

1. General Information		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Age:	*Clinic Visit Date (Month/Day/Year):														
*Country of Birth:		Country of Current Citizenship:		*Country of Current Residence:														
Is the patient a: (if applicable) <input type="checkbox"/> Migrant <input type="checkbox"/> Expatriate/Long-term visitor		If Expatriate/Long-term visitor, indicate reason for living in country: <input type="checkbox"/> Business/Occupational <input type="checkbox"/> Seasonal or Temporary Work <input type="checkbox"/> Student <input type="checkbox"/> Retirement/Leisure <input type="checkbox"/> Missionary/Humanitarian/Volunteer/Community Service <input type="checkbox"/> Other/Unknown																
If not born in country of current residence, indicate as closely as possible the date of first arrival (Month/Day/Year):																		
2. History of Recent Travel (for non-migration travel)		List in order, starting with the most recent trip, all international travel in the past 12 months. Enter separate records for each country visited during the trip if dates for each country are known. Indicate if the trip included travel on a Ship. Enter Migration Route in section 6 if applicable.																
*Trip Start Date Month/Day/Year	*Trip End Date Month/Day/Year	*Country	Ship	*Trip Start Date Month/Day/Year														
				*Trip End Date Month/Day/Year														
				*Country														
				Ship														
1.			<input type="checkbox"/>	4.			<input type="checkbox"/>											
2.			<input type="checkbox"/>	5.			<input type="checkbox"/>											
3.			<input type="checkbox"/>	6.			<input type="checkbox"/>											
3. History of Relevant Previous Travel (for non-migration travel)		List all countries visited or resided in during the past 5 years or earlier if relevant (exclude those in past 12 months listed above). List each country only once. CIRCLE all years of travel to that country.																
*Country:	1.	2.		3.														
*Years (20XX)	19	18	17	16	15	14+	19	18	17	16	15	14+	19	18	17	16	15	14+
4. Clinical Presentation		*Traveler seen (Check One): <input type="checkbox"/> During Travel <input type="checkbox"/> After Travel																
*Highest level of care at any time required for this illness? (Check One): <input type="checkbox"/> Outpatient <input type="checkbox"/> Inpatient ward <input type="checkbox"/> Inpatient ICU		If hospitalized, indicate if During Travel and/or After Return: <input type="checkbox"/> During Travel <input type="checkbox"/> After Return <input type="checkbox"/> Required Medical Evacuation																
*Did the patient receive pre-travel information? (Check One): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Not Applicable If YES, select the MAIN SOURCE of information: <input type="checkbox"/> Internet <input type="checkbox"/> Travel medicine specialist <input type="checkbox"/> General Practitioner <input type="checkbox"/> Relative/friend <input type="checkbox"/> Travel Agency <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____																		
Primary Reason for Travel Related to this visit: (Check One - Optional)																		
<input type="checkbox"/> Tourism (Vacation)		<input type="checkbox"/> Visiting ANY Family and Friends (Non-traditional VFR)																
<input type="checkbox"/> Business/Occupational		<input type="checkbox"/> Visiting Friends or Relatives (traditional VFR definition)																
<input type="checkbox"/> Conference <input type="checkbox"/> Corporate/Professional <input type="checkbox"/> Research <input type="checkbox"/> Other		<input type="checkbox"/> Missionary/Humanitarian/Volunteer/Community Service																
<input type="checkbox"/> Seasonal or Temporary Work (Migrant worker)		<input type="checkbox"/> Retirement																
<input type="checkbox"/> Student		<input type="checkbox"/> Military																
