



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



KentuckyPublicHealth
Prevent. Promote. Protect.

EPID 250 –MDRO
7/2024

Please Print

Record number, KDPH use only:

DEMOGRAPHIC DATA					
Patient's Last Name:		First:	M.I.:	Date of Birth: / /	Age:
				Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Unknown Additional identity (specify)	
City:		State:		Zip:	County of Residence:
Phone Number:			Ethnic Origin: <input type="checkbox"/> His. <input type="checkbox"/> Non-His.	Race: <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am.Ind. <input type="checkbox"/> Other	
Any international travel, healthcare, and/or hospitalization within the last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: <input type="checkbox"/> International Travel <input type="checkbox"/> International Healthcare <input type="checkbox"/> International Hospitalization					If yes, which countries:
DISEASE INFORMATION					
Organism name:			Date of Positive Lab Result: / /		Patient placed in contact precautions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes Date:
MDRO type: <input type="checkbox"/> Candida auris <input type="checkbox"/> CR-Acinetobacter <input type="checkbox"/> CR-Enterobacteriaceae <input type="checkbox"/> CR-Pseudomonas <input type="checkbox"/> VISA <input type="checkbox"/> VRSA <input type="checkbox"/> Other					
Hospitalized at time of specimen collection: <input type="checkbox"/> Yes <input type="checkbox"/> No		If Hospitalized, Name of Hospital:		Admission Date / /	Discharge Date / /
If Hospitalized, Admitted from: <input type="checkbox"/> Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other HC Facility <input type="checkbox"/> Other			Facility Name:		
Name of Agency completing form:		Name of Person completing form		Name of Ordering Physician:	
Address:				Address:	
Phone:		Date of Report: / /		Phone:	
LABORATORY INFORMATION					
Date of Specimen Collection	Name or Type of Test	Name of Laboratory		Specimen Source	
Type of culture: <input type="checkbox"/> Clinical <input type="checkbox"/> Surveillance		Organism previously identified in patient <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date / /			
Location of the patient at the time of specimen collection: <input type="checkbox"/> Outpatient office/clinic <input type="checkbox"/> SNF/Nursing home <input type="checkbox"/> ED/Urgent Care <input type="checkbox"/> Other healthcare setting <input type="checkbox"/> Acute Care hospital (inpatient) <input type="checkbox"/> Outpatient laboratory <input type="checkbox"/> Critical Access Hospital (inpatient) <input type="checkbox"/> Home (Home Health) <input type="checkbox"/> Long-term acute care hospital			Name of Facility/Location: County:		
DISPOSITION INFORMATION					
Status: <input type="checkbox"/> Still Hospitalized <input type="checkbox"/> Expired Discharged to: <input type="checkbox"/> Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other HC Facility <input type="checkbox"/> Other Specify Name:			Was the receiving facility notified of the patient's MDRO status: <input type="checkbox"/> Yes <input type="checkbox"/> 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