

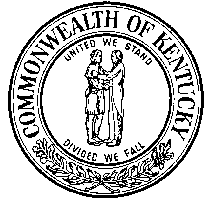
**Kentucky Reportable MDRO Form**

**Department for Public Health**

**Division of Epidemiology and Health Planning**

**275 East Main St., Mailstop HS2E-B**

**Frankfort, KY 40621-0001**



EPID 250 –MDRO

**KDPH use only:**

**Record No:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| DEMOGRAPHIC DATA | | | | | | | | | | | | | | | | | |
| Patient’s Last Name: First: M.I.: | | | | | | | | Date of Birth:  / / | | | | | | Age: | Gender  M F  Unk | | |
| City: State: Zip: | | | | | | | | | | | | | | | County of Residence: | | |
| Phone Number: | | Patient ID Number: | | | Ethnic Origin:  His.  Non-His. | | | | | | Race:  W B A/PI Am.Ind. Other | | | | | | |
| DISEASE INFORMATION | | | | | | | | | | | | | | | | | |
| Organism name: | | | | | | | | | Date of Onset  / / | | | | | | | Date of Diagnosis  / / | |
| MDRO type:  CRE-*E.coli* CRE-*Klebsiella*  CRE-Other ESBL MDR-Acinetobacter MRSA VRE Other | | | | | | | | | | | | | | | | | |
| Hospitalized:  Yes  No | | | Hospital Name: | | | | | | | | | Admission Date  / / | | | | | Discharge Date  / / |
| Admitted from:  Home LTC Facility Other HC Facility Other | | | | | | Specify Name: | | | | | | | | | | | |
| Agency completing form: | | | | | | | | | | Attending Physician: | | | | | | | |
| Name: Agency Type: | | | | | | | | | | Name: | | | | | | | |
| Address: | | | | | | | | | | Address: | | | | | | | |
| Phone: Date of Report: / / | | | | | | | | | | Phone: | | | | | | | |
| Person Completing Form:  Name: | | | | | | | | | | | | | | | | | |
| LABORATORY INFORMATION | | | | | | | | | | | | | | | | | |
| Date of Test | Name or Type of Test | | | Name of Laboratory | | | Specimen Source | | | | | | Results | | | | |
|  |  | | |  | | |  | | | | | |  | | | | |
|  |  | | |  | | |  | | | | | |  | | | | |
| Type of culture:  Clinical Surveillance | | | | | | | Patient infected or colonized:  Infected Colonized | | | | | | | | | | |
| DISPOSITION INFORMATION | | | | | | | | | | | | | | | | | |
| Status: Expired  Discharged to: Home LTC Facility Other HC Facility Other  Specify Name: | | | | | | | | | | | | | | | | | |
| Was the receiving facility notified of the patient’s MDRO status:  Yes No Unk | | | | | | | | | | | | | | | | | |
| Identifying Facility:  Name: Facility Type: | | | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | | |
| Phone: | | | | | | | | | | | | | | | | | |
| Outbreak Associated:  Yes No | | | | | | Outbreak reference number: | | | | | | | | | | | |

**Please include copy of laboratory results/Send to Secure Fax 502-696-3803**