



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:			Attending Physician: Name:		
Address:			Address:		
Phone:			Date of Report: / /		
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:		