Form approved OMB No. 0920-0978 Expires 8/31/2016

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.)

_____ _____ _____ Hospital: _____
(City) (State) (Zip Code)

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

1. STATE: (Residence of Patient) ☐☐

2. COUNTY: (Residence of Patient) _____

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 ☐ Male
2 ☐ Female

7b. ETHNIC ORIGIN:
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino
7 ☐ Unknown

7c. RACE: *(Check all that apply)*
1 ☐ Native Hawaiian or Other Pacific Islander
1 ☐ American Indian or Alaska Native
1 ☐ Asian
1 ☐ White
1 ☐ Black or African American
1 ☐ Unknown

8a. DATE OF INCIDENT STOOL COLLECTION POSITIVE FOR *C. diff*: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

8b. Positive diagnostic assay for C. diff: *(Check all that apply)*
1 ☐ EIA 1 ☐ GDH 1 ☐ NAAT
1 ☐ Culture 1 ☐ Cytotoxin 1 ☐ Unknown
1 ☐ Other (specify): _____

8c. Location of stool collection: *(Check one)*
1 ☐ Hospital Inpatient Facility ID _____
2 ☐ Long Term Acute Care Hospital Facility ID _____
3 ☐ Emergency Room
4 ☐ Long Term Care/ Skilled Nursing Facility Facility ID _____
5 ☐ Outpatient
6 ☐ Other (specify): _____
7 ☐ Unknown
8 ☐ Observation Unit/CDU

9. Was patient hospitalized at the time of, or within 7 days after, stool collection?
1 ☐ Yes 2 ☐ No 7 ☐ 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 ☐ Hospital Inpatient Facility ID _____
2 ☐ Long Term Acute Care Hospital Facility ID _____
3 ☐ Home
4 ☐ Long Term Care/ Skilled Nursing Facility Facility ID _____
5 ☐ Homeless
6 ☐ Incarcerated
7 ☐ Unknown
8 ☐ Other (specify): _____

11. HCFO classification questions:

a. Was stool collected ≥ 4 days after hospital admission?
1 ☐ Yes (HCFO) 2 ☐ No **(go to 11b.)**

b. If no, was stool collected at LTCF/SNF/LTACH?
1 ☐ Yes (HCFO) 2 ☐ No **(go to 11c.)**

c. If no, was the patient admitted from LTCF/SNF or another acute care setting?
1 ☐ Yes (HCFO) 2 ☐ No **(CO – complete CRF)**
Facility ID _____

d. If HCFO, was this case selected for full CRF based on sampling frame (1:10)?
1 ☐ Yes **(Complete CRF)** 2 ☐ No **(STOP data abstraction here!)**

12. Was CDI a primary or contributing reason for patient's admission?
1 ☐ Yes 2 ☐ No 3 ☐ Not Admitted 7 ☐ Unknown

13. Were other enteric pathogens detected from stool at the same date incident *C. diff* + stool was collected?
1 ☐ *Campylobacter*
2 ☐ *Salmonella*
3 ☐ Shiga Toxin-Producing *E. coli*
4 ☐ *Shigella*
5 ☐ None
6 ☐ No other pathogens tested
7 ☐ Unknown
8 ☐ Other (*specify*): _____
9 ☐ Norovirus
10 ☐ Rotavirus

14. Exclusion criteria for CA-CDI: *(Check all that apply)* ☐ None ☐ Unknown
1 ☐ Hospitalized (overnight) at any time in the 12 weeks prior to stool collection date.
If yes, Date of most recent discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐ ☐ Unknown
Facility ID _____
1 ☐ Overnight stay in LTACH at any time in the 12 weeks prior to stool collection date
Facility ID _____
1 ☐ Residence in LTCF/SNF at any time in the 12 weeks prior to stool collection date
Facility ID _____

