

Sample Reporting Form for SB 1058 Mandates*

Name of Facility: _____

Quarter (circle one) 1 2 3 4 Year of Report: _____

Facility NHSN ID#: _____ (5 digits)

Name of Person Completing Form: _____
Please print legibly

Contact Information:

Email: _____ Phone: _____

Healthcare associated Infections	Number of Cases	Denominator
1. MRSA Bloodstream Infections (BSIs)		# inpatient days
2. <i>Clostridium difficile</i> infections		# inpatient days
3. VRE BSIs		# inpatient days
4. Non-ICU Central line-associated BSIs not reported through NHSN <small>Denominator is total number of line days from facility excluding those reported via NHSN</small>		# line days
5. Deep or organ/space Surgical Site Infections not reported through NHSN		# of procedures
A. Orthopedic (consider total knee/hip)		
B. Cardiac (consider CABG)		
C. GI (consider colon resection)		

**Upon completion, please email this to infectioncontrol@cdph.ca.gov
or
fax to "HAI Program" at (510) 620-3425.**

For questions, please contact Sue Chen at sue.chen@cdph.ca.gov or phone (510) 620-3434.

*** This form is a sample; its use is not a requirement of Senate Bill 1058 or the California Department of Public Health**