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

Please Print

EPID 250 –MDRO
7/2024

Record number, KDPH use only:

DEMOGRAPHIC DATA

Patient's Last Name: First: M.I.:	Date of Birth: / /	Age:	Gender ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male ☐ Unknown Additional identity (specify)
City: State: Zip:			County of Residence:
Phone Number:	Ethnic Origin: ☐ His. ☐ Non-His.	Race: ☐W ☐B ☐A/PI ☐Am.Ind. ☐Other	
Any international travel, healthcare, and/or hospitalization within the last 12 months: ☐Yes ☐No If Yes: ☐International Travel ☐International Healthcare ☐International Hospitalization			If yes, which countries:

DISEASE INFORMATION

Organism name:	Date of Positive Lab Result: / /	Patient placed in contact precautions? ☐Yes ☐ No If yes Date:

MDRO type:
☐Candida auris ☐ CR-Acinetobacter ☐CR-Enterobacteriaceae ☐CR-Pseudomonas ☐VISA ☐VRSA ☐Other

Hospitalized at time of specimen collection: ☐Yes ☐ No	If Hospitalized, Name of Hospital:	Admission Date / /	Discharge Date / /
If Hospitalized, Admitted from: ☐Home ☐LTC Facility ☐Other HC Facility ☐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: ☐Clinical ☐Surveillance	Organism previously identified in patient ☐Yes ☐No If Yes, Date / /

Location of the patient at the time of specimen collection:
☐Outpatient office/clinic ☐SNF/Nursing home
☐ED/Urgent Care ☐Other healthcare setting
☐Acute Care hospital (inpatient) ☐Outpatient laboratory
☐Critical Access Hospital (inpatient) ☐Home (Home Health)
☐Long-term acute care hospital

Name of Facility/Location:

County:

DISPOSITION INFORMATION

Status: ☐Still Hospitalized ☐Expired Discharged to: ☐Home ☐LTC Facility ☐Other HC Facility ☐ Other Specify Name:	Was the receiving facility notified of the patient's MDRO status: ☐Yes ☐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