<input type="checkbox"/> Migration		<input type="checkbox"/> Planned Medical Care																
<input type="checkbox"/> Providing Medical Care		<input type="checkbox"/> Not Ascertainable																
*Main Presenting Symptoms or Reason for Referral (Check at least one symptom or reason below, but include all that apply):																		
Gastrointestinal	<input type="checkbox"/> Abdominal pain/discomfort <input type="checkbox"/> Acute diarrhea <input type="checkbox"/> Anal pruritus <input type="checkbox"/> Anorexia <input type="checkbox"/> Bloating <input type="checkbox"/> Bloody diarrhea (dysentery) <input type="checkbox"/> Chronic diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Jaundice <input type="checkbox"/> Nausea <input type="checkbox"/> Passed worm <input type="checkbox"/> Vomiting <input type="checkbox"/> Weight loss <input type="checkbox"/> Other																	
Genitourinary	<input type="checkbox"/> Discharge <input type="checkbox"/> Dysuria <input type="checkbox"/> Frequency <input type="checkbox"/> Flank pain <input type="checkbox"/> Genital lesion <input type="checkbox"/> Hematuria <input type="checkbox"/> Other																	
Lymphatic	<input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Lymphangitis <input type="checkbox"/> Lymphedema <input type="checkbox"/> Other																	
Musculoskeletal	<input type="checkbox"/> Arthralgia <input type="checkbox"/> Arthritis <input type="checkbox"/> Myalgia <input type="checkbox"/> Focal musculoskeletal pain <input type="checkbox"/> Other																	
Neurologic	<input type="checkbox"/> Confusion <input type="checkbox"/> Dizziness <input type="checkbox"/> Focal symptoms <input type="checkbox"/> Headache <input type="checkbox"/> LOC/syncope <input type="checkbox"/> Neck stiffness/photophobia <input type="checkbox"/> Seizure <input type="checkbox"/> Other																	
Respiratory	<input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Pleuritic chest pain <input type="checkbox"/> SOB <input type="checkbox"/> URI symptoms (runny nose/sore throat) <input type="checkbox"/> Wheeze <input type="checkbox"/> Other																	
Skin	<input type="checkbox"/> Diffuse rash <input type="checkbox"/> Focal rash <input type="checkbox"/> Itch <input type="checkbox"/> Skin lesion or nodule <input type="checkbox"/> Skin infection (superficial or deep) <input type="checkbox"/> Other																	
HEENT	<input type="checkbox"/> Ear symptoms <input type="checkbox"/> Eye symptoms <input type="checkbox"/> Nasal symptoms <input type="checkbox"/> Throat symptoms <input type="checkbox"/> Mouth or dental symptoms <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Other																	
Abnormal Lab Test	<input type="checkbox"/> Eosinophilia <input type="checkbox"/> Positive serology <input type="checkbox"/> Other abnormal blood test <input type="checkbox"/> Abnormal radiologic finding <input type="checkbox"/> Positive stool test <input type="checkbox"/> Other																	
<input type="checkbox"/> Cardiac Symptoms	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever/Sweats/Chills	<input type="checkbox"/> Bite/Scratch/Sting															
<input type="checkbox"/> Psychological Symptoms	<input type="checkbox"/> Thrombosis	<input type="checkbox"/> Trauma/Injury	<input type="checkbox"/> Screening															
<input type="checkbox"/> Other If 'Other', Specify:																		
*Date of Illness Onset (Use 1 of the 3 options)	(1) _____ (MM/DD/YYYY) (2) Number (1-30) _____ of (circle one) days/weeks/months/years before presentation (3) <input type="checkbox"/> Unknown/NA																	
Activities linked to Special Projects (Check all that apply)	<input type="checkbox"/> None/Not Applicable <input type="checkbox"/> Unplanned medical or dental care <input type="checkbox"/> Antibiotic taken during travel																	

