients on a ventilator	Conditionally required. Complete if you have chosen ventilator-associated pneumonia (VAP) as an event to follow in your Plan for this month. For each day of the month, at the same time each day, record the number of patients on the selected unit who are on a ventilator.
Total	Required. Totals for each column should be calculated. This is the number that will be entered into the NHSN application.
Label and data fields	Optional. Up to five numeric fields may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of NHSN before the field can be selected for use.

Table 8. Instructions for Completion of the Denominators for Neonatal Intensive Care Unit (NICU) (CDC 57.116) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Location code	Required. Enter the location code of the unit where you collect the data.
Month	Required. Record the 2-digit month during which the data were collected for this location.
Year	Required. Record the 4-digit year during which the data were collected for this location.
Number of patients (Pts)	Required. For each day of the month selected, record the number of patients in each birthweight category on the unit. Record this number at the same time each day.
Number of patients with each of the following:	Conditionally required. Complete if you have chosen central line-associated bloodstream infection (CLABSI) as an event to follow in your Plan for this month for this unit. If you choose to monitor CLABSI in the NICU population, you must collect data for both umbilical catheters and for non-umbilical central lines.
Umbilical catheter (U/C)	For each day of the month, at the same time each day, record the number of patients in each birthweight category on the selected unit who have an umbilical catheter in place.
Non-umbilical central line (CL)	For each day of the month, at the same time each day, record the number of patients in each birthweight category on the selected unit who have 1 or more non-umbilical central line(s) in place. **NOTE:** If an infant has both an umbilical catheter and a non-umbilical central line, count as an umbilical catheter day only.
Number of patients on a ventilator (VNT)	Conditionally required. Complete if you have chosen ventilator-associated pneumonia (VAP) as an event to follow in your Plan for this unit for this month. For each day of the month, at the same time each day, record the number of patients in each birthweight category on the selected unit who are on a ventilator.
Total	Required. Totals for each column should be calculated. This is the number that will be entered into the NHSN application.
Label and data fields	Optional. Up to five numeric fields may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of NHSN before the field can be selected for use.

Table 9. Instructions for Completion of Dialysis Event (DE) form (CDC 57.109) (Tables of Instructions List)

Data Field	Instructions for Completion
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Event ID #	Event ID # will be auto-entered by the computer.
Patient ID #	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. Enter DE.
Date of event	Required. Depending on the type of incident reported, enter either the date of hospitalization, or date of in-unit IV antimicrobial start, or for a patient, whose incident is a positive blood culture, enter the date the blood specimen was collected. Enter date of this-event using this format: MM/DD/YYYY.
Location	Required. Enter the location code of the outpatient dialysis unit where the patient was at the time of the DI.
Risk Factor: Vascular access type	Required. Check each access that the patient has.
Event Details: DI Incident type	Required. Check one or more of the incident types below: • Check Hospitalization if patient stayed overnight in a hospital, not just those related to infections or those where patient was directly admitted from the dialysis unit. Each time a patient is hospitalized, enter it as a new event. If a patient is hospitalized and returns to the dialysis unit on IV antimicrobials, both will be included in the same event – do not enter a second event. • Check In-unit IV antimicrobial start if patient is given IV

Data Field	Instructions for Completion
	antimicrobial agents in the dialysis unit for any reason, not just those with vancomycin or for a vascular access problem. If IV antimicrobials are stopped for less than 21 days and then restarted, this is NOT considered a new event. However, if IV antimicrobials are stopped for 21 or more days and then restarted, this is considered a new event. • Check Positive blood culture if the patient blood culture is positive, even if they did not have an associated hospitalization or in-unit IV antimicrobial start. Include blood cultures taken as an outpatient or within 1 day after a hospital admission. If the patient had an associated hospitalization or in-unit IV antimicrobial start, use the appropriate rule (above) for entering the event; if the patient had neither, enter a new event for positive blood culture occurring 21 or more days after a previous positive blood culture.
Problem (s)	Required. For each syndrome listed, check if present.
Pus, redness, or increased swelling at the vascular access site	Check if symptoms present. Do not check this if the patient is thought to have an access infection, but does not have the signs listed. Instead check "Other" and specify "Possible access infection." Similar rule for other responses: If the patient is thought to have the problem but does not meet the criteria, check "Other."
If applicable, check the access with pus, redness, or increased swelling:	If applicable, check one of the following: __ graft __ fistula __ temporary central line __ permanent central line __ port access device
Blood culture	Required. Check positive, negative, unknown, or not done. This applies only to blood cultures.
If positive, suspected source of positive blood culture	Conditionally required. If blood culture is positive, check "Vascular access" only if there is some objective evidence of vascular access infection. Check "A source other than the vascular access" if either (a) or (b) is true: (a) a culture from another site (e.g., leg wound, urine) shows the same organism found in the blood; (b) there is clinical evidence of infection at another site, but a culture was not taken from it. Check "Contamination" if the organism is thought by the physician, infection control practitioner, or head nurse to be a contaminant. Contamination is more likely if a common skin

Data Field	Instructions for Completion
	contaminant (e.g., coagulase negative staphylococci, diphtheroids, *Propionibacterium*, or *Bacillus* spp.) is isolated from only one blood culture. Check "Uncertain" if there is insufficient evidence to decide among the three previous categories.
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use (optional). **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information on the Event. This information may not be analyzed.

