*** Candida auris* CaseInvestigation Form**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Patient Demographics** | | | | | | | | | | | | | | |
| First name: | | | | | | | Middle name: | | | | | | | |
| Last name: | | | | | | | | | | | | | | |
| Date of birth: | | | | | | | | | | | | | | |
| Parent/Guardian: | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | |
| City: | | | | State: | | | | | Zip: | | | | | |
| Is this address for a long-term care hospital or nursing home? | | | | | | | Yes | | | | | | | No |
| Name of facility: | | | | | | | Facility type: | | | | | | | |
| Phone number: | | | | | | | Sex: M F | | | | | | | |
| Email address: | | | | | | | | | | | | | | |
| Primary language: | | | | | | | | | | | | | | |
| Ethnicity | | | | Race | | | | | | | | | | |
| Not Hispanic or  Latino | Hispanic or Latino | | | White | | | | | | | Black or African American | | | |
| American Indian or Alaska Native | | | | | | | Asian | | | |
| Native Hawaiian or Other Pacific   Islander | | | | | | | Unknown | | | |
| **Clinical Information** | | | | | | | | | | | | | | |
| Onset date (first date of symptoms): | | | | | Date of *Candida spp.* specimen collection: | | | | | | | | | |
| **Type(s) of sample (check all that apply)** | | | | | | | | | | | | | | |
| Unknown | | Blood | | Urine | | | | Sputum | | | | Bronchoalveolar Lavage   (BAL) | | |
| Wound | | Other sterile site: | | | | | | | | | | | | |
| Type of case | | | | Clinical | | | | | | Screening/Surveillance | | | | |
| If clinical case, did patient previously have a positive screening or surveillance culture? | | | | Yes | | | | | | No | | | | |
| Was antifungal susceptibility testing (AFST) performed? | | | | Yes | | | | | | No | | | | |
| **If AFST was performed, record MICs** | | | | | | | | | | | | | | |
| Fluconazole | | | | Voriconazole | | | | | | Amphotericin | | | | |
| Micofungin | | | | Caspofungin | | | | | | Anidulafungin | | | | |
| **Laboratory Report Form** | | | | | | | | | | | | | | |
| **What methods are used for AFST?** | | | | | | | | | | | | | | |
| Broth Microdilution | | | E-test | | | Automatic | | | | | | | Other | |
| Was it initially misidentified? | | | | Yes | | | | | No | | | | | |
| If yes, which method was used? | | | | API 20C Aux | | | | | VITEK-2 | | | | | |
| Phoenix | | | | MicroScan | | | | | Other | | | | | |
| If yes, as what? | | | | *Candida haemulonii* | | | | | *Candida famata* | | | | | |
| *Candida sake* | | | | *Candida spp.* | | | | | Other | | | | | |
| Was the patient known to be colonized with any other multidrug-resistant organisms (e.g., CRE, CRA, CRPA MRSA, or VRSA)? | | | | Yes (please specify): | | | | | No | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Healthcare Encounters** | | | | | | | | | | | | | | |
| At the time of *C. auris* specimen collection, was the patient admitted to a healthcare facility? | | | | Yes | | | | | | | No | | | |
| Facility name: | | | | | | | Facility type: | | | | | | | |
| Facility address: | | | | | Was the patient in Contact Precautions for the duration or part of their stay? | | | | | | Was this infection health care facility acquired? (In a facility 2 days prior to culture collection and no previous positive culture) | | | |
| Facility city: | Facility state: | Facility ZIP: | | | Duration | | | Part of   stay | | | Yes | | | No |
| Was the patient admitted to the facility? | | Yes | No | | Admit date: | | | | | | Discharge date: | | | |
| Died from illness? | | | | Yes | | | No | Date of death: | |
| From where was the patient admitted? | | Home | | | | Facility (please   specify): | | | | Other: | | | | |
| To where was the patient discharged? | | Home | | | | Facility (please   specify): | | | | Other: | | | | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Was the patient admitted to an intensive care (ICU) unit in the past 6 months? | Yes | No | | Facility name:  Length of stay: | | |
| Date of admission to the ICU | \_\_\_/\_\_\_/\_\_\_ | | Date of discharge from the ICU | | \_\_\_/\_\_\_/\_\_\_ | |
