

FACILITY: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

ROOM #: \_\_\_\_\_ DOB: \_\_\_\_\_



**DEFINITION OF INFECTION  
(INFECTION VERIFICATION REPORT)**

1. Date infection was first noted: \_\_\_\_\_ 2. Date of admission/readmission if less than 1 month prior: \_\_\_\_\_
3. Risk factors:  G-tube  Urinary catheter  Health Care Associated Infection  
 N/G tube  Trach  Admission  
 IV  Other \_\_\_\_\_  Ongoing Infection  
 No Infection

Check box only after criteria have been met	Infection Site	Criteria Check off only the signs & symptoms that resident exhibits	Condition and Comments
<input type="checkbox"/> <b>RESPIRATORY TRACT INFECTION</b>	<input type="checkbox"/> Common Cold Syndrome or Pharyngitis	<b>MUST HAVE</b> at least 2 of the following: <input type="checkbox"/> Runny nose or sneezing <input type="checkbox"/> Dry cough <input type="checkbox"/> Stuffy nose (i.e., congestion) <input type="checkbox"/> Sore throat or hoarseness or difficulty in swallowing <input type="checkbox"/> Swollen or tender glands in neck (cervical lymphadenopathy)	Fever may or may not be present. <b>Symptoms must be new</b> and not attributable to allergies.
	<input type="checkbox"/> Influenza-like Illness  Did the resident receive Influenza vaccine during current flu season? <input type="radio"/> Yes <input type="radio"/> No	<b>MUST HAVE:</b> <input type="checkbox"/> Fever <b>and</b> <b>MUST HAVE</b> at least 3 of the following: <input type="checkbox"/> chills <input type="checkbox"/> sore throat <input type="checkbox"/> new or increased dry cough <input type="checkbox"/> new headache or eye pain <input type="checkbox"/> malaise or loss of appetite <input type="checkbox"/> myalgias or muscle aches	If criteria for influenza-like illness and other upper or lower RTI are met at the same time, only the diagnosis of influenza-like illness should be recorded. Because of the increasing uncertainty surrounding the timing of the start of influenza season, the peak of influenza activity, and the length of the season, "seasonality" is no longer a criterion to define influenza-like illness.
	<input type="checkbox"/> Pneumonia  Did the resident receive pneumococcal vaccine? <input type="radio"/> Yes <input type="radio"/> No	<b>MUST HAVE</b> all three of the following: <input type="checkbox"/> Interpretation of a chest radiograph as demonstrating pneumonia or the presence of a new infiltrate <b>AND MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> new or increased cough <input type="checkbox"/> pleuritic chest pain <input type="checkbox"/> new or increased sputum production <input type="checkbox"/> new or changed lung examination abnormalities <input type="checkbox"/> O <sub>2</sub> saturation <94% on room air or a reduction in O <sub>2</sub> saturation of >3% from baseline <input type="checkbox"/> respiratory rate of ≥25 breaths/min. <b>AND MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> fever <input type="checkbox"/> leukocytosis <input type="checkbox"/> acute functional decline <input type="checkbox"/> acute change in mental status from baseline	For both pneumonia and lower RTI, the presence of underlying conditions that could mimic the presentation of a RTI (e.g., congestive heart failure or interstitial lung diseases) should be excluded by a review of clinical records and an assessment of presenting symptoms and signs.
	<input type="checkbox"/> Lower respiratory tract infections (i.e. bronchitis, tracheobronchitis)	<b>MUST HAVE</b> all three of the following: <input type="checkbox"/> Chest radiograph not performed or negative results for pneumonia or new infiltrate <b>AND MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> new or increased cough <input type="checkbox"/> pleuritic chest pain <input type="checkbox"/> new or increased sputum production <input type="checkbox"/> new or changed lung examination abnormalities <input type="checkbox"/> O <sub>2</sub> saturation <94% on room air or a reduction in O <sub>2</sub> saturation of >3% from baseline <input type="checkbox"/> respiratory rate of ≥25 breaths/min. <b>AND MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> fever <input type="checkbox"/> leukocytosis <input type="checkbox"/> acute functional decline <input type="checkbox"/> acute change in mental status from baseline	For both pneumonia and lower RTI, the presence of underlying conditions that could mimic the presentation of a RTI (e.g., congestive heart failure or interstitial lung diseases) should be excluded by a review of clinical records and an assessment of presenting symptoms and signs.
<input type="checkbox"/> <b>URINARY TRACT INFECTION</b>	<input type="checkbox"/> UTI in resident WITHOUT CATHETER	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> Acute dysuria or acute pain, swelling, or tenderness of the testes, epididymis, or prostate <u>or</u> <input type="checkbox"/> Fever or leukocytosis and at least 1 of the following: <input type="checkbox"/> acute costovertebral angle pain or tenderness <input type="checkbox"/> suprapubic pain <input type="checkbox"/> gross hematuria <input type="checkbox"/> new or marked increase in incontinence, frequency, and/or urgency <u>or</u> <input type="checkbox"/> In the absence of fever 2 or more of the following: <input type="checkbox"/> acute costovertebral angle pain or tenderness <input type="checkbox"/> suprapubic pain <input type="checkbox"/> gross hematuria <input type="checkbox"/> new or marked increase in incontinence <input type="checkbox"/> new or marked increase in frequency <input type="checkbox"/> new or marked increase in urgency <b>AND MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> At least 10 <sup>3</sup> cfu/mL of no more than 2 species microorganisms in a voided urine sample <u>or</u> <input type="checkbox"/> At least 10 <sup>2</sup> cfu/mL of any number of organisms in a specimen collected by in-and-out	UTI should be diagnosed when there are localizing genitourinary signs and symptoms and a positive urine result. A diagnosis of UTI can be made without localizing symptoms if a blood culture isolate is the same as the organism isolated from the urine and there is no alternate site of infection. In the absence of a clear alternate source of infection, fever or rigors with a positive urine culture result in the noncatheterized resident or acute confusion in the catheterized resident will often be treated as UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source.  Urine specimens for culture should be processed as soon as possible, preferably within 1-2 hrs. If urine specimens cannot be processed within 30 minutes of collection, they should be refrigerated. Refrigerated specimens should be cultured within 24 hrs.
	<input type="checkbox"/> UTI in resident WITH CATHETER <input type="radio"/> indwelling <input type="radio"/> intermittent <input type="radio"/> suprapubic	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> Fever, rigors, or new-onset hypotension, with no alternate site of infection <u>or</u> <input type="checkbox"/> Either acute change in mental status or acute functional decline, with no alternate diagnosis and leukocytosis <u>or</u> <input type="checkbox"/> New-onset suprapubic pain or costovertebral angle pain or tenderness <u>or</u> <input type="checkbox"/> Purulent discharge from around the catheter or acute pain, swelling, or tenderness of the testes, epididymis, or prostate <b>AND MUST HAVE:</b> <input type="checkbox"/> Urinary catheter specimen culture with at least 10 <sup>3</sup> cfu/mL of any organism(s)	Recent catheter trauma, catheter obstruction, or new-onset hematuria are useful localizing signs that are consistent with UTI but are not necessary for diagnosis.  Urinary catheter specimens for culture should be collected following replacement of the catheter (if current catheter has been in place > 14 days).