Table 10. Instructions for completion of Denominators for Outpatient Dialysis: Census Form (CDC 57.119) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Location code	Required. Enter the location code for the outpatient dialysis location from which you will collect data about dialysis incidents.
Month	Required. Record the 2-digit month during which the data were collected for this location.
Year	Required. Record the 4-digit year during which the data were collected for this location.
Number of chronic hemodialysis patients	Required. For each type of vascular access listed, record the number of patients who received hemodialysis at this location during the first two working days of the month. Record each patient only once. If a patient has both an implanted access (graft or fistula) and a temporary central line, record the temporary central line.
Total patients:	Required. Add the numbers from the column.
Label and data fields:	Optional. Up to five numeric fields may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of NHSN before the field can be selected for use.

Table 11. Instructions for completion of the AUR Option Forms (CDC 57.123 and CDC 57.124) (Tables of Instructions List)

Notice: The AUR Module is currently undergoing revisions, and no AUR data may be entered. NHSN users will be notified when the module updates are completed.

Table 12. Instructions for completion of the Surgical Site Infection (SSI) Form (CDC 57.120) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer.
Patient ID #	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. Enter SSI.
Date of event	Required. The date when the first clinical evidence of the SSI appeared or the date the specimen used to make or confirm the diagnosis was collected, whichever comes first. Enter date of this event using this format: MM/DD/YYYY.
NHSN procedure code	Required. Enter the appropriate NHSN procedure code. **NOTE:** An SSI cannot be "linked" to an operative procedure unless that procedure has already been added to NHSN. If the procedure was previously added, and the "Link to Procedure" button is clicked, the fields pertaining to the operation will be auto-entered by the computer.
Date of procedure	Required. Enter date using this format: MM/DD/YYYY.
ICD-9-CM procedure code	Optional. The ICD-9-CM code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-9-CM code is entered, the NHSN code will be auto-entered by the computer. If the NHSN code is entered first, you will have the option to select the appropriate ICD-9-CM code. In either case, it is optional to select the ICD-9-CM code. Only ICD-9-CM codes in Table 10 of the Procedure-associated Module section are allowed.
Outpatient Procedure	Required. Check Y if this operative procedure was performed on an outpatient; otherwise check N.
MDRO infection	Required. Enter "Yes", if the pathogen is being followed for the MDRO/CDAD

Data Field	Instructions for Data Collection
	Module and is part of your Monthly Reporting Plan: MRSA, MSSA (MRSA/MSSA), VRE, MDR-*Klebsiella*, MDR-*Acinetobacter* or *C. difficile*. If the pathogen for this event happens to be an MDRO but your facility is not following the MDRO/CDAD Module in your Monthly Reporting Plan, answer "No" to this question.
Location	Required. Enter the patient care area where the patient was assigned in the postoperative period. Inpatient or outpatient locations are allowed, but Operating Room locations are not allowed.
Date admitted to facility	Required. Enter date patient admitted to facility using this format: MM/DD/YYYY. If a patient is readmitted with a previously unreported event that was acquired during a preceding admission, enter the date of admission of the facility stay in which the event was acquired.
Event details specific event SSI	Required. Check the appropriate level of SSI from the list ___Superficial incisional primary (SIP) ___Superficial incisional secondary (SIS) ___Deep incisional primary (DIP) ___Deep incisional secondary (DIS) ___Organ/space: __(indicate specific site code from table shown in organ/space SSI definition)
Event details: SSI Specify criteria used	Required. Check each of the elements of the definition that were used to identify the specific type of SSI. Specific Organ/space event types have their own unique criteria which must be met. They are found in Table 17.
Event details: Detected	Required. Check A if SSI was identified before the patient was discharged from the facility following the operation. Check P if SSI was identified during post-discharge surveillance. Include as P those SSI identified by another facility (i.e., patient with SSI was admitted to a facility other than the one in which the operation was performed). Check R if SSI was identified due to patient readmission to the facility where the operation was done.
Event Details: Secondary bloodstream infection	Required. Check Y if there is a culture-confirmed bloodstream infection (BSI) and a related healthcare-associated infection at the surgical site, otherwise check N.
Event details: Died	Required. Check Y if patient died during the hospitalization, otherwise check N.
Event Details: SSI contributed to death	Conditionally required. If patient died, check Y if the SSI contributed to death, otherwise check N.
Event Details: Discharge date	Optional. Enter date patient discharged from facility using this format: MM/DD/YYYY. If a patient is readmitted with a previously unreported event that was acquired during a preceding admission, enter the date of discharge of the facility stay in which the event was acquired.

Data Field	Instructions for Data Collection
Event Details: Pathogens identified	Required. Enter Y if Pathogen Identified, N if otherwise. If Y, specify organism name on reverse. See Table 2a above for instructions.
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use. **NOTE:** Each Custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information on the event.

Table 13. Instructions for Completion of the Denominator for Procedure form (CDC 57.121) (Tables of Instructions List)

This form is used for reporting data on each patient having one of the NHSN operative procedures selected for monitoring.

