



**Kentucky Reportable MDRO Form**  
**Department for Public Health**  
**Division of Epidemiology and Health Planning**  
**275 East Main St., Mailstop HS2E-B**  
**Frankfort, KY 40621-0001**



**Kentucky Public Health**  
Prevent. Promote. Protect.

EPID 250 – MDRO  
 5/2025

Please Print

Record number, KDPH use only:

DEMOGRAPHIC DATA			
Patient's Last Name:		First:	M.I.:
Date of Birth: / /		Age:	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Unknown Additional identity (specify)			
City:		State:	Zip:
County of Residence:			
Phone Number:		Ethnic Origin:	Race:
		<input type="checkbox"/> His. <input type="checkbox"/> Non-His.	<input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am.Ind. <input type="checkbox"/> Other
Any international travel, healthcare, and/or hospitalization within the last 12 months: <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, which countries:
If Yes: <input type="checkbox"/> International Travel <input type="checkbox"/> International Healthcare <input type="checkbox"/> International Hospitalization			
DISEASE INFORMATION			
Organism name:		Date of Positive Lab Result: / /	Patient placed in contact precautions? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes Date:
MDRO type: <input type="checkbox"/> Candida auris <input type="checkbox"/> CR-Acinetobacter <input type="checkbox"/> CR-Enterobacteriaceae <input type="checkbox"/> CR-Pseudomonas <input type="checkbox"/> VISA <input type="checkbox"/> VRSA <input type="checkbox"/> Other			
Hospitalized at time of specimen collection: <input type="checkbox"/> Yes <input type="checkbox"/> No	If Hospitalized, Name of Hospital:		Admission Date / /
		Discharge Date / /	
If Hospitalized, Admitted from: <input type="checkbox"/> Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other HC Facility <input type="checkbox"/> Other		Facility Name:	
Name of Agency completing form:		Name of Person completing form	Name of Ordering Physician:
Address:		Address:	
Phone:		Date of Report: / /	Phone:
LABORATORY INFORMATION			
Date of Specimen Collection	Name or Type of Test	Name of Laboratory	Specimen Source
Type of culture: <input type="checkbox"/> Clinical <input type="checkbox"/> Surveillance	Organism previously identified in patient <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Date / /		
Location of the patient at the time of specimen collection: <input type="checkbox"/> Outpatient office/clinic <input type="checkbox"/> SNF/Nursing home <input type="checkbox"/> ED/Urgent Care <input type="checkbox"/> Other healthcare setting <input type="checkbox"/> Acute Care hospital (inpatient) <input type="checkbox"/> Outpatient laboratory <input type="checkbox"/> Critical Access Hospital (inpatient) <input type="checkbox"/> Home (Home Health) <input type="checkbox"/> Long-term acute care hospital		Name of Facility/Location:  County:	
DISPOSITION INFORMATION			
Status: <input type="checkbox"/> Still Hospitalized <input type="checkbox"/> Expired		Was the receiving facility notified of the patient's MDRO status: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Discharged to: <input type="checkbox"/> Home <input type="checkbox"/> LTC Facility <input type="checkbox"/> Other HC Facility <input type="checkbox"/> Other			
Specify Name:			
Any previous hospitalizations at your facility within the last six months: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Date of Previous Hospitalizations			
Admit / /	Discharge / /	Admit / /	Discharge / /
Admit / /	Discharge / /	Admit / /	Discharge / /
Admit / /	Discharge / /	Admit / /	Discharge / /
Outbreak Associated: <input type="checkbox"/> Yes <input type="checkbox"/> No		Outbreak reference number:	

**Please include copy of laboratory results/Send to Secure Fax 502-398-2462**