* = These items are required fields for successful online data entry. Note: Sections 2 & 3 may be omitted if not applicable.

5. *Pre-Existing Immunocompromising Conditions – those present prior to onset of the current travel-related illness: (check all that apply)

<input type="checkbox"/> None Known to Exist	<input type="checkbox"/> Pregnancy (any trimester)	<input type="checkbox"/> Diabetes Mellitus
<input type="checkbox"/> HIV Infection <i>If checked, select:</i> <input type="checkbox"/> CD4 < 200 <input type="checkbox"/> CD4 200-500 <input type="checkbox"/> CD4 > 500 <input type="checkbox"/> CD4 Unknown <i>Patient on antiretroviral therapy?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<input type="checkbox"/> Malignancy under active chemo- or radio-therapy (within 3 months) or advanced incurable malignancy <input type="checkbox"/> Solid malignancy <input type="checkbox"/> Hematological malignancy		
<input type="checkbox"/> Transplant at any time → <i>If checked, select type:</i>		
<input type="checkbox"/> Bone marrow transplant <input type="checkbox"/> Solid organ transplant	<input type="checkbox"/> Immunosuppressing/Immunomodulating Agents (within 3 months)	
<input type="checkbox"/> Other Immunocompromising Condition <i>Specify:</i> _____		

-----SECTIONS 6 and 7 are for MIGRANTS ONLY-----

6. Migration Route (within the last 5 years or relevant to recorded diagnosis) Migration route details UNKNOWN (if unknown, skip to section 7)
List in order, starting with the country of birth, all countries along the migration route. Use one line for each country.

*Country	*Arrival Year	*Departure Year
1.**Country of Birth:	N/A	
2.		
3.		
4.		
5.** Country of Current Residence:		N/A

7. Migrant Details *Is the person's preferred language the same as that spoken in the country of the GeoSentinel site?
 Yes No Unknown

*Status of migration (Check one): In transit Reached final destination country Unknown

Check if applicable: Unaccompanied minor Spent time in refugee camp Received organized pre-departure treatment or screening

*Status of the individual (Check One): Asylum seeker Refugee/asylee (accepted post arrival) Resettled refugee (accepted pre-arrival)
 Documented immigrant (permission to stay) Undocumented immigrant (no permission to stay)
 Unknown Not Asked

*Visit today is for (Check One): Protocol based health assessment for newly arrived migrant Primary care visit Specialty care referral arising from screening Acute Illness/Other situation or problem unrelated to screening (specify) _____

8. *Diagnoses

1) *Final Diagnosis: _____ Other info (species, organism, etc.): _____

*Status: Confirmed Probable *Activity: Active Resolved Ascertained by Screening

*Relation of diagnosis to travel:
 Travel Related Not Travel Related Imported Infection acquired in country of residence prior to travel Not Ascertainable

*Country of Exposure/Other (Enter the country of exposure or check the applicable box)
Country of Exposure: _____ Exposure Country Not Ascertainable Ship Plane Not Applicable (Migrants only)
More Specific Place of Exposure: (below country level – state, city, place, event) _____
If Country of Exposure is 'Not Ascertainable', 'Ship', or 'Plane', enter Region of Exposure: _____
 Exposure Region Not Ascertainable

*Primary Reason for Travel Related to this Diagnosis: (Check One)

<input type="checkbox"/> Tourism (Vacation) <input type="checkbox"/> Business/Occupational <input type="checkbox"/> Conference <input type="checkbox"/> Corporate/Professional <input type="checkbox"/> Research <input type="checkbox"/> Other <input type="checkbox"/> Seasonal or Temporary Work (Migrant worker) <input type="checkbox"/> Student <input type="checkbox"/> Migration <input type="checkbox"/> Providing Medical Care	<input type="checkbox"/> Visiting ANY Family and Friends (Non-traditional VFR) <input type="checkbox"/> Visiting Friends or Relatives (traditional VFR definition) <input type="checkbox"/> Missionary/Humanitarian/Volunteer/Community Service <input type="checkbox"/> Retirement <input type="checkbox"/> Military <input type="checkbox"/> Planned Medical Care <input type="checkbox"/> Not Ascertainable
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Relationship to specified Reason for Travel:
 Patient is traveling for the reason indicated Patient is the child/grandchild/parent Patient is the spouse/partner

*Diagnosis Method (Check all that apply)