Data Field	Instructions for Data Collection
Facility ID #	The NHSN-assigned facility ID will be auto-entered by the computer.
Procedure #	The NHSN-assigned Procedure # will be auto-entered by the computer
Patient ID #	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID #	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Check Female or Male to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity Hispanic or Latino Not Hispanic or Not Latino	Optional. If patient is Hispanic or Latino, check this box. If patient is not Hispanic or not Latino, check this box.
Race	Optional. Check all the boxes that apply to identify the patient's race.
Event type	Required. Enter the code for procedure (PROC).
NHSN Procedure code	Required. Enter the appropriate NHSN procedure code.
ICD-9-CM procedure code	Optional. The ICD-9-CM code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-9-CM code is entered, the NHSN code will be auto-entered by the computer. If the NHSN code is entered first, you will have the option to select the appropriate ICD-9-CM code. In either case, it is optional to select the ICD-9-CM code. Only those codes listed in

Data Field	Instructions for Data Collection
	Table 10 of the Procedure-associated Module section are allowed.
Date of procedure	Required. Record the date when the NHSN procedure was done using this format: MM/DD/YYYY.
Procedure Details:	
Outpatient:	Required. Check Y if this operative procedure was performed on an outpatient, otherwise check N.
Duration:	Required. Enter the interval in hours and minutes between the skin incision and skin closure.
Wound class:	Required. Check the appropriate wound class from the list.
General anesthesia:	Required. Check Y if general anesthesia was used for the operative procedure, otherwise check N.
ASA class:	Required. Check numeric ASA classification at the time of the operative procedure.
Emergency:	Required. Check Y if this operative procedure was a nonelective, unscheduled operative procedure, otherwise check N.
Trauma:	Required. Check Y if operative procedure was performed because of blunt or penetrating traumatic injury to the patient, otherwise check N.
Endoscope:	Required. Check Y if the entire operative procedure was performed using an endoscope/laparoscope, otherwise check N. **NOTE:** For CBGB, if the donor vessel was harvested using an endoscope, check Y.
Multiple procedures:	Required. Check Y if more than one category of NHSN operative procedure was performed through the same incision during the same trip to the operating room, otherwise check N.
Surgeon code:	Optional. Enter code of the surgeon who performed the principal operative procedure.
Implant:	Required. Check Y if a nonhuman-derived object, material, or tissue was permanently placed in a patient

Data Field	Instructions for Data Collection
Non-autologous Transplant:	during the operative procedure and will not be routinely manipulated for diagnostic or therapeutic purposes. Otherwise check N Required. Check Y if human cells, tissues, organs, or cellular- or tissue-based products that derived from another human body, either a donor cadaver or a live donor, were placed into a human recipient via grafting, infusion, or transfer. Otherwise check N.
CSEC: Height	Conditionally required. If operative procedure is CSEC, enter patient height in feet and inches or meters and centimeters.
CSEC: Weight	Conditionally required. If operative procedure is CSEC, enter patient weight in pounds or kilograms.
CSEC: Duration of labor	Conditionally required. If operative procedure is CSEC, enter hours patient labored in the hospital prior to operative procedure.
CSEC: Estimated blood loss	Conditionally required. If operative procedure is CSEC, enter the estimated blood loss in ml.
Circle one: FUSN RFUSN	Conditionally required. If operative procedure is FUSN or RFUSN, circle the procedure that was done.
FUSN/RFUSN: Spinal level	Conditionally required. If operative procedure is FUSN or RFUSN, check appropriate spinal level of procedure from list. • Atlas-Axis – C1-C2 only • Atlas-Axis/Cervical – C1-C7 (any combination) • Cervical – C3-C7 (any combination) • Cervical/Dorsal/Dorsolumbar – Extends from any cervical through any lumbar levels • Dorsal/dorsolumbar – T1 – L5 (any combination) • Lumbar/Lumbosacral – L1-S5 (any combination) • Not specified – Level not specified
FUSN/RFUSN: Diabetes mellitus	Conditionally required. If operative procedure is FUSN or RFUSN, check Y if patient is known to have diabetes mellitus, otherwise check N.
FUSN/RFUSN: Approach/Technique	Conditionally required. If operative procedure is FUSN or RFUSN, check appropriate surgical approach or technique from list.
HPRO:	Conditionally required. If operative procedure is HPRO, select TP (Total Primary), PP (Partial Primary), TR (Total Revision) or PR (Partial Revision) from the list.
KPRO:	Conditionally required. If operative procedure is KPRO, select T – Primary (Total), R – Revision (Total or Partial) from list.

Data Field	Instructions for Data Collection
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use.

