Your Hospital's Logo Here

METHICILLIN RESISTANT STAPH AUREUS (MRSA) TRACKING FORM

PATIENT IDENTIFICATION

This Patient was identified as being colonized or infected with MRSA		
DATE:	SITE:	SIGNATURE / TITLE:
DATE:	SITE:	SIGNATURE / TITLE:
DATE:	SITE:	SIGNATURE / TITLE:

Please alert the long term care facility who send patients who have MRSA on admission to Xxxxxx Hospital. (Any culture that is positive before 72 hours of admission or by history). The following long term care institution ________________________________ [name of institution] was called on ____________ [date] by ________________________________ [name of personnel] to make sure it is known that the patient was admitted from the facility with MRSA and will be returning to them. *(This allows the facility to address their own issues in a timely manner.)*

History - Present MRSA	
DATE:	SITE:
DATE:	SITE:
DATE:	SITE:
DATE:	SITE:

ID consult recommended on or before Day 10 of hospitalization involving any long term care MRSA patient. * If Vancomycin is ordered, please refer to the VANCOMYCIN RESTRICTION POLICY.

Nasal Culture Results	
DATE:	RESULTS:
DATE:	RESULTS:
DATE:	RESULTS:
DATE:	RESULTS:

Three (3) successive Negative Nasal Screens were documented on _______________. Therefore,

Contact Isolation for MRSA was discontinued on _______________.

Patient will remain in a Private Room.

WHITE = Permanent Part of Chart **YELLOW** = Forward to Case Management