



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 <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk
				/ /		
City:	State:	Zip:		County of Residence:		
Phone Number:	Patient ID Number:	Ethnic Origin: <input type="checkbox"/> His. <input type="checkbox"/> Non-His.		Race: <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am.Ind. <input type="checkbox"/> Other		
DISEASE INFORMATION						
Organism name:			Date of Onset	Date of Diagnosis		
			/ /	/ /		
MDRO type: <input type="checkbox"/> CRE- <i>E.coli</i> <input type="checkbox"/> CRE- <i>Klebsiella</i> <input type="checkbox"/> CRE-Other <input type="checkbox"/> ESBL <input type="checkbox"/> MDR-Acinetobacter <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Other						
Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No		Hospital Name:		Admission Date	Discharge Date	
				/ /	/ /	
Admitted from: <input type="checkbox"/> Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other HC Facility <input type="checkbox"/> Other			Specify Name:			
Agency completing form: Name:			Agency Type:		Attending Physician: 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		
Reason for Culture: <input type="checkbox"/> Clinical <input type="checkbox"/> Surveillance			Patient infected or colonized: <input type="checkbox"/> Infected <input type="checkbox"/> Colonized			
DISPOSITION INFORMATION						
Status: <input type="checkbox"/> Expired Discharged to: <input type="checkbox"/> Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other HC Facility <input type="checkbox"/> Other Specify Name:						
Was the receiving facility notified of the patient's MDRO status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk						
Identifying Facility: Name:		Facility Type:				
Address:						
Phone:						
Outbreak Associated: <input type="checkbox"/> Yes <input type="checkbox"/> No			Outbreak reference number:			