Table 14. Instructions for completion of High Risk Inpatient Influenza Vaccination (HRIIV) Monthly Monitoring Form – Method A (57.130)

(Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID	The NHSN-assigned facility ID number will be auto-entered by the computer.
Vaccination type: Influenza	Required. Influenza subtype: □ Seasonal □ Non-seasonal
Month	Required. Record using this format: MM
Year	Required. Record using this format: YYYY
1. Total # of patient admissions	Required. Total number of inpatient admissions during the month being reviewed.
2. Total # of patients meeting high risk criteria for influenza vaccination	Required. Total number of patients meeting high risk criteria during the month being reviewed.
3. Total # of patients previously vaccinated during current influenza season	Optional. Total number previously vaccinated during current influenza season.
4. Total # of patients meeting high risk criteria previously vaccinated during current influenza season	Required. Total number of patients meeting high risk criteria previously vaccinated during current influenza season during period evaluated.
5. Total high risk patients not previously vaccinate during current influenza season (Denominator: Box 2 - Box 4)	Required. Subtract total number in Box 4 from number in Box 2.
6. Patients meeting high risk criteria offered vaccination but declining for reasons other than medical contraindication	Required. Total number of patients meeting high risk criteria offered vaccination but declining for reasons other than medical contraindication.
7. Patients meeting high risk criteria offered vaccination but having medical contraindication	Required. Total number of patients meeting high risk criteria offered vaccination but having medical contraindication.
8. Patients meeting high risk criteria receiving vaccination during admission	Required. Total number of patients meeting high risk criteria who receive influenza vaccination during their admission.
9. Total patients offered vaccination for high risk criteria	Required. Total of boxes 6, 7 and 8.
Label and data fields:	Optional. Up to five label and five corresponding custom data fields are available for local use and the values entered. These fields may be analyzed.

Table 15. Instructions for Completion of the High Risk Inpatient Influenza Vaccination Monthly Monitoring Form – Method B (CDC 57.131) (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID	The NHSN-assigned facility ID number will be auto-entered by the computer.
Vaccination type: Influenza	Required. Influenza subtype: □Seasonal □Non-seasonal
Month	Required. Record using this format: MM
Year	Required. Record using this format: YYYY
1. Total # of patient Admissions	Required. Total number of inpatient admissions of greater than 24 hours during the month being reviewed.
2. Total # of patients previously vaccinated during current influenza season	Optional. Total number previously vaccinated during current influenza season.
3. Total # of patients meeting high risk criteria previously vaccinated during current influenza season	Required. Total number meeting high risk criteria that were previously vaccinated during current influenza season.
Label and data fields:	Optional. Up to five label and five corresponding custom data fields are available for local use and the values entered. These fields may be analyzed.

Table 16. Instructions for completion of the High Risk Inpatient Influenza Vaccination Method B Form – Part 1 (CDC 57.132)

(Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID	The NHSN-assigned facility ID number will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer.
Patient ID	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Circle F (Female) or M (Male) to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: M/DD/YYYY.
Ethnicity	Optional. Indicate the patient's ethnicity: Hispanic or Latino Not Hispanic or Not Latino
Race	Optional. Indicate the patient's race (all that apply): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Event type	Required. FLUVX
Vaccination Type	Influenza
Influenza subtype	Required. □ Seasonal □ Non-seasonal
Date admitted to facility	Required. Record the date of the patient admission using this format: MM/DD/YYYY.
High Risk Criteria for Seasonal Influenza	Required. Check all high risk criteria that apply.
High Risk Criteria For Non-seasonal Influenza	Required. Check all high risk criteria that apply.

Table 17. Instructions for completion of the High Risk Inpatient Influenza Vaccination Method B Form – Part 2 (CDC 57.133)

Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID	The NHSN-assigned facility ID number will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer
Patient ID	Required. Enter the alphanumeric patient ID number. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter the alphanumeric ID number assigned by the facility.
Patient name	Optional. Enter the last, first, and middle name of the patient.
Gender	Required. Circle F (Female) or M (Male) to indicate the gender of the patient.
Date of birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY
Ethnicity	Optional. Indicate the patient's ethnicity: Hispanic or Latino Not Hispanic or Not Latino
Race	Optional. Indicate the patient's race (all that apply): American Indian or Alaskan Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Event type	Required. FLUVX
Vaccination type	Influenza
Vaccine offered	Required. Check Yes or No
Vaccine declined	Required. Check Yes or No
Reason(s) vaccine declined A. Medical contraindications B. Personal reason(s) for declining	Conditionally Required. If patient declined influenza vaccination, Check all that apply in either section A or section B but not both. If reasons exist in both categories then section A, medical contraindications, takes priority and should be completed.

Data Field	Instructions for Data Collection
Vaccine administered	Required. Check Yes or No
Date vaccine administered	Conditionally required. If vaccine administered indicate date given using this format: MM/DD/YYYY
Type of influenza vaccine administered Seasonal or Non-seasonal	Conditionally required. If vaccine administered, indicate which vaccine and either Live attenuated vaccine or inactivated vaccine. If both seasonal and non-seasonal vaccines are administered, a separate form will be completed for each.
Manufacturer	Conditionally required. If vaccine administered, influenza vaccine manufacturer will be auto-entered by computer when vaccine type is selected.
Lot number	Conditionally required. If vaccine administered, enter the lot number of the vaccine given to the patient.
Route of administration	Conditionally required. If vaccine is administered, indicate the route of administration used.
Vaccine Information Statement Provided to Patient	Conditionally required. If vaccine is administered, indicate what type of information statement was provided, if any, and the edition date using this format: MM/DD/YYYY
Person administering vaccine: Vaccinator ID	Optional. If vaccine is administered, indicate vaccinator identifier. This is the vaccinator identifier assigned by the hospital and may consist of any combination of numbers and/or letters.
Person administering vaccine: Title	Optional. If vaccine is given indicate title of person administering vaccine (RN, LPN, Nurses Assistant, etc.).
Person administering vaccine: Name	Optional. If vaccine is given indicate name of vaccinator by last name, first name, middle name or initial
Person administering vaccine: Work address	Optional. This information may be auto-entered by the computer.
Custom fields and labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use. **NOTE:** Each custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter comments about this vaccination. These fields can not be analyzed.

