Form Approved
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Undetermined risk factors and modes of transmission for Candida auris infection — Colombia, 2016

Appendix 1a. Case Report Form for Cases of *Candida auris* and *Candidemia* [English]

Appendix 1a. Case Report Form for cases of *Candida auris* and *Candidemia*

Case ID: _____ Sex (M)(F) Age: _____ (years)(months)(days) Address:_____
Location: Country: _____ City: _____ Institution:_____
Date of admission (DD)(MM)(YY) Reason for admission: _____
Date of discharge (DD)(MM)(YY) Condition at discharge: Alive ( ) Dead ( ) Hospitalized ( ) Unknown ( )

Location During Hospitalization:

Was the patient transferred from another facility? (Yes)(No)(UNK)
Name and City of Hospital: _____ Date of transfer: (DD)(MM)(YY)

Admitted to the ICU: (Si)(No)(ND)
Date of admission to the ICU (DD)(MM)(YY) Date of discharge from the ICU (DD)(MM)(YY)

Locations of patient during hospitalization:
Unit: _____ room: _____ Date of arrival: (DD)(MM)(YY) Date leaving: (DD)(MM)(YY)
Unit: _____ room: _____ Date of arrival: (DD)(MM)(YY) Date leaving: (DD)(MM)(YY)
Unit: _____ room: _____ Date of arrival: (DD)(MM)(YY) Date leaving: (DD)(MM)(YY)
Unit: _____ room: _____ Date of arrival: (DD)(MM)(YY) Date leaving: (DD)(MM)(YY)
Unit: _____ room: _____ Date of arrival: (DD)(MM)(YY) Date leaving: (DD)(MM)(YY)

Was the patient in the Operating Room? (Yes)(No)(UKN), If yes, please complete the following:
Operating room:_____ Date: (DD)(MM)(YY) Procedure/Operation:_____
Operating room:_____ Date: (DD)(MM)(YY) Procedure/Operation:_____
Operating room:_____ Date: (DD)(MM)(YY) Procedure/Operation:_____

Risk Factors

Previous Hospitalizations:	**Comorbilities:**
Has the patient been hospitalized in the past 90 days? (Yes)(No)(UNK) Hospital and City: _____ Date of Admission: (DD)(MM)(YY) Reason for hospitalization: _____ Date of discharge: (DD)(MM)(YY)	Diabetes: (Yes)(No)(UNK) Solid tumor: (Yes)(No)(UNK) Hematologic Malignancy: (Yes)(No)(UNK) Bone Marrow Transplant: (Yes)(No)(UNK)

Hospital and City: _____ Date of Admission: (DD)(MM)(YY)
Reason for hospitalization: _____ Date of discharge: (DD)(MM)(YY)

Has the patient ever been previously diagnosed with candida? (Yes)(No)(UNK)
Date:(DD) (MM) (YY)
What species was isolated? _____

Has the patient ever previously received an antifungal? (Yes)(No)(UNK)
Which?_____ Began: (DD)(MM)(YY) Stopped: (DD)(MM)(YY)
Indication for treatment: _____

Chronic renal failure: (Yes)(No)(UNK)
Hemodialysis (Yes)(No)(UNK)
Liver disease:(Yes)(No)(UNK)
Immunosuppressed: (Yes)(No)(UNK)
Please select:(Autoimmune)(Transplant) (Corticosteroids) (Cancer)
HIV/AIDS: (Yes)(No)(UNK)
CD4: _____ Viral load: _____
Others:(Yes)(No)(UNK) Which?: _____

Current Hospitalization

Procedure:

Hemodialysis: (Yes)(No)(UNK)	Begin date: (DD) (MM) (YY)	End date: (DD) (MM) (YY)
Central venous catheter (Yes)(No)(UNK)	Begin date: (DD) (MM) (YY)	End date: (DD) (MM) (YY)
Respiratory support: (BiPAP) (Intubation)	Begin date: (DD) (MM) (YY)	End date: (DD) (MM) (YY)
Bronchoscopy: (Yes)(No)(UNK)	Begin date: (DD) (MM) (YY)	End date: (DD) (MM) (YY)
Physical Therapy: (Yes)(No)(UNK)	Begin date: (DD) (MM) (YY)	End date: (DD) (MM) (YY)

Treatments:
Chemotherapy: (Yes)(No)(UNK)
Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)
TPN: (Yes)(No)(UNK)
Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)
Corticosteroides: (Yes)(No)(UNK)
¿Which? _____ Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)
¿Which? _____ Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)

