



**Pitt BSI score**

**Patient observations on the date of collection for the positive blood culture (or up to 48 hours before if not available):**

Temperature (°C) [most extreme value]	_ _ _ .  _ _	<input type="checkbox"/> Unknown	
Respiratory rate (/min) [highest value]	_ _ _ _	<input type="checkbox"/> Unknown	
Heart rate (/min) [highest value]	_ _ _ _	<input type="checkbox"/> Unknown	
Systolic BP (mmHg) [lowest value]	_ _ _ _	<input type="checkbox"/> Unknown	
Mental status [lowest value]	<input type="checkbox"/> Alert	<input type="checkbox"/> Disoriented	
	<input type="checkbox"/> Stuporous	<input type="checkbox"/> Comatose	<input type="checkbox"/> Unknown
Acute hypotensive event (drop in systolic BP >30mmHg and diastolic BP >20mmHg)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

**In the 48 hours leading up to the date of collection for the positive blood culture, did any of the following occur:**

Intravenous vasopressor agents required	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Mechanical ventilation needed	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Cardiac arrest	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

**Antibiotic treatment details – include both empiric and targeted treatment**

Drug name	Start date (dd-mmm-yyyy)	End date (dd-mmm-yyyy)	Route (oral / intravenous / other)

**BSI details**

Was BSI primary or secondary	<input type="checkbox"/> Primary (unknown origin / central line)	<input type="checkbox"/> Secondary (defined infection focus)	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Skin / Soft tissue	<input type="checkbox"/> Pulmonary	<input type="checkbox"/> Digestive tract
If secondary, what was the likely source	<input type="checkbox"/> Urinary tract	<input type="checkbox"/> Surgical site	<input type="checkbox"/> Unknown
	<input type="checkbox"/> Other, please specify _____		

If *S. aureus*, was it a complicated BSI?

Presence of implanted prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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## Patient Case Record Form F05 – BSI episode

ACORN ID: \_\_\_\_\_

Duration of BSI >2 days  Yes

No

Unknown

BSI-related fever >3 days  Yes

No

Unknown

Completed by: \_\_\_\_\_

Completion date: \_\_\_\_\_