

MRSA Investigation Form

Patient Information

Name of Facility: _____		Community : _____	
Name:			
Surname:		First:	
Address:			
DOB	D:	M:	Y:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		HCP:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Ethnicity: <input type="checkbox"/> Dene <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> Other	
Phone(s):			

Community Associated MRSA

Medical Risk Factor <input type="checkbox"/> Past History of MRSA <input type="checkbox"/> Household contact of a MRSA positive person <input type="checkbox"/> Chronic Disease/Immunosuppressive therapy <input type="checkbox"/> Preexisting injury, wound or break in skin <input type="checkbox"/> Surgery in previous 12 months <input type="checkbox"/> Hospitalization in previous 12 months <input type="checkbox"/> Other _____	If female, pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes	Social Risk Factors <input type="checkbox"/> Alcohol <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Smoker <input type="checkbox"/> Organized sports <input type="checkbox"/> Institutionalized <input type="checkbox"/> History of homelessness <input type="checkbox"/> History of incarceration <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Other _____
	If recent surgery or hospitalization: Hospital: _____ Date: _____ <input type="checkbox"/> In patient <input type="checkbox"/> Out patient	

Current Living Arrangements

Number of people living in house:	Water supply: <input type="checkbox"/> Municipal <input type="checkbox"/> Unregulated/self-supplied <input type="checkbox"/> Trucked in (Frequency: _____ times per week)
Number of rooms in house:	
Ages of people in living in house:	
Employer/School/Daycare:	

Clinical Information

Infection Site: Specify site of Positive Culture:		
Severity of Infection		
Mild <input type="checkbox"/> Infected scratches <input type="checkbox"/> Insect bite/s <input type="checkbox"/> Furuncle/Carbuncle <input type="checkbox"/> Small Abscess (no packing req'd)	Moderate <input type="checkbox"/> Cellulitis <input type="checkbox"/> Moderate abscess(es) <input type="checkbox"/> Infected wounds <input type="checkbox"/> Multiple infected skin sites	Severe <input type="checkbox"/> Extensive cellulitis <input type="checkbox"/> Large or multiple abscesses <input type="checkbox"/> Deep, infected wounds <input type="checkbox"/> Associated systemic features
Onset Date: D: M: Y:	Diagnosis Date: D: M: Y:	Date of Recovery: D: M: Y:
Required hosp. for this episode? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: Facility: _____ Admit Date: D: M: Y: Admitting diagnosis: _____ Duration of hospitalization: _____ (days/weeks)	Transfer Date (if applicable) D: M: Y: <hr/> Discharge Date: D: M: Y:	Did this person die? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was MRSA the: <input type="checkbox"/> Primary cause <input type="checkbox"/> Contributing cause <input type="checkbox"/> Neither

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Treatment - Please see NWT Guidelines for the Prevention and Control of MRSA Transmission (HSS website)

- NO treatment is required since patient is colonized and has no active infection.
 Conservative treatment (for mild infections): Warm compresses and/or incision and drainage

Moderate to severe infections:

- Oral antibiotics:

Name _____ Dose _____ Days _____

- IV/IM antibiotics:

Name _____ Dose _____ Days _____

Interventions

Required:

- Patient teaching

(See Brochures: 'Superbugs in the NWT – Protect Yourself!' and 'Where MRSA Superbugs Live' available at http://www.hthss.gov.nt.ca/english/publications/alphabetical_listing/publications_s_z.asp#S)

As Appropriate:

- Referral to home care
 Home cleaning kit provided
 Referral to social services for increased water
 Referral to social services for laundry facilities
 Other: _____
 None

Other Comments:

Signed:

Date: