KNHSS
Kuwait National Healthcare-associated
Infections Surveillance System

Facility name : --------------	Code -------------

HAI Surveillance Follow up Form

Patient information	
Patient ID:	File number:
Patient Name:	Date of admission: ____/_____/____(dd/ mm/ yyyy)
Event Type: ❑BSI ❑UTI ❑Pneumonia	❑Other (not SSI) specify :
Secondary Bloodstream Infection: **1**❑ Yes **0**❑No	❑Other Condition Developed, specify:
Died: **1**❑ Yes	If died; Event Contributed to Death: **1**❑Yes **0**❑No
Discharged: ❑	Discharge/death date____/_____/____(dd/ mm/ yyyy)
Doctor's Signature ----------------- Nurse's Signature ------------------------	Date: ___/____/___(dd/ mm/ yyyy

This form will be filled and sent if the following conditions happened after sending the original event form:

- Patient developed Secondary BSI or other condition you want to report
- Patient died during hospitalization
- Patient discharged

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