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<input type="checkbox"/> <b>SYSTEMIC INFECTION</b>	<input type="checkbox"/> Primary bloodstream infection	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> 2 or more blood cultures positive with the same organism <input type="checkbox"/> diagnosis by physician of bloodstream infection (bacteria)	More detailed criteria for bloodstream infections are not given for the following reasons: 1. Resident will, in all likelihood, be in hospital for diagnosis, and 2. Reports of laboratory work and resident's condition when in hospital are frequently unavailable to LTCFs.
	<input type="checkbox"/> Unexplained febrile episode	<b>MUST HAVE</b> at least 2 of the following: <input type="checkbox"/> Documentation in the medical record of fever (>=100°F) on <b>TWO</b> or more occasions at least 12 hours apart in any 3-day period with no known infectious or non-infectious cause	
<input type="checkbox"/> <b>SKIN, SOFT TISSUE AND MUCOSAL INFECTION</b>  Site: _____	<input type="checkbox"/> Cellulitis  <input type="checkbox"/> Soft tissue  <input type="checkbox"/> Wound	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> Pus at a wound, skin or soft tissue site <u>or</u> <input type="checkbox"/> New or increasing presence of at least 4 or more of the following: <input type="checkbox"/> heat at site <input type="checkbox"/> redness at site <input type="checkbox"/> fever <input type="checkbox"/> swelling at site <input type="checkbox"/> tenderness or pain at site <input type="checkbox"/> serous drainage from site <input type="checkbox"/> acute functional decline <input type="checkbox"/> leukocytosis <input type="checkbox"/> acute change in mental status from baseline	Presence of organisms cultured from the surface (e.g., superficial swab sample) of a wound is not sufficient evidence that the wound is infected. More than 1 resident with streptococcal skin infection from the same serogroup (e.g., A, B, C, G) in a long-term care facility (LTCF) may indicate an outbreak.
	<input type="checkbox"/> Fungal <input type="checkbox"/> Oral <input type="checkbox"/> Perioral <input type="checkbox"/> Skin	Oral candidiasis <b>MUST HAVE BOTH</b> : <input type="checkbox"/> Presence of raised white patches on inflamed mucosa or plaques on oral mucosa, <u>and</u> <input type="checkbox"/> Diagnosis by a medical or dental provider  Fungal skin infections <b>MUST HAVE BOTH</b> : <input type="checkbox"/> Character rash or lesions, <u>and</u> <input type="checkbox"/> Either physician diagnosis or lab confirmation	Mucocutaneous <i>Candida</i> infections are usually due to underlying clinical conditions such as poorly controlled diabetes or severe immunosuppression. Although they are not transmissible infections in the healthcare setting, they can be a marker for increased antibiotic exposure. Dermatophytes have been known to cause occasional infections and rare outbreaks in the LTCF setting.
	Herpesvirus infections <input type="checkbox"/> Herpes Simplex <input type="checkbox"/> Herpes Zoster	<b>MUST HAVE BOTH</b> : <input type="checkbox"/> A vesicular rash, <u>and</u> <input type="checkbox"/> Either physician diagnosis or lab confirmation	Reactivation of herpes simplex ("cold sores") or herpes zoster ("shingles") is not considered a healthcare-associated infection.
	<input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Right <input type="checkbox"/> Left	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> Pus appearing from 1 or both eyes, present for at least 24 hours <u>or</u> <input type="checkbox"/> New or increased conjunctival erythema, with or without itching <u>or</u> <input type="checkbox"/> New or increased conjunctival pain, present for at least 24 hours	Conjunctivitis symptoms ("pink eye") should not be due to allergic reaction or trauma.
	<input type="checkbox"/> Scabies	<b>MUST HAVE BOTH</b> : <input type="checkbox"/> A maculopapular and/or itching rash, <u>AND</u> <input type="checkbox"/> Physician diagnosis <u>or</u> <input type="checkbox"/> Lab confirmation <u>or</u> <input type="checkbox"/> Epidemiologic linkage to a case of scabies with lab confirmation.	An epidemiologic linkage to a case can be considered if there is evidence of geographic proximity in the facility, temporal relationship to the onset of symptoms, or evidence of common source of exposure. Care must be taken to rule out rashes due to skin irritation, allergic reactions, eczema, and other noninfectious skin conditions.
