

Hospital outcome			
Hospital code (country code – __ __ – __ __ __ hospital ID)			
ACORN ID __ __ __ __ __ __ __ __ __ __			
Date of admission __ __ – __ __ __ – __ __ __ __			
Final surveillance categorisation			
Number of infection episodes __ __		(Enter the number of ACORN infection episodes (F02) during this admission – maximum of 5)	
Infection episode #1			
Infection episode enrolment date __ __ – __ __ __ – __ __ __ __			
Final infection episode diagnosis	<input type="checkbox"/> Central nervous system <input type="checkbox"/> ENT / Upper respiratory tract <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Skin / Soft tissue <input type="checkbox"/> Urinary tract <input type="checkbox"/> Melioidosis <input type="checkbox"/> Other (diagnosis documented) <input type="checkbox"/> Unknown (not documented)	<input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Lower respiratory tract <input type="checkbox"/> Intra-abdominal <input type="checkbox"/> Bone / Joint <input type="checkbox"/> Genital <input type="checkbox"/> Typhoid <input type="checkbox"/> Undefined (infection treated but no site / source of identified) <input type="checkbox"/> Infection rejected (alternative diagnosis made)	<input type="checkbox"/> Eye <input type="checkbox"/> Pneumonia <input type="checkbox"/> Necrotising enterocolitis <input type="checkbox"/> Surgical site <input type="checkbox"/> Febrile neutropenia
Infection episode #2			
Infection episode enrolment date __ __ – __ __ __ – __ __ __ __			
Final infection episode diagnosis	<input type="checkbox"/> Central nervous system <input type="checkbox"/> ENT / Upper respiratory tract <input type="checkbox"/> Gastrointestinal <input type="checkbox"/> Skin / Soft tissue <input type="checkbox"/> Urinary tract <input type="checkbox"/> Melioidosis <input type="checkbox"/> Other (diagnosis documented) <input type="checkbox"/> Unknown (not documented)	<input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Lower respiratory tract <input type="checkbox"/> Intra-abdominal <input type="checkbox"/> Bone / Joint <input type="checkbox"/> Genital <input type="checkbox"/> Typhoid <input type="checkbox"/> Undefined (infection treated but no site / source of identified) <input type="checkbox"/> Infection rejected (alternative diagnosis made)	<input type="checkbox"/> Eye <input type="checkbox"/> Pneumonia <input type="checkbox"/> Necrotising enterocolitis <input type="checkbox"/> Surgical site <input type="checkbox"/> Febrile neutropenia
Infection episode #3			
Infection episode enrolment date __ __ – __ __ __ – __ __ __ __			
Final infection episode diagnosis	<input type="checkbox"/> Central nervous system <input type="checkbox"/> ENT / Upper respiratory tract	<input type="checkbox"/> Cardiovascular system <input type="checkbox"/> Lower respiratory tract	<input type="checkbox"/> Eye <input type="checkbox"/> Pneumonia

Patient Case Record Form F03 – Discharge

ACORN ID: _____

- | | | |
|---|---|--|
| <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Intra-abdominal | <input type="checkbox"/> Necrotising enterocolitis |
| <input type="checkbox"/> Skin / Soft tissue | <input type="checkbox"/> Bone / Joint | <input type="checkbox"/> Surgical site |
| <input type="checkbox"/> Urinary tract | <input type="checkbox"/> Genital | <input type="checkbox"/> Febrile neutropenia |
| <input type="checkbox"/> Melioidosis | <input type="checkbox"/> Typhoid | |
| <input type="checkbox"/> Other (diagnosis documented) | <input type="checkbox"/> Undefined (infection treated but no site / source of identified) | |
| <input type="checkbox"/> Unknown (not documented) | <input type="checkbox"/> Infection rejected (alternative diagnosis made) | |

Infection episode #4

Infection episode enrolment date (dd-mmm-yyyy)

|_|_|_|-|_|_|_|-|_|_|_|_|_|

- | | | | |
|-----------------------------------|--|---|--|
| Final infection episode diagnosis | <input type="checkbox"/> Central nervous system | <input type="checkbox"/> Cardiovascular system | <input type="checkbox"/> Eye |
| | <input type="checkbox"/> ENT / Upper respiratory tract | <input type="checkbox"/> Lower respiratory tract | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Intra-abdominal | <input type="checkbox"/> Necrotising enterocolitis |
| | <input type="checkbox"/> Skin / Soft tissue | <input type="checkbox"/> Bone / Joint | <input type="checkbox"/> Surgical site |
| | <input type="checkbox"/> Urinary tract | <input type="checkbox"/> Genital | <input type="checkbox"/> Febrile neutropenia |
| | <input type="checkbox"/> Melioidosis | <input type="checkbox"/> Typhoid | |
| | <input type="checkbox"/> Other (diagnosis documented) | <input type="checkbox"/> Undefined (infection treated but no site / source of identified) | |
| | <input type="checkbox"/> Unknown (not documented) | <input type="checkbox"/> Infection rejected (alternative diagnosis made) | |

Infection episode #5

Infection episode enrolment date (dd-mmm-yyyy)

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- | | | | |
|-----------------------------------|--|---|--|
| Final infection episode diagnosis | <input type="checkbox"/> Central nervous system | <input type="checkbox"/> Cardiovascular system | <input type="checkbox"/> Eye |
| | <input type="checkbox"/> ENT / Upper respiratory tract | <input type="checkbox"/> Lower respiratory tract | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Gastrointestinal | <input type="checkbox"/> Intra-abdominal | <input type="checkbox"/> Necrotising enterocolitis |
| | <input type="checkbox"/> Skin / Soft tissue | <input type="checkbox"/> Bone / Joint | <input type="checkbox"/> Surgical site |
| | <input type="checkbox"/> Urinary tract | <input type="checkbox"/> Genital | <input type="checkbox"/> Febrile neutropenia |
| | <input type="checkbox"/> Melioidosis | <input type="checkbox"/> Typhoid | |
| | <input type="checkbox"/> Other (diagnosis documented) | <input type="checkbox"/> Undefined (infection treated but no site / source of identified) | |
| | <input type="checkbox"/> Unknown (not documented) | <input type="checkbox"/> Infection rejected (alternative diagnosis made) | |

Discharge details

- | | | |
|------------------|--|--|
| Discharge status | <input type="checkbox"/> Alive | <input type="checkbox"/> Dead |
| | <input type="checkbox"/> Left against medical advice | <input type="checkbox"/> Moribund: discharged to die at home |
| Discharge to | <input type="checkbox"/> Home | <input type="checkbox"/> Long-term care facility <input type="checkbox"/> Other hospital |
| | <input type="checkbox"/> Unknown | <input type="checkbox"/> NA (if death) |

Patient Case Record Form F03 – Discharge

ACORN ID: _____

Date of discharge (dd-mmm-yyyy)	_ _ _ - _ _ _ _ - _ _ _ _ _ _
Total number of days on ICU during admission	_ _ _ _

Completed by: _____

Completion date: _____