Maryland Department of Health and Mental Hygiene

CRE CASE REPORT FORM

Patient Name: ____________________ ______________________ **DOB:** ____ / ____/ ______
Last First

Sex: M F Unknown **Patient Address:** ____

Patient Medical Record # _____________________________________ **Admission Date** ___ / ___/ ____
(if patient admitted to a hospital)

Processing Laboratory ____

Requesting Facility (if applicable) ____

Requesting Physician (if applicable) ____

Specimen Collection Date: ___________________

Specimen Source: ___________________________

If urine culture, colony count: ☐ **<10,000** ☐ **10,000 – 49,999** ☐ **50,000 – 100,000** ☐ **>100,000**

Species isolated

☐ ***Escherichia coli*** ☐ ***Klebsiella pneumoniae*** ☐ **Other *Klebsiella spp* (specify)**____________________

☐ ***Enterobacter spp* (specify)** __________________________________

☐ **Other (specify)** ____

ATI/Kirby Bauer Susceptibilities

	MIC	Interpretation
Doripenem	____	____
Ertapenem	____	____
Imipenem	____	____
Meropenem	____	____
Cefotaxime	____	____
Ceftriaxone	____	____
Ceftazidime	____	____

Confirmatory Testing Results

Test Type	Performed?	Result (circle)
Modified Hodge	☐	+ --
PCR	☐	+ --
Other _____________ (specify)	☐	+ --