<input type="checkbox"/> <b>GASTRO INTESTINAL TRACT INFECTION</b>	<input type="checkbox"/> Gastroenteritis	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> 3 or more loose or watery stools above what is normal for resident within a 24 hour period <input type="checkbox"/> 2 or more episodes of vomiting within a 24 hour period <u>or BOTH</u> of the following: <input type="checkbox"/> stool culture positive for pathogen: Salmonella, Shigella, E. coli Campylobacter, O157:H7 <b>AND</b> <input type="checkbox"/> at least 1 of the following: nausea, vomiting diarrhea, abdominal pain or tenderness	Care must be taken to exclude noninfectious causes of symptoms. New medications may cause diarrhea, nausea, or vomiting; initiation of new enteral feeding may be associated with diarrhea; and nausea or vomiting may be associated with gallbladder disease. Presence of new GI symptoms in a single resident may prompt enhanced surveillance for additional cases. In the presence of an outbreak, stool specimens should be sent to confirm the presence of norovirus or other pathogens (e.g., rotavirus or E. coli O157:H7).
	<input type="checkbox"/> Norovirus gastroenteritis	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> 3 or more loose or watery stools above what is normal for resident within a 24 hour period <input type="checkbox"/> 2 or more episodes of vomiting within a 24 hour period <b>AND</b> : <input type="checkbox"/> stool specimen where norovirus is positively detected (electron microscopy, enzyme immunoassay or PCR)	In the absence of laboratory confirmation, an outbreak (2 or more cases occurring in a LTCF of acute gastroenteritis due to norovirus infection may be assumed to be present if all of the following criteria are present ("Kaplan Criteria"): a. vomiting in more than half of affected persons; b. a mean incubation period of 24-48 hrs; c. a mean duration of illness of 12-60 hrs; and d. no bacterial pathogen is identified in stool culture.
	<input type="checkbox"/> <i>Clostridium difficile</i> infection	<b>MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> 3 or more loose or watery stools above what is normal for resident within a 24 hour period <input type="checkbox"/> Presence of toxic megacolon documented radiologically <b>AND MUST HAVE</b> at least 1 of the following: <input type="checkbox"/> Positive lab test for C. difficile toxin A or B, or a toxin producing C. difficile organism is identified via culture or PCR <input type="checkbox"/> Pseudomembranous colitis is identified during endoscopic exam or surgery or in histopathologic exam of biopsy specimen	A primary episode of C diff infection is defined as one that has occurred without any previous history of C diff infection or that has occurred >8 wks after the onset of a previous episode. A recurrent episode of C diff infection is defined as an episode of C diff infection that occurs 8 wks or sooner after the onset of a previous episode, provided that the symptoms form the earlier (previous) episode have resolved. Individuals previously infected with C diff may continue to remain colonized even after symptoms resolve. In an outbreak of GI infections, individuals could have positive test results for C diff toxin because of ongoing colonization and also be coinfecting with another pathogen. It is important that other surveillance criteria be used to differentiate infections in this situation.

4. Was resident hospitalized due to this infection?  No  Yes

5. Labs completed?  No  Yes Specify:  Culture type: \_\_\_\_\_  CBC  Other: \_\_\_\_\_  
 Results: \_\_\_\_\_ Temp: \_\_\_\_\_

6. Chest X-ray completed?  No  Yes Results: \_\_\_\_\_

7. Isolation initiated?  No  Yes Specify:  Contact Precautions  Droplet Precautions

8. MD/APRN orders?  No  Yes Write complete order and stop date: \_\_\_\_\_

\_\_\_\_\_  
 Name of Physician: \_\_\_\_\_

Report prepared by: \_\_\_\_\_ Date of report: \_\_\_\_\_

Reviewed by Nurse Manager: \_\_\_\_\_ Date: \_\_\_\_\_