Texas Tech University Health Sciences Center El Paso

Post-Op/Hospital Discharge/Post-Clinic Procedure Healthcare Associated Infection Communication Form

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>(Patient Name)</th>
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<tbody>
<tr>
<td>On:</td>
<td>(Date)</td>
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Developed:
- [ ] Post-op/procedure wound infection: ____________________________
- [ ] Endometritis: ____________________________
- [ ] Other: ____________________________

Culture(s): ________________________________________________________

Treatment: ________________________________________________________

Was patient re-admitted? [ ] Yes [ ] No

If yes, date: ________________________________________________________

Patient Medical Record Number: ____________________________

Physician’s Name: ____________________________

Does infection meet CDC Definitions for Healthcare Associated Infections? [ ] Yes [ ] No

If yes, list the criteria met: 1.

Comment:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

(Signature of Person Reporting Infection) ____________________________ (Date) ____________________________

Thank you for providing this information to Infection Control. All information will remain confidential and is only used to track sources of and calculate infection rates.

Should you have any questions, please call your Infection Control Nurse or designee.

The above Healthcare Associated Infection has been reported to:

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

(Signature of Person Reporting Infection) ____________________________ (Date) ____________________________

*Note: More information regarding Healthcare-Associated Infections is available at www.cdc.gov/hai/