Healthcare Associated MRSA Vs Community Associated Screening Questionnaire

NAME____ **DOB**___________________

DEPARTMENT______________ **SUPERVISOR'S NAME**____________________

Date of Exposure _________________________________

Date diagnosed with MRSA_________________________

Physician's Name_________________________________

Outpatient YES NO

Inpatient YES NO

Hospital name____________________________________

If yes, was culture obtained less than 48-hrs. after admission? YES NO

Laboratory confirmed? YES NO

Infection site_____________________________________

Culture site______________________________________

Date culture obtained______________________________

Name of laboratory that performed the culture_________________________________

Genetic testing performed? YES NO

List MRSA antibiotic sensitivities____

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Please check all that apply:

___ Hospitalization of self or family member in previous 12-months

___ History of caring for ill family member or friend in past 12-months

___ Antibiotic use currently, or in the previous 6 months

___ History of surgery, dialysis, or other medical procedure in past 12-months

___ History of diabetes

___ History of any chronic or acute illness

___ History of previous MRSA infection or colonization

___ Invasive device, implant or other medical devices present

___ Gym membership

___ Participation in group sports

___ History of volunteer work in previous 12-months

___Visit to jail or prison in previous 12-months

Explain all positive responses:

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Signature Date