UK Health Security Agency

Staphylococcus capitis in hospitalised infants

Minimum data collection form

Version 2.00, October 2021

UKHSA Microbiology request form

Withdrawn August 2022

SAMPLE INFORMATION

Sender's Name	Hospital name
Contact email	Phone number

PATIENT DETAILS

ID	Sex ☐ Male ☐ Female
Forename	Surname
Date of birth	NHS number
Hospital	Unit/ward

SAMPLE TYPE (please provide detail on all referred samples)

Sample site	Sample date	Sample site	Sample date	Sample site	Sample date
☐ Blood		☐ Wound		☐ Line site	
☐ Line tip		☐ Naso-pharyngeal aspirate		☐ Skin	
☐ Nose		☐ Environment		☐ Faeces	
☐ Urine		☐ Cerebrospinal fluid		☐ Sputum	
☐ Rectal swab		☐ Environmental swab		☐ Other	

If other, please specify

REASON FOR REFERRAL (please select all that apply)

☐ Likely NRCS-A clone	☐ Unusual antibiotic resistance	☐ Screening exercise in unit
☐ Sporadic case	☐ Suspected hospital-associated	☐ Suspected outbreak

Please state any other information relevant to the referral

CLINICAL INFORMATION

Birth weight (grams) Gestational age (weeks)

Admission date

Multiple pregnancy ☐ Singleton ☐ Twins ☐ Triplets ☐ Other

Inter-hospital transfer ☐ Yes ☐ No (If yes please give details below)

For the most recent transfer: Transfer from (hospital) Date of transfer

Indwelling tubes and catheters present at the time of diagnosis ☐ Yes ☐ No

If yes, please specify type (select all that apply)
☐ Endotracheal tube ☐ Urinary catheter ☐ Gastrostomy tube ☐ Peripheral venous catheter
☐ Nasogastric tube ☐ Chest drain ☐ Peripheral arterial catheter ☐ Other

☐ Central line present (If yes, please select type of line below)

Type of central line ☐ Broviac ☐ Femoral ☐ Hickman ☐ Longline ☐ Umbilical arterial catheter ☐ Umbilical venous catheter

Treated with antibiotics for *Staphylococcus capitis*? ☐ Yes ☐ No (If yes, please give details below)

Name of antibiotic Duration of course

Current status ☐ Asymptomatic (*S. capitis* colonisation) ☐ Symptomatic (*S. capitis* infection) ☐ Died due to *S. capitis*
☐ Other (please specify)