

### CDI Surveillance Form

1	Patient unique number		
2	Chart # (if applicable)		
3	a) Type of Care (Acute, LTC, Other)		
	b) Facility (Name)		
4	Patient Care Unit in Facility		
5	Type of patient care unit	<input type="checkbox"/> Surgical Unit <input type="checkbox"/> Critical Care Unit <input type="checkbox"/> Medical Unit <input type="checkbox"/> Obstetrical Unit <input type="checkbox"/> Combined (med/surg) Unit <input type="checkbox"/> Other; specify _____	
6	Date of Birth	____/____/____ DD MMM YYYY Month = (ie., May)	
7	Date of Admission	____/____/____ DD MMM YYYY	
8	Reason for Admission		
9	Date of Discharge	____/____/____ DD MMM YYYY	
10	Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	
11	Date of current positive lab test?	____/____/____ DD MMM YYYY	
12	Why was the specimen collected?	<input type="checkbox"/> clinical signs and symptoms <input type="checkbox"/> other _____	
13	Has the patient ever had CDI before?	<input type="checkbox"/> No <input type="checkbox"/> Yes, less than 2 months ago <input type="checkbox"/> Yes, more than 2 months ago <input type="checkbox"/> Unknown	
14	Where was the CDI acquired? (Check one answer only)	<input type="checkbox"/> Same as treatment facility (#3b) – nosocomial If not acquired in the same facility as #3b <input type="checkbox"/> Another Acute Care (AC) in region _____ <input type="checkbox"/> Another LTC in region _____ <input type="checkbox"/> An exposure outside the region _____ <input type="checkbox"/> Healthcare associated <input type="checkbox"/> Community-associated <input type="checkbox"/> Unknown	
15	Did patient require ICU admission for this episode?	<input type="checkbox"/> No <input type="checkbox"/> Yes, admitted to ICU for complications of CDI	
16	Treatment for CDI	<input type="checkbox"/> Metronidazole <input type="checkbox"/> x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> Vancomycin <input type="checkbox"/> x 1 <input type="checkbox"/> x 2 <input type="checkbox"/> No antibiotic <input type="checkbox"/> Other	
17	Patient disposition at 30 days after diagnosis	<input type="checkbox"/> Alive, in hospital due to CDI <input type="checkbox"/> Alive, in hospital for other reasons <input type="checkbox"/> Alive, in a LTC facility <input type="checkbox"/> Discharged from hospital prior to 30 days <input type="checkbox"/> Deceased <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	

1. Patient unique reference number
2. Chart number for those facilities that use a chart number as a patient identifier
3. a) Type of care – Placement of the patient at the time of the positive culture; identify if it was acute care, long term care, or other. Other = living in the community or living in a personal care home at the time of the positive culture.  
b) Facility – If applicable, identify the name of the acute care facility or the long term care facility where patient resided when the positive culture was identified. The facilities can be identified from the drop down tab.
4. Name of patient care unit in the facility in Question 3 eg., , H4N, 3B.
5. If the patient was in a facility when laboratory confirmation was known, indicate the type of service provided on that Unit: medical, surgical, and critical care units. The ICP should use best judgment to determine to which unit the transmission is associated.
6. Date of Birth: Please enter Day (##), Month (eg., May) and Year (2008) in this order.
7. Date of Admission: Enter Day (##), Month (eg., May) and Year (2008) in this order.
8. Reason for Admission: why is the person in the facility?
9. Date of Discharge: Enter Day (##), Month (eg., May) and Year (2008) in this order.  
Not applicable – for example, if the person is a resident of LTC
10. Sex: Check male or female gender as appropriate
11. What was the date of this patient’s newly identified CDI culture? Enter day (##), Month (eg., May), and Year (2007) in this order, from the most recent diagnosed episode of CDI.
12. Identify the reason for the CDI testing.
13. Assess if the person has had previous testing for CDI and determine if this is a recurrence of CDI or a reinfection.
14. Where was the CDI acquired? - Use the definitions to guide making this decision.
  - *Same as treatment facility* – This applies to CDIs which have been acquired in the treatment facility identified in #3b. If the CDI has not been acquired in the treatment facility identified in #3b choose an option in the **type of care box**:
    - Acute Care
    - Long Term Care
    - Other
  - **In the facility box** – choose either the acute care or long term care facility or choose one of the following options: outside your health region, healthcare associated, community-associated, or personal care home,
15. Outcome: Did the patient require an ICU admission due to CDI?
16. What antibiotics were prescribed for CDI? How many courses of the antibiotic were required to treat the person? X1 = one course of antibiotic; X2 = two courses of antibiotic; Other – indicate the type of antibiotic used and if one, two or more courses were required
17. Disposition: At 30 days post CDI diagnosis, where was the person?
18. Comments - for personal use not for entry into the database.