



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



Kentucky Public Health
Prevent. Promote. Protect.

EPID 250 – MDRO
 5/2025

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"/> ED/Urgent Care <input type="checkbox"/> Acute Care hospital (inpatient) <input type="checkbox"/> Critical Access Hospital (inpatient) <input type="checkbox"/> Long-term acute care hospital	Name of Facility/Location: <input type="checkbox"/> SNF/Nursing home <input type="checkbox"/> Other healthcare setting <input type="checkbox"/> Outpatient laboratory <input type="checkbox"/> Home (Home Health) 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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Date of Previous Hospitalizations	
Admit / / Discharge / /	Admit / / Discharge / /
Admit / / Discharge / /	Admit / / Discharge / /
Admit / / Discharge / /	Admit / / Discharge / /
Outbreak Associated: <input type="checkbox"/> Yes <input type="checkbox"/> No	Outbreak reference number:

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