<input type="checkbox"/> Microscopy <input type="checkbox"/> Culture <input type="checkbox"/> Antigen test <input type="checkbox"/> Nucleic acid amplification test (e.g. PCR, LAMP, RT-PCR)	<input type="checkbox"/> Paired serology: seroconversion/≥4-fold rise in titre Positive serology from single blood draw: <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Both IgM and IgG <input type="checkbox"/> Clinical	<input type="checkbox"/> Radiology <input type="checkbox"/> Histopathology <input type="checkbox"/> Typical exposure history <input type="checkbox"/> Laboratory macroscopic identification <input type="checkbox"/> Other <i>Specify:</i> _____
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Urinalysis
 IGRA
 PPD/TST/Mantoux

2)	*Final Diagnosis:			Other info (species, organism, etc.):			
*Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable		*Activity: <input type="checkbox"/> Active <input type="checkbox"/> Resolved		<input type="checkbox"/> Ascertained by Screening			
*Relation of diagnosis to travel: <input type="checkbox"/> Travel Related <input type="checkbox"/> Not Travel Related <input type="checkbox"/> Imported Infection acquired in country of residence prior to travel <input type="checkbox"/> Not Ascertainable							
*Country of Exposure/Other (Enter the country of exposure or check the applicable box) Country of Exposure: _____ <input type="checkbox"/> Exposure Country Not Ascertainable <input type="checkbox"/> Ship <input type="checkbox"/> Plane <input type="checkbox"/> Not Applicable (Migrants only) More Specific Place of Exposure: (below country level – state, city, place, event) _____ If Country of Exposure is 'Not Ascertainable', 'Ship', or 'Plane', enter Region of Exposure: _____ <input type="checkbox"/> Exposure Region Not Ascertainable							
*Primary Reason for Travel Related to this Diagnosis: (Check One)							
<input type="checkbox"/> Tourism (Vacation) <input type="checkbox"/> Business/Occupational <input type="checkbox"/> Conference <input type="checkbox"/> Corporate/Professional <input type="checkbox"/> Research <input type="checkbox"/> Other <input type="checkbox"/> Seasonal or Temporary Work (Migrant worker) <input type="checkbox"/> Student <input type="checkbox"/> Migration <input type="checkbox"/> Providing Medical Care		<input type="checkbox"/> Visiting ANY Family and Friends (Non-traditional VFR) <input type="checkbox"/> Visiting Friends or Relatives (traditional VFR definition) <input type="checkbox"/> Missionary/Humanitarian/Volunteer/Community Service <input type="checkbox"/> Retirement <input type="checkbox"/> Military <input type="checkbox"/> Planned Medical Care <input type="checkbox"/> Not Ascertainable					
Relationship to specified Reason for Travel: <input type="checkbox"/> Patient is traveling for the reason indicated <input type="checkbox"/> Patient is the child/grandchild/parent <input type="checkbox"/> Patient is the spouse/partner							
*Diagnosis Method (Check all that apply)							
<input type="checkbox"/> Microscopy <input type="checkbox"/> Culture <input type="checkbox"/> Antigen test <input type="checkbox"/> Nucleic acid amplification test (e.g. PCR, LAMP, RT-PCR)		<input type="checkbox"/> Paired serology: seroconversion/≥4-fold rise in titre Positive serology from single blood draw: <input type="checkbox"/> IgM <input type="checkbox"/> IgG <input type="checkbox"/> Both IgM and IgG <input type="checkbox"/> Clinical		<input type="checkbox"/> Radiology <input type="checkbox"/> Histopathology <input type="checkbox"/> Typical exposure history <input type="checkbox"/> Laboratory macroscopic identification <input type="checkbox"/> Other Specify: _____		<input type="checkbox"/> Urinalysis <input type="checkbox"/> IGRA <input type="checkbox"/> PPD/TST/Mantoux	
Additional Questions for Malaria Diagnoses:							
