

Patient ID: \_\_\_\_\_

Specimen ID: \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_ (Last, First, M.I.) Phone No.: ( ) \_\_\_\_\_ - \_\_\_\_\_  
 Address: \_\_\_\_\_ (Number, Street, Apt. No.) Chart Number: \_\_\_\_\_  
 \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) Hospital: \_\_\_\_\_

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

- Patient identifier information is NOT transmitted to CDC -

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



<b>1. STATE:</b> (Residence of Patient) [ ][ ]	<b>2. COUNTY:</b> (Residence of Patient) _____	<b>3. STATE ID:</b> [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]	<b>4a. LAB/HOSPITAL WHERE TOXIN ASSAY PERFORMED:</b> _____	<b>4b. PROVIDER ID WHERE PATIENT TREATED:</b> _____
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<b>5. DATE OF BIRTH:</b> Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]	<b>6. AGE:</b> [ ][ ][ ]	<b>7a. SEX:</b> 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female	<b>7b. ETHNIC ORIGIN:</b> 1 <input type="checkbox"/> Hispanic or Latino 2 <input type="checkbox"/> Not Hispanic or Latino 7 <input type="checkbox"/> Unknown	<b>7c. RACE: (Check all that apply)</b> 1 <input type="checkbox"/> Native Hawaiian or Other Pacific Islander 1 <input type="checkbox"/> American Indian or Alaska Native 1 <input type="checkbox"/> White 1 <input type="checkbox"/> Black or African American 1 <input type="checkbox"/> Asian 1 <input type="checkbox"/> Unknown
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<b>8a. DATE OF INCIDENT STOOL COLLECTION POSITIVE FOR C. diff:</b> Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]	<b>8b. Positive diagnostic assay for C. diff:</b> (Check all that apply) 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): _____	<b>8c. Location of stool collection: (Check one)</b> 1 <input type="checkbox"/> Hospital Inpatient Facility ID _____ 2 <input type="checkbox"/> Long Term Acute Care Hospital Facility ID _____ 3 <input type="checkbox"/> Emergency Room 4 <input type="checkbox"/> Long Term Care/ Skilled Nursing Facility Facility ID _____ 5 <input type="checkbox"/> Outpatient 6 <input type="checkbox"/> Other (specify): _____ 7 <input type="checkbox"/> Unknown 8 <input type="checkbox"/> Observation Unit/CDU
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<b>9. Was patient hospitalized at the time of, or within 7 days after, stool collection?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown <b>If YES, Date of Admission:</b> Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ]	<b>10. Where was the patient a resident 4 days prior to stool collection? (Check one)</b> 1 <input type="checkbox"/> Hospital Inpatient Facility ID _____ 2 <input type="checkbox"/> Long Term Acute Care Hospital Facility ID _____ 3 <input type="checkbox"/> Home 4 <input type="checkbox"/> Long Term Care/ Skilled Nursing Facility Facility ID _____ 5 <input type="checkbox"/> Homeless 6 <input type="checkbox"/> Incarcerated 7 <input type="checkbox"/> Unknown 8 <input type="checkbox"/> Other (specify): _____
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<b>11. HCFO classification questions:</b> <b>a. Was stool collected ≥ 4 days after hospital admission?</b> 1 <input type="checkbox"/> Yes (HCFO) 2 <input type="checkbox"/> No (go to 11b.) <b>b. If no, was stool collected at LTCF/SNF/LTACH?</b> 1 <input type="checkbox"/> Yes (HCFO) 2 <input type="checkbox"/> No (go to 11c.) <b>c. If no, was the patient admitted from LTCF/SNF or another acute care setting?</b> 1 <input type="checkbox"/> Yes (HCFO) 2 <input type="checkbox"/> No (CO - complete CRF) Facility ID _____ <b>d. If HCFO, was this case selected for full CRF based on sampling frame (1:10)?</b> 1 <input type="checkbox"/> Yes (Complete CRF) 2 <input type="checkbox"/> No (STOP data abstraction here!)	<b>12. Was CDI a primary or contributing reason for patient's admission?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Admitted 7 <input type="checkbox"/> Unknown <b>13. Were other enteric pathogens detected from stool at the same date incident C. diff + stool was collected?</b> 1 <input type="checkbox"/> Campylobacter 5 <input type="checkbox"/> None 8 <input type="checkbox"/> Other (specify): _____ 2 <input type="checkbox"/> Salmonella 6 <input type="checkbox"/> No other pathogens tested 3 <input type="checkbox"/> Shiga Toxin-Producing E. coli 9 <input type="checkbox"/> Norovirus 4 <input type="checkbox"/> Shigella 7 <input type="checkbox"/> Unknown 10 <input type="checkbox"/> Rotavirus
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<b>14. Exclusion criteria for CA-CDI: (Check all that apply)</b> <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 Facility ID _____ 1 <input type="checkbox"/> Overnight stay in LTACH at any time in the 12 weeks prior to stool collection date Facility ID _____ 1 <input type="checkbox"/> Residence in LTCF/SNF at any time in the 12 weeks prior to stool collection date Facility ID _____	<b>15. Exposures to healthcare:</b> <b>a. Chronic Hemodialysis prior to incident C. diff + stool:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown <b>b. Surgical procedure in the 12 weeks prior to incident C. diff + stool:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown <b>c. ER visits in the 12 weeks prior to incident C. diff + stool:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown <b>d. Observation/CDU stay in the 12 weeks prior to incident C. diff + stool:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown
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<b>16. Patient outcome:</b> 1 <input type="checkbox"/> Survived <b>Date of Discharge:</b> Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ] <b>If survived, patient was discharged to:</b> 2 <input type="checkbox"/> Long Term Acute Care Hospital Facility ID _____ 3 <input type="checkbox"/> Home 4 <input type="checkbox"/> Long Term Care/ Skilled Nursing Facility Facility ID _____ 5 <input type="checkbox"/> Other _____	<b>2 <input type="checkbox"/> Died</b> <b>Date of Death:</b> Mo. [ ][ ] Day [ ][ ] Year [ ][ ][ ][ ] 7 <input type="checkbox"/> Unknown
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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 D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

<b>17a. Colectomy</b> (related to CDI): 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown  <b>If YES, Date of Procedure</b> Mo.      Day      Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>17b. ICU Admission</b> (on the day of or after incident stool collection): 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 7 <input type="checkbox"/> Unknown  <b>If YES, Date of ICU Admission</b> Mo.      Day      Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> Unknown	<b>17c. Any additional positive stool test for C. diff ≥ 2 and ≤ 8 weeks after the last C. diff+ stool specimen?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  <b>If YES, Date of first recurrent specimen</b> Mo.      Day      Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
<b>18. RADIOGRAPHIC FINDINGS</b> (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	<b>19. Was pseudomembranous colitis listed in the surgical pathology, endoscopy, or autopsy report</b> (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	<b>20.1 LABORATORY FINDINGS</b> (within 7 days before or after incident C. diff + stool): <b>a. Albumin ≤ 2.5g/dl:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Done 7 <input type="checkbox"/> Information not available  <b>b. White blood cell count ≤ 1,000/μl:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Done 7 <input type="checkbox"/> Information not available  <b>c. White blood cell count ≥ 15,000/μl:</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Done 7 <input type="checkbox"/> Information not available
<b>20.2 CLINICAL FINDINGS</b> (within 7 days before and up to 1 day after incident C. diff + stool): <b>d. Diarrhea:</b> 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  <b>e. Upper GI Symptoms:</b> 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		<b>21. UNDERLYING CONDITIONS:</b> (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
<b>22. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Not Admitted 7 <input type="checkbox"/> Unknown  <b>If YES, what was the POA code assigned to it?</b> 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	<b>23. At time of incident C. diff + stool, patient was:</b> 1 <input type="checkbox"/> Pregnant 2 <input type="checkbox"/> Post-partum 3 <input type="checkbox"/> Neither 7 <input type="checkbox"/> Unknown  <b>Delivery Date:</b> Mo.      Day      Year <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<b>24. MEDICATIONS TAKEN 12 WEEKS PRIOR TO INCIDENT STOOL COLLECTION DATE</b> (including current hospital stay if collection date > admission date): (If none or no chart available, check appropriate box)  <b>a. Proton pump inhibitor</b> 1 <input type="checkbox"/> Yes                      2 <input type="checkbox"/> No                      7 <input type="checkbox"/> Unknown (e.g. Esomeprazole, Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole)  <b>b. H2 Blockers</b> (e.g. Famotidine, Ranitidine, Cimetidine) 1 <input type="checkbox"/> Yes                      2 <input type="checkbox"/> No                      7 <input type="checkbox"/> Unknown  <b>c. Immunosuppressive therapy</b> (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): _____  <b>d. Antimicrobial therapy</b> (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"/> Ceftriaxone                      1 <input type="checkbox"/> Doxycycline                      1 <input type="checkbox"/> Metronidazole                      1 <input type="checkbox"/> Tetracycline 1 <input type="checkbox"/> Amoxicillin                      1 <input type="checkbox"/> Cefdinir                      1 <input type="checkbox"/> Cefuroxime                      1 <input type="checkbox"/> Ertapenem                      1 <input type="checkbox"/> Moxifloxacin                      1 <input type="checkbox"/> Tigecycline 1 <input type="checkbox"/> Amoxicillin/Clavulanic Acid                      1 <input type="checkbox"/> Cefepime                      1 <input type="checkbox"/> Cephalexin                      1 <input type="checkbox"/> Gentamicin                      1 <input type="checkbox"/> Nitrofurantoin                      1 <input type="checkbox"/> Tobramycin 1 <input type="checkbox"/> Ampicillin                      1 <input type="checkbox"/> Cefotaxime                      1 <input type="checkbox"/> Ciprofloxacin                      1 <input type="checkbox"/> Imipenem                      1 <input type="checkbox"/> Penicillin                      1 <input type="checkbox"/> Trimethoprim -Sulfamethoxazole 1 <input type="checkbox"/> Amp/sulb                      1 <input type="checkbox"/> Cefoxitin                      1 <input type="checkbox"/> Clarithromycin                      1 <input type="checkbox"/> Levofloxacin                      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"/> Clindamycin                      1 <input type="checkbox"/> Linezolid                      1 <input type="checkbox"/> Rifampin                      1 <input type="checkbox"/> Other (specify): _____ 1 <input type="checkbox"/> Aztreonam                      1 <input type="checkbox"/> Ceftazidime                      1 <input type="checkbox"/> Daptomycin                      1 <input type="checkbox"/> Meropenem                      1 <input type="checkbox"/> Rifaximin  <b>e. Was patient treated for previous suspected or confirmed CDI in the prior 12 weeks?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  If YES, which medication was taken (check all that apply, or unknown if applicable): <input type="checkbox"/> Metronidazole <input type="checkbox"/> Vancomycin <input type="checkbox"/> Fidaxomicin <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown		
<b>- SURVEILLANCE OFFICE USE ONLY -</b>		
<b>25. CRF status:</b> 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	<b>26. Previous unique CDI episode</b> (>8 weeks prior to this episode): 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No If yes, Previous STATEID: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<b>27. Initials of S.O:</b> _____
<b>28. COMMENTS:</b> _____ _____ _____ _____		<b>29. Identified through audit</b> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No