Specimen Type: Check appropriate specimen and fill in requested information (Only one sample per form).

- ☐ Blood
- ☐ CSF
- ☐ Peritoneal Fluid
- ☐ Pleural Fluid
- ☐ Synovial fluid
  Source: ____________
- ☐ Other Invasive Site
  Source: ____________

SSTI (MRSA only)

- ☐ Wound/Tissue/Biopsy
  - ☐ Pus
  - ☐ Abscess
  - ☐ Deep Wound
    - ☐ Surgical
  - ☐ Furuncle
  - ☐ Boil
- ☐ Other: ____________

DATE COLLECTED: ____ / ____ / ____ (mm dd year)

PATIENT: ______________________ (last) ______________________ (first)

BIRTH DATE: ____ / ____ / ____ (mm dd year) SSN #: ____ – ____ – ____

ADDRESS: ______________________

CITY: ____________ STATE: ____ ZIP: ____

PHONE: ( ) - ____________ GENDER: ☐ Female ☐ Male

RACE: ☐ White ☐ Black ☐ Asian ☐ American Indian / Alaskan Native ☐ Native Hawaiian / Pacific Islander ☐ Unknown

ETHNICITY: ☐ Hispanic ☐ Non Hispanic ☐ Unknown

PATIENT ID #: ______________________

CLINICIAN: ______________________ (please print, last, first) CLINICIAN ID #: ____________

PHONE: ( ) - ____________ CLINICIAN'S Signature:

Invasive Disease Reporting / Antimicrobial Resistant Surveillance Test Request Form

Required Information

Organism (complete Patient History Part A)

- ☐ MRSA (also complete Patient History Part B)
- ☐ VISA / VRSA (also complete Patient History Part B)
- ☐ S. pneumoniae
- ☐ S. pyogenes
- ☐ H. influenzae
- ☐ N. meningitidis
- ☐ Enterococcus faecium
- ☐ Enterococcus faecalis
- ☐ Enterococcus species: ____________
- ☐ Other, Specify: ____________

Lab #: ____________

Patient Facility (if different from submitter)

Facility Name: ____________

Facility City, State: ____________

Susceptibility Testing Results

- ☐ Not Done
- Done: Method
  - ☐ Broth Microdilution
    - ☐ Manual
    - ☐ Automated
  - ☐ E-test
  - ☐ Disk-diffusion
  - ☐ Other: ____________

Patient History

A. At time of specimen collection:

Inpatient ? ☐ Yes ☐ No

ICU / CCU ? ☐ Yes ☐ No

Admit date: ____ / ____ / ____ (mm dd year)

B. For all MRSA submitted: (to be completed by ICP) (check all that apply)

- ☐ >= 2 days hospitalization
- ☐ History of hospitalization within the last year
- ☐ History of surgery within the last year
- ☐ Dialysis within the last year
- ☐ LTCF resident within the last year
- ☐ Permanent indwelling catheter
- ☐ Percutaneous medical device
- ☐ Previous culture positive for MRSA
- ☐ Athlete
- ☐ Prisoner
- ☐ Healthcare worker

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Facility Name: ______________________

Address: ______________________

City: ____________ State: ____ Zip: ____