Did the patient receive a malaria prophylaxis prescription/medication for the trip? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know							
If yes, what agent? <input type="checkbox"/> Atovaquone-Proguanil (Malarone) <input type="checkbox"/> Doxycycline <input type="checkbox"/> Mefloquine <input type="checkbox"/> Primaquine <input type="checkbox"/> Tafenoquine <input type="checkbox"/> Other <input type="checkbox"/> Don't know							
How often did the patient take their malaria prophylaxis? <input type="checkbox"/> Always, exactly as directed (100% of doses) <input type="checkbox"/> Usually (>=75-99%) <input type="checkbox"/> Sometimes (50-74%) <input type="checkbox"/> Infrequently (<50%) <input type="checkbox"/> Never <input type="checkbox"/> Don't know							
If the patient was not fully compliant with their prophylaxis, why? <input type="checkbox"/> Forgot <input type="checkbox"/> Concerns about side effects <input type="checkbox"/> Used other preventive measures <input type="checkbox"/> No/minimal perceived risk <input type="checkbox"/> Other <input type="checkbox"/> Don't know							
We are interested in collecting antibiotic resistance information on a limited number of bacteria. If there is a CULTURE diagnosis of any of the nine following bacteria, then complete the antibiotic resistance information on next page: *Salmonella species *Salmonella Typhi *Salmonella Paratyphi *Campylobacter species *Shigella species *Staphylococcus aureus *E. coli *Klebsiella pneumoniae *Streptococcus pneumoniae							
*Antibiotic Resistance Enter antibiotic sensitivity information for the one organism considered most clinically important where diagnosis method is CULTURE S=Sensitive, I/R=Intermediate/Resistant, Unk=Unknown/Not Done/Not Reported (Check 'I/R' if results include I-Intermediate or R-Resistant for ANY drug in the category) <input type="checkbox"/> Sensitivity Testing Not Done							
The following diagnosis codes apply to all 9 bacteria: • 108 – BACTEREMIA • 699 – SEPSIS • 259 – ABSCESS, PYOGENIC (NOT SKIN, NOT TONSILLAR, NOT LIVER, NOT LUNG) • 739 – ABSCESS, PYOGENIC LIVER							
192 – SALMONELLA SPECIES Specimen Type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Other <input type="checkbox"/> Unknown				193 – SALMONELLA TYPHI or 632 – SALMONELLA PARATYPHI Organism: <input type="checkbox"/> Salmonella Typhi <input type="checkbox"/> Salmonella Paratyphi Specimen Type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood/Bone Marrow <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Salmonella species				Salmonella Typhi or Salmonella Paratyphi			
<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>	<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Generation Cephalosporin (e.g. Cefixime, Cefotaxime, Ceftriaxone, Ceftazidime)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Generation Cephalosporin (e.g. Cefixime, Cefotaxime, Ceftriaxone, Ceftazidime)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroquinolone (e.g. Ciprofloxacin, Norfloxacin, Ofloxacin, Levofloxacin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroquinolone (e.g. Ciprofloxacin, Norfloxacin, Ofloxacin, Levofloxacin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macrolide (e.g. Azithromycin, Erythromycin, Clarithromycin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macrolide (e.g. Azithromycin, Erythromycin, Clarithromycin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carbapenem (e.g. Imipenem, Meropenem, Ertapenem)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carbapenem (e.g. Imipenem, Meropenem, Ertapenem)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amoxicillin, Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amoxicillin, Ampicillin
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chloramphenicol

