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

EPID 250 –MDRO

Record number, KDPH use only:

Please Print

DEMOGRAPHIC DATA

Patient's Last Name: First: M.I.:	Date of Birth: / /	Age:	Gender ☐ M ☐F ☐ Unk	
City: State: Zip:			County of Residence:	
Phone Number:	Patient ID 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: / /		
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: ☐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

Dates of Previous Hospitalizations:

Admit / / Discharge / /		Admit / / Discharge / /	
Admit / / Discharge / /		Admit / / Discharge / /	
Admit / / Discharge / /		Admit / / Discharge / /	

Outbreak Associated:	Outbreak reference number:

Please include copy of laboratory results/Send to Secure Fax 502-398-2462