Vasopressors: (Yes)(No)(UNK)
¿Which? _____ Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)
¿Which? _____ Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)

¿Other treatments?
_____
Begin:(DD)(MM)(YY) End:(DD)(MM)(YY)

Antimicrobials:
¿What treatment was used for this candidemia?:_____dose:_____
Begin:(DD) (MM) (YY) End:(DD) (MM) (YY)
Other antimicrobials:
Name and dose:_____
Begin:(DD) (MM) (YY) End:(DD) (MM) (YY)
Name and dose:_____
Begin:(DD) (MM) (YY) End:(DD) (MM) (YY)
Name and dose:_____
Begin:(DD) (MM) (YY) End:(DD) (MM) (YY)
Name and dose:_____
Begin:(DD) (MM) (YY) End:(DD) (MM) (YY)
Name and dose:_____
Begin:(DD) (MM) (YY) End:(DD) (MM) (YY)

Clinical and Laboratory Findings

Clinical:
Weight:_____ Height:_____
Evidence of severe sepsis(Yes)(No)(UNK)
Sepsis: at least 2 of the following
(a) temperature >38.3C or <36C, (b) heart rate >90, (c) respiratory rate >20) with evidence of infection
Severe sepsis = sepsis plus respiratory failure
Did the patient experience a decompensation during the hospital stay? (Yes)(No)(UNK) Date: (DD)(MM)(YY)
Details:_____
_____
_____

Radiology:
Any findings on imagige: (Yes)(No)(UNK)
Which?
_____
Date: (DD)(MM)(YY)

Laboratory:
(closest available to date of positive candida culture)
Date:(DD)(MM)(YY)
WBC: _____
%PMNs:_____
Hb: _____
PLT: _____
Creatine: _____
BUN: _____
Glucose: _____
AST: _____
ALT: _____
Bilirrubin total: _____
Albumin: _____
Lactate: _____

Candida culture

First positive Candida or *C. auris* culture: Date:(DD)(MM)(YY)
Type of sample: (**blood**)(**urine**) (**wound**) (**BAL**) (**other**)
Which? _____

MIC:
Fluconazole: _____
Voriconazole: _____
Amphotericin: _____
Caspofungin: _____
Anidulafungin: _____
Micafungin: _____

Cultures (1 year before and after positive Candida culture)

Type of Sample	Date of Collection	Date of Report	Results (microrganism isolated)	MICs
	(DD)(MM)(YY)	(DD)(MM)(YY)		
	(DD)(MM)(YY)	(DD)(MM)(YY)		
	(DD)(MM)(YY)	(DD)(MM)(YY)		

	(DD)(MM)(YY)	(DD)(MM)(YY)		
	(DD)(MM)(YY)	(DD)(MM)(YY)		
	(DD)(MM)(YY)	(DD)(MM)(YY)		

Additional Information for Candidemia Cases in those less than one year of age

Born prematurely: (Yes)(No)(UNK) Delivery: (vaginal) (c-section)
Gestation at time of birth: ____ (weeks) Birth weight: _____ (Kgs)

Select the type of nutrition received: (breastmilk)(formula)(combination)(other)
If formula received, what type? _____
Were any additives, probiotics or thickening agents used (Yes)(No)(UNK): Which?_____
Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)

Was there any skin breakdown (eg. Rash, open wounds)?: (Yes)(No)(UNK) ; What?:_____

Received prophylactic antifungals? (Yes)(No)(UNK) ; Which?: _____

Required an operation? (Yes)(No)(UNK) Which?: _____ Date: (DD)(MM)(YY)
Which?: _____ Date: (DD)(MM)(YY)

Any additional procedures performed apart from those mentioned previously or above? (Yes)(No)(UNK)
Which?: _____ Date: (DD)(MM)(YY)
Which?: _____ Date: (DD)(MM)(YY)

Was the patient exposed to any of the following:

- Incubator (Yes)(No)(UNK) Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)
- Feeding tube (Yes)(No)(UNK) Specify: (nose) (mouth) (PEG)
  Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)
- Cardiac monitor (Yes)(No)(UNK) Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)
- Phototherapy: (Yes)(No)(UNK) Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)
- Steroids for respiratory development (Yes)(No)(UNK)
  Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)
- Other: _____ Date: (DD)(MM)(YY) For how long? _____ (hours)(days)(weeks)(months)
- *Subject to change as investigation reveals additional information about cases*