Infection Surveillance Project

***Missouri Alliance for* HOME CARE**

CVC Active Surveillance *Individual* Patient Tracking Form

Patient Name / ID# _____ SOC _____

Month/Quarter/Year _____

IV Site Oral Gastrointestinal Blood

[ ] Peripheral*

[ ] Central (includes PICC & Port) Specify:

DX: _____ Last ACF/ECF: _____

Primary Nurse: _____ Institution: _____

Device Days:

(Counting days on service with pt. in home and device in place; any portion of day = 1 day)

Date in: _____ to Date (out): _____ # of Days: _____

Date in: _____ to Date (out): _____ # of Days: _____

Date in: _____ to Date (out): _____ # of Days: _____

Total Device Days: _____

Number of infections: _____

Signs & Symptoms Observed Related to Presence of an Infection: (Check box and/or describe)

Date first observed: _____

- □ Elevated WBC
- □ Fever/chills (T 100.4)
- □ Mental Status Changes
- □ IV Site Purulent Drainage
- □ CVC/IV Site Pain
- □ IV Site Erythema
- □ Increased Urine Sediment/Cloudy Urine
- □ Hematuria
- □ Malodorous Urine
- □ Dysuria/Flank Pain
- □ Dyspnea
- □ Erythema
- □ Wound Pain
- □ Purulent Drainage
- □ Increased Amount of Wound Drainage
- □ Cough
- □ Change in Sputum Color
- □ Other: _____

Explanation/Description: _____

Source of suspected infection (if known): _____

Factors associated with development of infection: _____

Has the Physician been notified of above observations? □ Yes □ No

If yes, name of MD who was notified: _____ Phone: _____

Date notified: _____ Time: _____

Orders Received

Lab Orders: _____

Medications Ordered: _____ Date/Time Started: _____

Order to DC central venous catheter due to suspected infection? □ Yes □ No

Other: _____

Results/Findings: **Resolution Date:** _____

Pathogens Identified: _____

*New Diagnosis: □ Yes □ No If yes, state: _____

Follow-up Required/Additional Comments: _____

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*Is the infection communicable and reportable? □ Yes □ No If yes, report to your clinical supervisor within 24 hours.

Reported by: (name) _____ Date: _____ Time: _____