

Patient ID: _____

Specimen ID: _____

- CLOSTRIDIUM DIFFICILE INFECTION (CDI) SURVEILLANCE EMERGING INFECTIONS PROGRAM CASE REPORT FORM -

Patient's Name: _____ Phone No.: () _____
(Last, First, M.I.)

Address: _____ Chart Number: _____
(Number, Street, Apt. No.)

(City) (State) (Zip Code)

Hospital: _____

- Patient identifier information is NOT transmitted to CDC -

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES
 CENTERS FOR DISEASE CONTROL AND PREVENTION
 ATLANTA, GA 30333

**CLOSTRIDIUM DIFFICILE INFECTION (CDI) SURVEILLANCE
 EMERGING INFECTIONS PROGRAM CASE REPORT**



1. STATE: <small>(Residence of Patient)</small>		2. COUNTY: <small>(Residence of Patient)</small>		3. STATE ID:			4a. LAB/HOSPITAL WHERE TOXIN ASSAY PERFORMED:		4b. PROVIDER ID WHERE PATIENT TREATED:		
[] []		_____		[] [] [] [] [] [] [] [] [] []			_____		_____		
5. DATE OF BIRTH: Mo. Day Year [] [] [] [] [] [] [] [] [] [] [] []			6. AGE: [] [] [] []		7a. SEX: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female		7b. ETHNIC ORIGIN: 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 7 <input type="checkbox"/> Unknown		7c. RACE: (Check all that apply) 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Unknown		
8a. DATE OF INCIDENT STOOL COLLECTION POSITIVE FOR C. diff: Mo. Day Year [] [] [] [] [] [] [] [] [] [] [] []			8b. Positive diagnostic assay for C. diff: <small>(Check all that apply)</small> 1 <input type="checkbox"/> EIA 1 <input type="checkbox"/> GDH 1 <input type="checkbox"/> NAAT 1 <input type="checkbox"/> Culture 1 <input type="checkbox"/> Cytotoxin 1 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Other (specify): _____			8c. Location of stool collection: (Check one) 1 <input type="checkbox"/> Hospital Inpatient 4 <input type="checkbox"/> Long Term Care/ Skilled Nursing Facility 7 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Long Term Acute Care Hospital 5 <input type="checkbox"/> Outpatient 8 <input type="checkbox"/> Observation Unit/CDU 3 <input type="checkbox"/> Emergency Room 6 <input type="checkbox"/> Other (specify): _____					
9. Was patient hospitalized at the time of, or within 7 days after, stool collection? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown If YES, Date of Admission: Mo. Day Year [] [] [] [] [] [] [] [] [] [] [] []						10. Where was the patient a resident 4 days prior to stool collection? (Check one) 1 <input type="checkbox"/> Hospital Inpatient 4 <input type="checkbox"/> Long Term Care/ Skilled Nursing Facility 7 <input type="checkbox"/> Unknown 2 <input type="checkbox"/> Long Term Acute Care Hospital 5 <input type="checkbox"/> Homeless 8 <input type="checkbox"/> Other (specify): _____ 3 <input type="checkbox"/> Home 6 <input type="checkbox"/> Incarcerated					
11. HCFO classification questions: a. Was stool collected ≥ 4 days after hospital admission? 1 <input type="checkbox"/> Yes (HCFO) 2 <input type="checkbox"/> No (go to 11b.) b. If no, was stool collected at LTCF/SNF/LTACH? 1 <input type="checkbox"/> Yes (HCFO) 2 <input type="checkbox"/> No (go to 11c.) c. If no, was the patient admitted from LTCF/SNF or another acute care setting? 1 <input type="checkbox"/> Yes (HCFO) 2 <input type="checkbox"/> No (CO - complete CRF) d. If HCFO, was this case selected for full CRF based on sampling frame (1:10)? 1 <input type="checkbox"/> Yes (Complete CRF) 2 <input type="checkbox"/> No (STOP data abstraction here!)						12. Was patient admitted due to CDI: (is CDI listed in the medical record as the reason for admission?) 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Admitted 7 <input type="checkbox"/> Unknown					
						13. Were other enteric pathogens detected from stool at the same date incident C. diff + stool was collected? 1 <input type="checkbox"/> Campylobacter 5 <input type="checkbox"/> None 9 <input type="checkbox"/> Norovirus 2 <input type="checkbox"/> Salmonella 6 <input type="checkbox"/> No other pathogens tested 10 <input type="checkbox"/> Rotavirus 3 <input type="checkbox"/> Shiga Toxin-Producing E. coli 7 <input type="checkbox"/> Unknown 4 <input type="checkbox"/> Shigella 8 <input type="checkbox"/> Other (specify): _____					
14. Exclusion criteria for CA-CDI: (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Hospitalized (overnight) at any time in the 12 weeks prior to stool collection date. If yes, Date of most recent discharge: Mo. Day Year [] [] [] [] [] [] [] [] [] [] [] [] <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Overnight stay in LTACH at any time in the 12 weeks prior to stool collection date 1 <input type="checkbox"/> Residence in LTCF/SNF at any time in the 12 weeks prior to stool collection date CO cases: not eligible for health interview if any of these boxes are checked. HCFO and Prisoners: not eligible for health interview.						15. Exposures to healthcare: a. Chronic Hemodialysis prior to incident C. diff + stool: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown b. Surgical procedure in the 12 weeks prior to incident C. diff + stool: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown c. ER visits in the 12 weeks prior to incident C. diff + stool: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown d. Observation/CDU stay in the 12 weeks prior to incident C. diff + stool: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown					
16. Patient outcome: 7 <input type="checkbox"/> Unknown 1 <input type="checkbox"/> Survived Date of Discharge: Mo. Day Year [] [] [] [] [] [] [] [] [] [] [] [] If survived, patient was discharged to: 2 <input type="checkbox"/> Long Term Acute Care Hospital 4 <input type="checkbox"/> Long Term Care/ Skilled Nursing Facility 7 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Home 5 <input type="checkbox"/> Other _____						2 <input type="checkbox"/> Died Date of Death: Mo. Day Year [] [] [] [] [] [] [] [] [] [] [] []					