15. Exposures to healthcare:

a. Chronic Hemodialysis prior to incident *C. diff* + stool:
1 ☐ Yes 2 ☐ No 7 ☐ Unknown

b. Surgical procedure in the 12 weeks prior to incident *C. diff* + stool:
1 ☐ Yes 2 ☐ No 7 ☐ Unknown

c. ER visits in the 12 weeks prior to incident *C. diff* + stool:
1 ☐ Yes 2 ☐ No 7 ☐ Unknown

d. Observation/CDU stay in the 12 weeks prior to incident *C.diff* + stool:
1 ☐ Yes 2 ☐ No 7 ☐ Unknown

16. Patient outcome: 7 ☐ Unknown
1 ☐ Survived
Date of Discharge: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐
2 ☐ Died
Date of Death: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

If survived, patient was discharged to:
2 ☐ Long Term Acute Care Hospital Facility ID _____
3 ☐ Home
4 ☐ Long Term Care/ Skilled Nursing Facility Facility ID _____
5 ☐ Other _____
7 ☐ Unknown

17a. Colectomy (related to CDI):
1 ☐ Yes 2 ☐ No 7 ☐ Unknown

If YES, Date of Procedure
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

17b. ICU Admission (on the day of or after incident stool collection):
1 ☐ Yes 2 ☐ No 7 ☐ Unknown

If YES, Date of ICU Admission
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐ ☐ Unknown

17c. Any additional positive stool test for *C. diff* ≥ 2 and ≤ 8 weeks after the last *C. diff* + stool specimen?
1 ☐ Yes 2 ☐ No

If YES, Date of first recurrent specimen
Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

18. RADIOGRAPHIC FINDINGS (within 7 days before or after incident *C. diff* + stool):
1 ☐ Toxic megacolon 4 ☐ Both
2 ☐ Ileus 5 ☐ Not Done
3 ☐ Neither 7 ☐ 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 ☐ Yes 3 ☐ Not Done
2 ☐ No 7 ☐ Information not available

20.1 LABORATORY FINDINGS (within 7 days before or after incident *C. diff* + stool):

a. Albumin ≤ 2.5g/dl:
1 ☐ Yes 2 ☐ No 3 ☐ Not Done
7 ☐ Information not available

b. White blood cell count ≤ 1,000/µl:
1 ☐ Yes 2 ☐ No 3 ☐ Not Done
7 ☐ Information not available

c. White blood cell count ≥ 15,000/µl:
1 ☐ Yes 2 ☐ No 3 ☐ Not Done
7 ☐ Information not available

20.2 CLINICAL FINDINGS (within 7 days before and up to 1 day after incident *C. diff* + stool):

d. Diarrhea:
1 ☐ Diarrhea by definition (unformed or watery stool, ≥ 3/day for ≥ 1 day)
2 ☐ Diarrhea documented, but unable to determine if it is by definition
3 ☐ No Diarrhea documented
4 ☐ "Asymptomatic" documented in medical record
7 ☐ Information not available

e. Upper GI Symptoms:
1 ☐ Nausea
2 ☐ Vomiting
3 ☐ Neither
4 ☐ Both
7 ☐ Information not available

21. UNDERLYING CONDITIONS: (*Check all that apply*) If none or no chart available, check appropriate box 1 ☐ None 1 ☐ Unknown

1 ☐ AIDS
1 ☐ Chronic Cognitive Deficit
1 ☐ Chronic Kidney Disease
1 ☐ Chronic Liver Disease
1 ☐ Chronic Pulmonary Disease
1 ☐ Congenital Heart Disease
1 ☐ Congestive Heart Failure
1 ☐ Connective Tissue Disease
1 ☐ CVA/Stroke
1 ☐ Dementia
1 ☐ Diabetes
1 ☐ Diverticular Disease
1 ☐ Hemiplegia/Paraplegia
1 ☐ HIV
1 ☐ Inflammatory Bowel Disease
1 ☐ Myocardial Infarct
1 ☐ Peptic Ulcer Disease
1 ☐ Peripheral Vascular Disease
1 ☐ Primary Immunodeficiency
1 ☐ Short Gut Syndrome
1 ☐ Solid Organ Transplant
1 ☐ Stem Cell Transplant
1 ☐ Solid Tumor (non metastatic)
1 ☐ Hematologic Malignancy
1 ☐ Metastatic Solid Tumor

22. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?
1 ☐ Yes 2 ☐ No 3 ☐ Not Admitted 7 ☐ Unknown

If YES, what was the POA code assigned to it?
1 ☐ Y,Yes 3 ☐ U, Unknown 5 ☐ Missing
2 ☐ N, No 4 ☐ W, Clinically Undetermined 6 ☐ Not Applicable

23. At time of incident *C. diff* + stool, patient was:
1 ☐ Pregnant 2 ☐ Post-partum 3 ☐ Neither 7 ☐ Unknown

Delivery Date: Mo. ☐☐ Day ☐☐ Year ☐☐☐☐

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 1 ☐ Yes 2 ☐ No 7 ☐ Unknown
(e.g. Esomeprazole, Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole)

b. H2 Blockers (e.g. Famotidine, Ranitidine, Cimetidine) 1 ☐ Yes 2 ☐ No 7 ☐ Unknown

c. Immunosuppressive therapy (*Check all that apply*) 1 ☐ None 1 ☐ Unknown
1 ☐ Steroids 1 ☐ Chemotherapy 1 ☐ Other agents (*specify*): _____

d. Antimicrobial therapy (*Check all that apply*) 1 ☐ Yes, name unknown 1 ☐ None 1 ☐ Unknown

1 ☐ Amikacin
1 ☐ Amoxicillin
1 ☐ Amoxicillin/Clavulanic Acid
1 ☐ Ampicillin
1 ☐ Amp/sulb
1 ☐ Azithromycin
1 ☐ Aztreonam
1 ☐ Cefazolin
1 ☐ Cefdinir
1 ☐ Cefepime
1 ☐ Cefotaxime
1 ☐ Cefoxitin
1 ☐ Cefpodoxime
1 ☐ Ceftazidime
1 ☐ Ceftriaxone
1 ☐ Cefuroxime
1 ☐ Cephalexin
1 ☐ Ciprofloxacin
1 ☐ Clarithromycin
1 ☐ Clindamycin
1 ☐ Daptomycin
1 ☐ Doxycycline
1 ☐ Ertapenem
1 ☐ Gentamicin
1 ☐ Imipenem
1 ☐ Levofloxacin
1 ☐ Linezolid
1 ☐ Meropenem
1 ☐ Metronidazole
1 ☐ Moxifloxacin
1 ☐ Nitrofurantoin
1 ☐ Penicillin
1 ☐ Piperacillin-Tazobactam
1 ☐ Rifampin
1 ☐ Rifaximin
1 ☐ Tetracycline
1 ☐ Tigecycline
1 ☐ Tobramycin
1 ☐ Trimethoprim -Sulfamethoxazole
1 ☐ Vancomycin (IV)
1 ☐ Other (specify): _____

e. Was patient treated for <u>previous</u> suspected or confirmed CDI in the <u>prior 12 weeks</u>?
☐ Yes ☐ No ☐ Unknown

If YES, which medication was taken (check all that apply, or unknown if applicable):
☐ Metronidazole ☐ Vancomycin ☐ Fidaxomicin ☐ Other, specify: _____ ☐ Unknown

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25. CRF status:
1 ☐ Complete 3 ☐ Edited & Correct
2 ☐ Incomplete 4 ☐ Chart unavailable after 3 requests

26. Previous unique CDI episode (>8 weeks prior to this episode):
1 ☐ Yes 2 ☐ No
If yes, Previous STATEID: ☐☐☐☐☐☐☐☐☐

27. Initials of S.O: _____

29. Identified through audit
1 ☐ Yes 2 ☐ No

28. COMMENTS: _____