Table 18. Instructions for Completion of the High Risk Inpatient Influenza Vaccination Standing Orders Form - Optional (CDC 57.134)

Seasonal Influenza (Tables of Instructions List)

Data Field	Instructions for Data Collection
Facility ID	Required. Blank space for facility to place identification information of the facility as indicated or required by the facility.
Patient ID	Required. Blank space for facility to place patient identification label or stamp as indicated. Minimum information required includes the alphanumeric patient ID number (This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters), gender and date of birth.
High risk inclusion criteria	Required. Check all that apply for seasonal influenza
Vaccine offered	Required. Check Yes or No
Vaccine declined	Required. Check Yes or No
Reason(s) vaccine declined	Conditionally required. Check all that apply in either section A or section B but not both. If reasons exist in both categories then section A, medical contraindications, takes priority and should be completed.
Orders	Required. Check Immunize or DO NOT Immunize.
Standing order	Optional. Check if hospital policy provides for standing immunization order.
Physician signature	Conditionally required. Signature of ordering physician if standing order policy is not in place and checked.
Vaccine administered	Required. Check Yes or No
Date Administered	Conditionally required. If vaccine administered place date here.
Type of influenza vaccine administered	Conditionally required. If vaccine administered indicate type of vaccine administered, manufacturer and lot number.
Route of administration	Conditionally required. If vaccine administered, indicate route used.
Vaccine information statement provided to patient	Conditionally required. If vaccine administered indicate type and edition date of vaccine information statement provided, if no vaccine information statement was provided or if it is unknown.
Vaccinator ID	Conditionally required. If vaccine administered indicate ID number of person administering the vaccine. This could be the employee number of the vaccinator or a vaccinator ID assigned by the hospital and may consist of any combination of numbers and/or letters. Indicate the Title of the vaccinator.
Name	Conditionally required. If vaccine administered indicate name of person administering the vaccine using last name first, followed by first and middle name.
Work address, city, state, zip	Optional. If vaccine administered indicate work address of person

Data Field	Instructions for Data Collection
code	administering the vaccine. Typically this would be the same as the hospital facility.

Non-Seasonal Influenza Vaccine

Data Field	Instructions for Data Collection
Facility ID	Required. Blank space for facility to place identification information of the facility as indicated or required by the facility.
Patient ID	Required. Blank space for facility to place patient identification label or stamp as indicated. Minimum information required includes the alphanumeric patient ID number (This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters), gender and date of birth.
High risk inclusion criteria	Required. Check all that apply for non-seasonal influenza
Vaccine offered	Required. Check Yes or No
Vaccine declined	Required. Check Yes or No
Reason(s) vaccine declined	Conditionally required. Check all that apply in either section A or section B but not both. If reasons exist in both categories then section A, medical contraindications, takes priority and should be completed.
Orders	Required. Check Immunize or DO NOT Immunize.
Standing order	Optional. Check if hospital policy provides for standing immunization order.
Physician signature	Conditionally required. Signature of ordering physician if standing order policy is not in place and checked.
Vaccine administered	Required. Check Yes or No
Date Administered	Conditionally required. If vaccine administered place date here.
Type of influenza vaccine administered	Conditionally required. If vaccine administered indicate type of vaccine administered, manufacturer and lot number.
Route of administration	Conditionally required. If vaccine administered, indicate route used.
Vaccine Information statement provided to patient	Conditionally required. If vaccine administered indicate type and edition date of vaccine information statement provided, if no vaccine information statement was provided or if it is unknown.
Vaccinator ID	Conditionally required. If vaccine administered indicate ID number of person administering the vaccine. This could be the employee number of the vaccinator or a vaccinator ID assigned by the hospital and may consist of any combination of numbers and/or letters. Indicate the Title of the vaccinator.
Name	Conditionally required. If vaccine administered indicate name of person

Data Field	Instructions for Data Collection
	administering the vaccine using last name first, followed by first and middle name.
Work address, city, state, zip code	Conditionally required. If vaccine administered indicate work address of person administering the vaccine. Typically this would be the same as the hospital facility.

