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

Please Print

EPID 250 –MDRO
7/2024

Record number, KDPH use only:

DEMOGRAPHIC DATA

Patient's Last Name: First: M.I.: Date of Birth: / / Age:

Gender: ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Unknown Additional identity (specify)

City: State: Zip: County of Residence:

Phone Number:

Ethnic Origin: ☐ His. ☐ Non-His.

Race: ☐ W ☐ B ☐ A/PI ☐ Am.Ind. ☐ Other

Any international travel, healthcare, and/or hospitalization within the last 12 months: ☐ Yes ☐ No
If Yes: ☐ International Travel ☐ International Healthcare ☐ International Hospitalization

If yes, which countries:

DISEASE INFORMATION

Organism name:

Date of Positive Lab Result: / /

Patient placed in contact precautions? ☐ Yes ☐ No If yes Date:

MDRO type:
☐ Candida auris ☐ CR-Acinetobacter ☐ CR-Enterobacteriaceae ☐ CR-Pseudomonas ☐ VISA ☐ VRSA ☐ Other

Hospitalized at time of specimen collection: ☐ Yes ☐ No

If Hospitalized, Name of Hospital:

Admission Date / /

Discharge Date / /

If Hospitalized, Admitted from:
☐ Home ☐ LTC Facility ☐ Other HC Facility ☐ Other

Facility Name:

Name of Agency completing form: Name of Person completing form

Address:

Phone: Date of Report: / /

Name of Ordering Physician:

Address:

Phone:

LABORATORY INFORMATION

Date of Specimen Collection	Name or Type of Test	Name of Laboratory	Specimen Source

Type of culture:
☐ Clinical ☐ Surveillance

Organism previously identified in patient ☐ Yes ☐ No
If Yes, Date / /

Location of the patient at the time of specimen collection:
☐ Outpatient office/clinic
☐ ED/Urgent Care
☐ Acute Care hospital (inpatient)
☐ Critical Access Hospital (inpatient)
☐ Long-term acute care hospital
☐ SNF/Nursing home
☐ Other healthcare setting
☐ Outpatient laboratory
☐ Home (Home Health)

Name of Facility/Location:

County:

DISPOSITION INFORMATION

Status: ☐ Still Hospitalized ☐ 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

Any previous hospitalizations at your facility within the last six months: ☐ Yes ☐ No
Date of Previous Hospitalizations

Admit / / Discharge / / Admit / / Discharge / /
Admit / / Discharge / / Admit / / Discharge / /
Admit / / Discharge / / Admit / / Discharge / /

Outbreak Associated:
☐ Yes ☐ No

Outbreak reference number:

Please include copy of laboratory results/Send to Secure Fax 502-398-2462