New York State Department of Health

Health Care Facility Infection Control (Nosocomial) Report

Facility Name: _____ PFI (4-digit facility # required): _____

Street Address: _____ Census: _____

Street Address: _____

City: _____ County: _____

Zip Code: _____ Region: _____

Type: Hospital ☐ LTCF ☐

Contact Person: _____ Phone Number: _____

Title: _____ Fax Number: _____

E-mail: _____

Date of Report: _____

Type of Report: ☐ Outbreak/Increased incidence

☐ Single case nosocomially-acquired reportable communicable disease (*submission of DOH-389 is required*)

☐ Other: _____

Site(s) of infection: ☐ Blood ☐ Eye ☐ Gastrointestinal ☐ Other: _____

(*check all that apply*) ☐ Respiratory ☐ Skin ☐ Urinary

DATE OF ONSET OF SYMPTOMS: (earliest case) _____

PREDOMINATE SYMPTOMS AND DURATION OF ILLNESS: (if fever, include range) _____

_____

_____

NUMBER OF LABORATORY CONFIRMED CASES TO DATE: Patients: _____ Staff: _____

NUMBER OF SUSPECT CASES TO DATE: Patients: _____ Staff: _____

NUMBER TRANSFERRED TO HOSPITAL: Patients: _____ Staff: _____

NUMBER OF CASES RESULTING IN DEATH: Patients: _____ Staff: _____

AFFECTED LOCATION(S) IN FACILITY:

Number of Units: _____ Number of Floors: _____

AFFECTED LOCATION TYPES:

☐ Cardiac ☐ General Medicine ☐ Med/Surg ☐ Surgical

☐ Nursery ☐ OB/GYN ☐ Oncology ☐ Not Applicable

☐ Ortho ☐ Pediatrics ☐ Rehab ☐ Other: _____

AFFECTED ICU TYPES:

☐ Cardiac ☐ General ☐ Medical ☐ Surgical ☐ Other: _____

☐ Neonatal ☐ Neurological ☐ Pediatrics ☐ Not Applicable

AFFECTED TRANSPLANT UNIT TYPES:

☐ Bone Marrow ☐ Cardiac ☐ Not Applicable

☐ Renal Cardiac ☐ Liver ☐ Other

OTHER UNIT TYPE: _____

Please FAX to 518-402-5165

CAUSATIVE AGENT: _____

SUSPECT/CONFIRMED: ☐ Suspect ☐ Confirmed

HAVE ANY LABORATORY SPECIMENS BEEN COLLECTED:

☐ Yes ☐ No

If yes, what specimens were collected? (check all that apply):

☐ Blood ☐ CSF ☐ Nasal Pharyngeal ☐ Urine

☐ Sputum ☐ Stool ☐ Tracheal Aspirate ☐ Other: _____

If yes, what types of tests were performed? (check all that apply):

☐ Culture ☐ PCR ☐ Rapid Antigen

☐ Serology ☐ Urine Antigen ☐ Other: _____

Name of Laboratory: _____

CONTROL MEASURES TAKEN BY FACILITY (check all that apply):

☐ Antibiotics ☐ Antiviral ☐ Cohort Patients ☐ Cohort Staffing

☐ Education/Inservice ☐ Isolation ☐ Limit/modify patient activities ☐ Minimize floating

☐ Notify Visitors ☐ Reinforce Handwashing ☐ Other: _____

Additional measures not checked above: _____

_____

_____

_____

_____

_____

FOR OFFICE USE ONLY

No close out form for this case (e.g. Scabies): ☐

Paper Log Number: _____ Level of Investigation: _____

Date Received: _____ Lead Investigator: _____

Received by: _____ Follow-up by: _____

Central Office Contact to Facility: ☐ Yes ☐ No If yes, date: _____

Regional Epidemiology Staff Contact to Facility ☐ Yes ☐ No Date of Initial Contact: _____

Comments: _____

_____

_____

_____

_____

_____

Stat: ☐