Table 19. Instructions for Completion of the Laboratory-identified MDRO or CDAD Event form (CDC 57.128) (Tables of Instructions List)

Data Field	Instructions for Form Completion
Facility ID	The NHSN-assigned facility ID number will be auto-entered by the computer.
Event #	Event ID number will be auto-entered by the computer.
Patient ID	Required. Enter the alphanumeric patient ID. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters. This should be an ID that remains the same for the patient across all visits and admissions.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter any other patient ID assigned by the facility.
Patient Name, Last First, Middle	Optional. Enter the name of the patient. If available, data will be auto-entered from Patient Form.
Gender	Required. Circle M (Male) or F (Female) to indicate the gender of the patient.
Date of Birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity (specify)	Optional. Enter the patient's ethnicity: Hispanic or Latino Not Hispanic or Not Latino
Race (specify)	Optional. Enter the patient's race: Select all that apply. American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Event Details	
Event Type	Required. Event type = LabID.
Date Specimen Collected	Required. Enter the date the specimen was collected for this event using format: MM/DD/YYYY
Specific Organism Type	Required. Check the pathogen identified for this specimen for one of the following laboratory-identified MDRO types: MRSA, MSSA (if tracking MRSA & MSSA), VRE, MDR-*Klebsiella*, MDR-*Acinetobacter* or *C. difficile*. Use one form per LabID event (i.e., 1 form for each pathogen).
Outpatient	Required. Circle "Yes" if the patient meets the definition of an NHSN Outpatient: A patient whose date of admission to the healthcare facility and date of discharge are the same day. If the patient was an outpatient, do not enter Date Admitted to Facility, Location, or Date Admitted to Location.
Specimen Body Site	Required. Enter the main body site from which the specimen was taken using the description that is most specific. (e.g., digestive system, central

Data Field	Instructions for Form Completion
	nervous system, etc.)
Specimen Source	Required. Enter the specific anatomic site from which the specimen was taken using the source description that is most accurate from the available choices (e.g., bile specimen, specimen from brain, etc.)
Date Admitted to Facility	Conditionally required. Enter the date the patient was admitted to facility using this format: MM/DD/YYYY. If the patient was OP only and not admitted, leave this blank.
Location	Conditionally required. Enter the patient care area where the patient was assigned when the laboratory-identified MDRO or *C. difficile* event specimen was collected (i.e., the NHSN "transfer rule" does not apply for LabID events). Special Case: If a specimen collected in the emergency department is positive for an MDRO or CDAD, and the patient it is collected from is admitted to the facility on the SAME date into a location that is monitoring LabID Events for the identified MDRO or CDAD, then that specimen can be reported as the first specimen for the patient in that admitting inpatient location for the month. If the facility is also monitoring LabID Events for the same MDRO or CDAD in the emergency department, then the same specimen for the patient would also be reported a second time for that outpatient location.
Date Admitted to Location	Conditionally required. Enter the date the patient was admitted to the patient care area where laboratory-identified monitoring is being performed and where the specimen was collected from the patient. Special Emergency Department Cases: Note that because of existing business rules for edit checks in NHSN, the date of specimen collection must be the same date or later than the admission date.
Documented prior evidence of infection or colonization with this specific organism type?	Required. Circle "Yes" or "No" depending on whether there is prior evidence as documented by a healthcare provider or laboratory report that the patient had a specimen that was positive for the same specific organism type (includes flags for 'known positive'). Statements from the patient should not be treated as documented evidence. If there is a previous LabID event for this organism type entered in NHSN in a prior month, the system will auto-populate with a "Yes." **Do not answer this question if organism type is MSSA.**
Required for CDAD (Optional for Other MDROs)	
Has patient been discharged from your facility in the past 3 months?	Conditionally Required. Circle "Yes" if the patient has been an inpatient and discharged from your facility in the past three months, otherwise circle "No".
Date of last discharge from your facility	Conditionally Required. If the patient was discharged from your facility in the past 3 months (previous question is circled "Yes"), enter the most recent date of discharge prior to the current admission. Use format: MM/DD/YYYY
Custom Fields	
Labels	Optional. Up to two date fields, 2 numeric and 10 alphanumeric fields that may be customized for local use. **NOTE:** Each Custom Field must be set up

Data Field	Instructions for Form Completion
	in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter any information on the Event. This information may not be analyzed.

Table 20. Instructions for Completion of the MDRO or CDAD Infection Event form (CDC 57.126) (Tables of Instructions List)

Data Field	Instructions for Form Completion
Facility ID	The NHSN-assigned facility ID number will be auto-entered by the computer
Event #	Event ID number will be auto-entered by the computer
Patient ID	Required. Enter the alphanumeric patient ID. This is the patient identifier assigned by the hospital and may consist of any combination of numbers and/or letters. This should be an ID that remains the same for the patient across all visits and admissions.
Social Security #	Optional. Enter the 9-digit numeric patient Social Security Number.
Secondary ID	Optional. Enter any other patient ID assigned by the facility.
Patient Name, Last First Middle	Optional. Enter the name of the patient.
Gender	Required. Circle M (Male) or F (Female) to indicate the gender of the patient.
Date of Birth	Required. Record the date of the patient birth using this format: MM/DD/YYYY.
Ethnicity (specify)	Optional. Enter the patient's ethnicity: Hispanic or Latino Not Hispanic or Not Latino
Race (specify)	Optional. Enter the patient's race: (select all that apply) American Indian or Alaska Native Asian Black or African American Native Hawaiian or Other Pacific Islander White
Event Details	
Event Type	Required. Enter infection event type other than BSI, DE, Pneumonia, SSI, or UTI. For reporting MDRO infections that are BSI, Pneumonia, SSI, or UTI, use those infection forms and instructions.
Date of Event	Required. Enter the date the first clinical symptoms of infection occurred or the date the first positive specimen was collected, whichever came first. Use format: MM/DD/YYYY.
Post Procedure Event	Required. Circle "Yes" if the infection occurred after an NHSN-defined procedure but before discharge from the facility, otherwise circle "No".
Date of Procedure	Conditionally required. If an NHSN-defined procedure was performed, enter date using this format: MM/DD/YYYY
MDRO/CDAD Infection	Required. Enter "Yes", if the pathogen is being followed for the MDRO/CDAD Module for Infection Surveillance in that location as part of your Monthly Reporting Plan: MRSA, MSSA (MRSA/MSSA), VRE, MDR-*Klebsiella*, MDR-*Acinetobacter* or *C. difficile*. If the pathogen for this event happens to be an MDRO but your facility is not