| **Locations of patient during hospitalization** | | | | | | |
| Unit/floor: | Room: | | Dates:  \_\_\_/\_\_\_/\_\_\_to\_\_\_/\_\_\_/\_\_\_ | | On Contact Precautions? | |
| Yes | No |
| Unit/floor: | Room: | | Dates:  \_\_\_/\_\_\_/\_\_\_to\_\_\_/\_\_\_/\_\_\_ | | On Contact Precautions? | |
| Yes | No |
| Unit/floor: | Room: | | Dates:  \_\_\_/\_\_\_/\_\_\_to\_\_\_/\_\_\_/\_\_\_ | | On Contact Precautions? | |
| Yes | No |
| Unit/floor: | Room: | | Dates:  \_\_\_/\_\_\_/\_\_\_to\_\_\_/\_\_\_/\_\_\_ | | On Contact Precautions? | |
| Yes | No |
| Did the patient have a roommate (or ward mates if general ward) at any point while not on Contact Precautions? | | | Yes | | No | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Risk Factors** | | | | | | | | | | | | | | | |
| Was the patient admitted to an ICU unit in the past 6 months? | | | | | Yes | | | No | | Facility name:  Month/year: | | | | | |
| Was the patient transferred to any other facility from the reporting facility? | | | | | Yes | | | No | | Receiving facility name:  Month/year: | | | | | |
| Acute care hospital | | | | | Long-term care facility | | | | | Long-term acute care hospital | | | | | |
| Was MDRO status communicated to receiving facility (Facility Transfer Form used)? | | | | | Yes | | | | | | | No | | | |
| Has the patient had any surgical procedures in the past year? | | | | | Yes | | | | | | | No | | | |
| List surgical procedures: | | | | | | | | | | | | | | | |
| Has the patient had any out-patient procedures in the past year? | | | | | Yes | | | | | | | No | | | |
| List out-patient procedures: | | | | | | | | | | | | | | | |
| Is the patient bed-bound? | | | | | Yes | | | | | | | No | | | |
| **Underlying Medical Conditions (check all that apply)** | | | | | | | | | | | | | | | |
| Diabetes | | Hemodialysis | | Chronic Liver   Disease | | | | | Chronic Respiratory   Disease | | | | | | Chronic Renal   Disease |
| HIV (not AIDS) | | AIDS/CD4 count >200 | | | | Transplant Recipient | | | | | | | Other immunosuppressed   state: | | |
| Cancer: | | | | | | Other: | | | | | | | | | |
| **Has the patient had exposure to any of the following devices in place in the past 6 months? (check all that apply)** | | | | | | | | | | | | | | | |
| Mechanical ventilation | | | Central venous catheter | | | | Peripheral IV | | | | | | | Dialysis catheter | |
| Urinary catheter | | | Endotracheal intubation | | | | Gastrostomy tube | | | | | | | NG tube | |
| Tracheostomy | | | Nephrostomy tube | | | | Surgical drain | | | | | | | Hemodialysis | |
| Intra-abdominal drain or catheter | | | | | Surgical drain | | | | | | Other surgical procedure or device   (please specify) | | | | |
| **Travel History** | | | | | | | | | | | | | | | |
| Has the patient traveled outside of the U.S. in the past year? | | | | | Location: | | | | | | | | | Date: | |
| Yes | No | | | | Location: | | | | | | | | | Date: | |
| Did the patient receive medical care outside of the U.S.? | | | | | Location: | | | | | | | | | Date: | |
| Yes | No | | | | Location: | | | | | | | | | Date: | |
| **Treatment History** | | | | | | | | | | | | | | | |
| In the **2 weeks** prior to the *C. auris* specimen collection | | | | | | | | | | | | | | | |
| Did the patient receive broad spectrum antibiotics? | | | | | Yes | | | | | | | No | | | |
| Did the patient receive antifungal medication? | | | | | Yes | | | | | | | No | | | |
| If yes, please specify antifungal (e.g., fluconazole): | | | | | | | | | | | | | | | |
| After the *C. auris* was identified, did the patient receive antifungal medication? | | | | | Yes | | | | | | | No | | | |

|  |  |  |
| --- | --- | --- |
| If yes, please specify antifungal (e.g., fluconazole) and treatment dates:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_to\_\_\_/\_\_\_/\_\_\_\_ | | |
| **Contacts** | | |
| **List all contacts below and indicate if they are a familial contact, healthcare worker contact, or facility roommate.** | | |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Name: | Phone number: | Contact type: |
| Additional notes: | | |