*** Candida auris* CaseInvestigation Form**

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| **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 |

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| **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: |

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| 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 |

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| **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  |

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| 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: |
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| Name:  | Phone number:  | Contact type: |
| Additional notes: |