Data Field	Instructions for Form Completion
	following the MDRO/CDAD Module in your Monthly Reporting Plan, answer "No" to this question.
NHSN Procedure code	Conditionally required. Answer this question only if this patient developed the MDRO or *C. difficile* infection during the same admission as an operative procedure. Enter the appropriate NHSN procedure code. **NOTE:** An MDRO infection cannot be "linked" to an operative procedure unless that procedure has already been added to NHSN. If the procedure was previously added, and the "Link to Procedure" button is clicked, the fields pertaining to the operation will be auto-entered by the computer.
ICD-9-CM Procedure Code	Optional. The ICD-9-CM code may be entered here instead of (or in addition to) the NHSN Procedure Code. If the ICD-9-CM code is entered, the NHSN code will be auto-entered by the computer. If the NHSN code is entered first, you will have the option to select the appropriate ICD-9-CM code. In either case, it is optional to select the ICD-9-CM code.
Specific Organism Type	Required. Check the pathogen(s) identified for this infection event. You may select up to 3.
Date Admitted to Facility	Required. Enter date patient admitted to facility using this format: MM/DD/YYYY
Location	Required. Enter the nursing care area where the patient was assigned when the MDRO or *C. difficile* infection (CDI) was acquired. If the MDRO or CDI developed in a patient within 48 hours of discharge from a location, indicate the discharging location, not the current location of the patient.
Specific Event Type	Required. List the specific CDC-defined infection event type. For event type = BSI, PNEU, SSI or UTI this form should not be used. Use the form designed for that event.
Signs & Symptoms	Required. Using the criteria in Table 17, check all signs and symptoms used to confirm the diagnosis of this infection event in the observed patient.
Laboratory or Diagnostic Testing	Conditionally required. Indicate whether any blood cultures, other laboratory tests or radiologic exams were used to diagnose the infection.
***Clostridium difficile*-Associated Disease**	
Admitted to ICU for CDAD complications	Conditionally required. If pathogen is *C. difficile*, circle "Yes" to indicate admission to ICU for *C. difficile* complications (e.g., shock that requires vasopressor therapy), otherwise circle "No".
Surgery for CDAD complications	Conditionally required. If pathogen is *C. difficile*, circle "Yes" to indicate surgery for *C. difficile* complications, otherwise circle "No". Surgery might include colectomy for toxic megacolon, perforation or refractory colitis.
Secondary Bloodstream Infection	Required. Circle "Yes" if there is a culture-confirmed bloodstream infection (BSI) during this admission, secondary to this infection, for the same pathogen. Otherwise circle "No".
Died	Required. Circle "Yes" if the patient died during this hospitalization, otherwise circle "No".
Event Contributed to Death	Conditionally Required. **MDRO**: If the patient died during this admission, circle "Yes" if the MDRO infection contributed to death, otherwise circle "No".

Data Field	Instructions for Form Completion
	CDAD: Circle "Yes" only if the patient died within 30 days after *C. difficile* infection symptom onset and during the current hospital admission.
Discharge Date	Optional. Enter the date the patient was discharged from the facility using this format: MM/DD/YYYY. If the patient died during this admission enter the death date.
Pathogens Identified	Required. Circle "Yes" if pathogen identified, "No" if otherwise; if "Yes" indicate the pathogen identified on the antibiogram on page 2. If the pathogen was *C. difficile,* enter it under *Other Organisms* but do not include antibiogram. **NOTE:** Any infection reported as an MDRO or CDI must have a pathogen identified.
Custom Fields and Labels	Optional. Up to two date fields, two numeric fields, and 10 alphanumeric fields may be customized for local use. **NOTE:** Each custom Field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter comments for local use and the values entered. These fields may not be analyzed.