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS E-11, Atlanta, Georgia 30333; ATTN: PRA (0920-0978).

17a. Colectomy (related to CDI): 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown If YES, Date of Procedure Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>	17b. ICU Admission (on the day of or after incident stool collection): 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown If YES, Date of ICU Admission Mo. Day Year <input type="checkbox"/> Unknown <input type="text"/> <input type="text"/> <input type="text"/>	17c. Any additional positive stool test for C. diff ≥ 2 and ≤ 8 weeks after the last C. diff + stool specimen? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If YES, Date of first recurrent specimen Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>
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18. RADIOGRAPHIC FINDINGS (within 7 days before or after incident C. diff + stool): 1 <input type="checkbox"/> Toxic megacolon 4 <input type="checkbox"/> Both 2 <input type="checkbox"/> Ileus 5 <input type="checkbox"/> Not Done 3 <input type="checkbox"/> Neither 7 <input type="checkbox"/> Information not available	19. Was pseudomembranous colitis listed in the surgical pathology, endoscopy, or autopsy report (within 7 days before or after incident C. diff + stool)? 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Not Done 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Information not available	20.1 LABORATORY FINDINGS (within 7 days before or after incident C. diff + stool): a. Albumin ≤ 2.5g/dl: 1 <input type="checkbox"/> Yes 3 <input type="checkbox"/> Not Done 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Information not available b. White blood cell count ≤ 1,000/μl: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Done 7 <input type="checkbox"/> Information not available c. White blood cell count ≥ 15,000/μl: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Done 7 <input type="checkbox"/> Information not available
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20.2 CLINICAL FINDINGS (within 7 days before and up to 1 day after incident C. diff + stool): d. Diarrhea: 1 <input type="checkbox"/> Diarrhea by definition (unformed or watery stool, ≥ 3/day for ≥ 1 day) 2 <input type="checkbox"/> Diarrhea documented, but unable to determine if it is by definition 3 <input type="checkbox"/> No Diarrhea documented 4 <input type="checkbox"/> "Asymptomatic" documented in medical record 7 <input type="checkbox"/> Information not available		e. Upper GI Symptoms: 1 <input type="checkbox"/> Nausea 2 <input type="checkbox"/> Vomiting 3 <input type="checkbox"/> Neither 4 <input type="checkbox"/> Both 7 <input type="checkbox"/> Information not available
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21. UNDERLYING CONDITIONS: (Check all that apply) If none or no chart available, check appropriate box 1 <input type="checkbox"/> None 1 <input type="checkbox"/> Unknown			
1 <input type="checkbox"/> AIDS	1 <input type="checkbox"/> Connective Tissue Disease	1 <input type="checkbox"/> Inflammatory Bowel Disease	1 <input type="checkbox"/> Stem Cell Transplant
1 <input type="checkbox"/> Chronic Cognitive Deficit	1 <input type="checkbox"/> CVA/Stroke	1 <input type="checkbox"/> Myocardial Infarct	1 <input type="checkbox"/> Solid Tumor (non metastatic)
1 <input type="checkbox"/> Chronic Kidney Disease	1 <input type="checkbox"/> Dementia	1 <input type="checkbox"/> Peptic Ulcer Disease	1 <input type="checkbox"/> Hematologic Malignancy
1 <input type="checkbox"/> Chronic Liver Disease	1 <input type="checkbox"/> Diabetes	1 <input type="checkbox"/> Peripheral Vascular Disease	1 <input type="checkbox"/> Metastatic Solid Tumor
1 <input type="checkbox"/> Chronic Pulmonary Disease	1 <input type="checkbox"/> Diverticular Disease	1 <input type="checkbox"/> Primary Immunodeficiency	
1 <input type="checkbox"/> Congenital Heart Disease	1 <input type="checkbox"/> Hemiplegia/Paraplegia	1 <input type="checkbox"/> Short Gut Syndrome	
1 <input type="checkbox"/> Congestive Heart Failure	1 <input type="checkbox"/> HIV	1 <input type="checkbox"/> Solid Organ Transplant	

22. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Admitted 7 <input type="checkbox"/> Unknown If YES, what was the POA code assigned to it? 1 <input type="checkbox"/> Y, Yes 3 <input type="checkbox"/> U, Unknown 5 <input type="checkbox"/> Missing 2 <input type="checkbox"/> N, No 4 <input type="checkbox"/> W, Clinically Undetermined 6 <input type="checkbox"/> Not Applicable	23. At time of incident C. diff + stool, patient was: 1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 7 <input type="checkbox"/> Unknown Delivery Date: Mo. Day Year <input type="text"/> <input type="text"/> <input type="text"/>
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24. MEDICATIONS TAKEN 12 WEEKS PRIOR TO INCIDENT STOOL COLLECTION DATE (including current hospital stay if collection date > admission date): (If none or no chart available, check appropriate box)						
a. Proton pump inhibitor (e.g. Esomeprazole, Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole)		1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	7 <input type="checkbox"/> Unknown		
b. H2 Blockers (e.g. Famotidine, Ranitidine, Cimetidine)		1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No	7 <input type="checkbox"/> Unknown		
c. Immunosuppressive therapy (Check all that apply)		1 <input type="checkbox"/> None	1 <input type="checkbox"/> Unknown			
1 <input type="checkbox"/> Steroids 1 <input type="checkbox"/> Chemotherapy 1 <input type="checkbox"/> Other agents (specify): _____						
d. Antimicrobial therapy (Check all that apply)		1 <input type="checkbox"/> Yes, name unknown	1 <input type="checkbox"/> None	1 <input type="checkbox"/> Unknown		
1 <input type="checkbox"/> Amikacin	1 <input type="checkbox"/> Cefazolin	1 <input type="checkbox"/> Ceftazidime	1 <input type="checkbox"/> Clarithromycin	1 <input type="checkbox"/> Imipenem	1 <input type="checkbox"/> Nitrofurantoin	1 <input type="checkbox"/> Tigecycline
1 <input type="checkbox"/> Amoxicillin	1 <input type="checkbox"/> Cefdinir	1 <input type="checkbox"/> Ceftizoxime	1 <input type="checkbox"/> Clindamycin	1 <input type="checkbox"/> Levofloxacin	1 <input type="checkbox"/> Ofloxacin	1 <input type="checkbox"/> Tobramycin
1 <input type="checkbox"/> Amoxicillin/ Clavulanic Acid	1 <input type="checkbox"/> Cefepime	1 <input type="checkbox"/> Ceftriaxone	1 <input type="checkbox"/> Daptomycin	1 <input type="checkbox"/> Linezolid	1 <input type="checkbox"/> Penicillin	1 <input type="checkbox"/> Trimethoprim -Sulfamethoxazole
1 <input type="checkbox"/> Amp/subl	1 <input type="checkbox"/> Cefotaxime	1 <input type="checkbox"/> Cefuroxime	1 <input type="checkbox"/> Doxycycline	1 <input type="checkbox"/> Meropenem	1 <input type="checkbox"/> Piperacillin-Tazobactam	1 <input type="checkbox"/> Vancomycin (IV)
1 <input type="checkbox"/> Azithromycin	1 <input type="checkbox"/> Cefpodoxime	1 <input type="checkbox"/> Cephalexin	1 <input type="checkbox"/> Ertapenem	1 <input type="checkbox"/> Metronidazole	1 <input type="checkbox"/> Tetracycline	
1 <input type="checkbox"/> Cefaclor	1 <input type="checkbox"/> Cefprozil	1 <input type="checkbox"/> Ciprofloxacin	1 <input type="checkbox"/> Gentamicin	1 <input type="checkbox"/> Moxifloxacin	1 <input type="checkbox"/> Ticarcillin/Clavulanic Acid	1 <input type="checkbox"/> Other (specify): _____

- SURVEILLANCE OFFICE USE ONLY -

25. CRF status: 1 <input type="checkbox"/> Complete 3 <input type="checkbox"/> Edited & Correct 2 <input type="checkbox"/> Incomplete 4 <input type="checkbox"/> Chart unavailable after 3 requests	26. Previous unique CDI episode (>8 weeks prior to this episode): 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If yes, Previous STATEID: <input type="text"/>	27. Initials of S.O: _____	29. Identified through audit 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No
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28. COMMENTS: _____
