

**Maryland Department of Health
CRO CASE REPORT FORM**

Patient Name: _____
Last First

DOB: ___ / ___ / ___

Sex: M F Unknown Patient Address: _____

Patient Medical Record # _____

Admission Date ___ / ___ / ___
 (if patient admitted to a hospital)

Processing Laboratory _____

Requesting Facility (if applicable) _____
 (e.g. long term care facility, other hospital campus, etc.)

Requesting Physician (if applicable) _____
 (e.g. outpatient provider)

Specimen Collection Date: _____ Specimen/Accession # : _____

Specimen Source: _____

Species isolated

- Escherichia coli* *Klebsiella pneumoniae* Other *Klebsiella spp* (specify) _____
- Enterobacter spp* (specify) _____ *Acinetobacter baumannii* (or other organism included in *A. baumannii/calcoaceticus* complex)
- Other (specify) _____ *Pseudomonas aeruginosa*

Antibiotic Susceptibility Testing (MIC or zone diam)

		<u>Pseudomonas only</u>	
Doripenem	_____	Cefepime	_____
Ertapenem	_____	Ceftazidime	_____
Imipenem	_____	Ceftaz/Avi	_____
Meropenem	_____	Cefto/Tazo	_____

Molecular Testing

Type of test performed

- Automated molecular assay (Verigene, Biofire etc)
- Carba-R
- PCR
- Other (specify) _____

Result

- KPC
- NDM
- VIM
- OXA-48
- IMP
- Other (specify) _____

Phenotypic Testing

- MHT Positive Negative
- mCIM Positive Negative
- CarbaNP Positive Negative