



VISA/VRSA Reporting Form

Please submit one report per patient per admission within 72 hours. Attach all laboratory results including antibiotic susceptibility test results. Fax form to Indiana Department of Health (317)-234-2812 or upload to NBS Morbidity Report.

Reporting facility: _____

Reporter name: _____

Address: _____

Phone number: _____

Patient information

| | |
|---|-----------------------|
| Patient name: | NBS ID: |
| DOB: | Phone: |
| Address: | County: |
| Did the patient die from the infection? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of death: |

Laboratory information *****Attach all laboratory reports and antibiotic susceptibility testing results.*****

| | |
|--|---|
| Collection date: | Specimen type: <input type="checkbox"/> Clinical <input type="checkbox"/> Surveillance |
| Specimen source: | |
| Vancomycin susceptibility: <input type="checkbox"/> Intermediate <input type="checkbox"/> Resistant | |

Clinical information

| | | | |
|--|---|---|---|
| Admission date: From: <input type="checkbox"/> Transfer form used upon admission | | Discharge date: To: <input type="checkbox"/> Transfer form used upon discharge | |
| Contact precautions start date: | | Roommates: <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: | |
| Invasive devices at time of specimen collection <input type="checkbox"/> Central venous line <input type="checkbox"/> Mechanical vent <input type="checkbox"/> Urinary catheter <input type="checkbox"/> Wound VAC <input type="checkbox"/> Other: | Invasive procedures in past 6 months: | History of MDROs <input type="checkbox"/> MRSA <input type="checkbox"/> VRSA <input type="checkbox"/> VRE <input type="checkbox"/> ESBL <input type="checkbox"/> CRE <input type="checkbox"/> <i>C. auris</i> <input type="checkbox"/> Drug-resistant PA <input type="checkbox"/> Drug-resistant AB | Recent travel history <input type="checkbox"/> Yes <input type="checkbox"/> No Where: When: |
| Hospitalized in the last 3 months in acute care hospital or long-term acute care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Facility name: | Resident of a long-term care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No Facility name: | Antibiotic use in past 30 days Antibiotic: Start date: Stop date: | Treatment Antibiotic: Start date: Stop date: |
| Preexisting Conditions: <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Heart failure/CHF <input type="checkbox"/> Emphysema/COPD <input type="checkbox"/> Chronic renal insufficiency/chronic renal disease <input type="checkbox"/> Obesity <input type="checkbox"/> Acute/Chronic respiratory failure <input type="checkbox"/> Peri/Hemi/Quadriplegia <input type="checkbox"/> Wound/Ulcer/Abscess <input type="checkbox"/> Chronic/Recurring UTI <input type="checkbox"/> Cancer/Malignancy <input type="checkbox"/> Other: | | | |
| Infection Associated with VRSA: | Diagnosis Date: | Hospitalized for infection: <input type="checkbox"/> Yes <input type="checkbox"/> No | Admitted to ICU: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Recommendations



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Please submit one report per patient per admission within 72 hours. Attach all laboratory results including antibiotic susceptibility test results. Fax form to Indiana Department of Health (317)-234-2812 or upload to NBS Morbidity Report.

We recommend placing the patient in contact precautions (if applicable).

We recommend flagging the patient chart in case the patient is readmitted to limit transmission.

We recommend utilizing a transfer form if patient is transferred.

If the patient had a roommate, we have a concern of transmission. Screening may be recommended.

If you would like additional resources, please visit the [HAI/AR Website](#).