Table 21. Instructions for Completion of the MDRO and CDAD Prevention Process and Outcome Measures Monthly Monitoring form (CDC 57.127) (Tables of Instructions List)

Data Field	Instructions for Form Completion
Facility ID #	The NHSN-assigned facility ID number will be auto-entered by the computer
Month	Required. Enter the 2-digit month during which surveillance was performed.
Year	Required. Enter the 4-digit year during which surveillance was performed.
Location Code	Required. Enter the code of the patient care location where the outcome measures monitoring was done.
Setting: Inpatient Days	Conditionally Required. If this is an inpatient location, enter the total number of patient days for this location for the month.
Admissions	Conditionally required. Enter the total number of admissions for this location if Active Surveillance Testing (AST) or LabID event monitoring was performed.
Setting: Outpatient (or Emergency Room) Encounters	Conditionally required. If LabID Event monitoring is performed in outpatient and/or emergency room locations, enter the total number of encounters occurring during the surveillance month. If performing Overall facility-wide surveillance and Settings = *Both* on the Monthly Reporting Plan, enter Inpatient Days, Admissions and Outpatient Encounters.
MDRO and CDAD Infection Surveillance or LabID Event Reporting	
Infection Surveillance	Conditionally required. Check any MDRO or *C. difficile* organism selected for monitoring in the location during the time period specified.
LabID Event	Conditionally required. Check any MDRO or *C. difficile* organism selected for LabID event reporting in the location during the time period specified.
Process Measures (Optional)	
Hand Hygiene Performed	Required for hand hygiene adherence process measures. Enter the total number of observed contacts during which an HCW touched either the patient or inanimate objects in the immediate vicinity of the patient and appropriate hand hygiene was performed (i.e., Hand Hygiene Performed).
Indicated	Required for hand hygiene adherence process measures. Enter the total number of observed contacts during which an HCW touched either the patient or inanimate objects in the immediate vicinity of the patient and therefore, appropriate hand hygiene was indicated (i.e., Hand Hygiene Indicated).

Data Field	Instructions for Form Completion
Gown and Gloves Used	Required for gown and gloves use adherence process measures. Among patients on Contact Precautions, enter the total number of observed contacts between an HCW and a patient or inanimate objects in the immediate vicinity of the patient for which gloves and gowns had been donned prior to the contact (i.e., Gown and Gloves Used).
Indicated	Required for gown and gloves use adherence process measures. Among patients on Contact Precautions, enter the total number of observed contacts between an HCW and a patient or inanimate objects in the immediate vicinity of the patient and therefore, gloves and gowns were indicated (i.e., Gown and Gloves Indicated).
Active Surveillance Testing (For MRSA & VRE only)	
Active Surveillance Testing performed	Required for active surveillance testing adherence process measures. For MRSA and VRE only. Check those for which active surveillance testing is being done.
Timing of AST • Adm • Both	Required for active surveillance testing adherence process measures. Choose the time period when surveillance testing will be performed. Specimens for AST can be obtained at the time of admission (Adm), or at the time of admission and for patients' stays of > 3 days, at the time of discharge/transfer (Both).
AST Eligible Patients • All • NHx	Required for admission surveillance testing adherence process measures. If all admitted patients were tested choose All. Circle NHx if performing AST only on those patients admitted to the patient care location with no documentation at the time of admission of MRSA and/or VRE colonization or infection in ≤ 12 months (NHx). That is, no specimen positive for MRSA and/or VRE for this patient during previous stays at this facility or from information provided by referring facilities in ≤ 12 months.
Admission AST • Performed • Eligible	Required for admission surveillance testing adherence process measures. Enter the number of patients eligible for admission AST and who had a specimen obtained for testing ≤ 3 days of admission (i.e., Admission AST Performed). Enter the number of patients eligible for admission surveillance testing. (i.e., Admission AST Eligible)
Discharge/Transfer AST • Performed • Eligible	Required for discharge/transfer active surveillance testing adherence process measures. For patients' stays > 3 days, enter the number of discharged or transferred patients eligible for AST and who had a specimen obtained for testing prior to discharge or transfer, not including the admission AST (i.e., Discharge/Transfer AST Performed). For patients' with stays of > 3 days, enter the number of patients eligible for discharge/transfer surveillance testing; were negative if tested on

Data Field	Instructions for Form Completion
	admission. (i.e., Discharge/Transfer AST Eligible).
Outcome Measures (Optional) - MRSA & VRE ONLY	
Prevalent Cases	
AST/Clinical Positive	Required for prevalent case - AST/clinical positive outcome measures. Enter the number of patients with MRSA and/or VRE isolated from a specimen collected for AST or for clinical reasons on admission (≤ 3 days) (i.e., the MRSA or VRE cannot be attributed to this patient care location).
Known Positive	Enter the number of patients with documentation on admission of MRSA or VRE colonization or infection, from the admitting or referring facility, in ≤ 12 months (i.e., patient is known to be colonized or infected with MRSA and/or VRE within the last year). All MRSA or VRE colonized patients already in the ICU during the first month of surveillance should be considered "Known Positive".
Incident Cases	
AST/Clinical Positive	Required for incident case - AST/clinical positive outcome measures. Enter the number of patients with a stay > 3 days: • With no documentation on admission of MRSA and/or VRE colonization or infection, from the admitting or referring facility, in ≤ 12 months (i.e., patient is not known to be colonized or infected with MRSA and/or VRE within the last year and is negative if tested on admission), AND • MRSA and/or VRE isolated from a specimen collected for AST or clinical reasons > 3 days after admission and up to discharge/transfer from the patient care location.
Custom Fields and Labels	Optional. Up to 5 numeric fields may be customized for local use. **NOTE:** Each custom field must be set up in the Facility/Custom Options section of the application before the field can be selected for use.
Comments	Optional. Enter comments for local use and the values entered. These fields may not be analyzed.