115 – CAMPYLOBACTER SPECIES Specimen Type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Other <input type="checkbox"/> Unknown				200 – SHIGELLA SPECIES Specimen Type: <input type="checkbox"/> Stool <input type="checkbox"/> Blood <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
<i>Campylobacter</i> species				<i>Shigella</i> species			
<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>	<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroquinolone (e.g. Ciprofloxacin, Norfloxacin, Ofloxacin, Levofloxacin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Generation Cephalosporin (e.g. Cefixime, Cefotaxime, Ceftriaxone, Ceftazidime)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macrolide (e.g. Azithromycin, Erythromycin, Clarithromycin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroquinolone (e.g. Ciprofloxacin, Norfloxacin, Ofloxacin, Levofloxacin)
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Macrolide (e.g. Azithromycin, Erythromycin, Clarithromycin)
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amoxicillin, Ampicillin

Resistance for **E.COLI** or **KLEBSIELLA PNEUMONIAE** – below are listed diagnosis codes for which culture of one of these organisms is most likely
144 – PNEUMONIA (BACTERIAL OR VIRAL), OTHER SPECIFIC ETIOLOGY; **215** – URINARY TRACT INF, ACUTE; **255** – PYELONEPHRITIS;
585 – ANTIBIOTIC RESISTANT ORGANISM; **791** – E. COLI, SHIGA TOXIN PRODUCING (aka Enterohemorrhagic E. COLI, EHEC/Verocytotoxin-producing E. coli, VTEC) includes E. coli 0157:H7; **807** – E. COLI: ENTEROTOXIGENIC (ETEC); **838** – E. COLI: ENTEROAGGREGATIVE (EAEC); ENTEROPATHOGENIC (EPEC) or ENTEROINVASIVE (EIEC)

Organism: *E. coli* *Klebsiella pneumoniae*
 Specimen Type: Urine Blood Sputum Stool Other Unknown

<i>E. coli</i>				<i>Klebsiella pneumoniae</i>			
<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>	<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Generation Cephalosporin (e.g. Cefixime, Cefotaxime, Ceftriaxone, Ceftazidime)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Generation Cephalosporin (e.g. Cefixime, Cefotaxime, Ceftriaxone, Ceftazidime)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroquinolone (e.g. Ciprofloxacin, Norfloxacin, Ofloxacin, Levofloxacin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Fluoroquinolone (e.g. Ciprofloxacin, Norfloxacin, Ofloxacin, Levofloxacin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carbapenem (e.g. Imipenem, Meropenem, Ertapenem)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Carbapenem (e.g. Imipenem, Meropenem, Ertapenem)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polymyxins (e.g. Colistin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polymyxins (e.g. Colistin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amoxicillin, Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4th Generation Cephalosporin (e.g. Cefipime)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4th Generation Cephalosporin (e.g. Cefipime)				

Resistance for **STAPHYLOCOCCUS AUREUS** – below are listed diagnosis codes for which culture of one of these organisms is most likely (Note: Do NOT enter information for other Staph species e.g. Staph epidermidis/coagulase negative staphylococcus)
142 – SKIN AND SOFT TISSUE INFECTION: ERYSIPELAS, CELLULITIS, GANGRENE; **144** – PNEUMONIA (BACTERIAL OR VIRAL), OTHER SPECIFIC ETIOLOGY; **413** – SKIN AND SOFT TISSUE INFECTION (SKIN ABSCESS or SECONDARY BACTERIAL INFECTION OF EXISTING LESION); **537** – ENDOCARDITIS; **585** – ANTIBIOTIC RESISTANT ORGANISM; **785** – SKIN AND SOFT TISSUE INFECTION, SUPERFICIAL: IMPETIGO, FOLLICULITIS, FURUNCLE, CARBUNCLE, PARONYCHIA, ECTHYMA

Specimen Type: Swab Blood Sputum Other Unknown

<i>Staphylococcus aureus</i>			
<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Flucloxacillin, Oxacillin, Nafcillin, or other (MRSA-Methicillin-resistant Staphylococcus aureus)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lincosamide (e.g. Clindamycin, Lincomycin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Glycopeptide (e.g. Vancomycin, Teicoplanin)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tetracyclines (e.g. Doxycycline)

Resistance for **STREPTOCOCCUS PNEUMONIAE** – below are listed diagnosis codes for which culture of one of these organisms is most likely
144 – PNEUMONIA (BACTERIAL OR VIRAL), OTHER SPECIFIC ETIOLOGY; **537** – ENDOCARDITIS; **585** – ANTIBIOTIC RESISTANT ORGANISM; **650** – MENINGITIS, PNEUMOCOCCAL

Specimen Type: Sputum Blood CSF Other Unknown

<i>Streptococcus pneumoniae</i>			
<u>S</u>	<u>I/R</u>	<u>Unk</u>	<u>Drug (Category)</u>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3rd Generation Cephalosporin (e.g. Cefixime, Cefotaxime, Ceftriaxone, Ceftazidime)
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cotrimoxazole (trimethoprim-sulfamethoxazole)