

Patient ID: _____ Specimen ID: _____
 Patient's Name: _____
 Address: _____ Chart Number: _____
 _____ Hospital: _____

Form Approved
 OMB No. 092-0978
 Expires xx/xx/xxxx

**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. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED	4b. FACILITY ID WHERE PATIENT TREATED
_____	_____	_____	_____	_____

5. DATE OF BIRTH: ____/____/____	6. AGE: _____	7a. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	7b. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	7c. RACE: (Check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown
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8a. DATE OF INCIDENT C. diff+ STOOL COLLECTION ____/____/____	8b. Positive diagnostic assay for C. diff+: (Check all that apply) <input type="checkbox"/> EIA <input type="checkbox"/> GDH <input type="checkbox"/> NAAT <input type="checkbox"/> Culture <input type="checkbox"/> Cytotoxin <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____	8c. Location of incident C. diff+ stool collection (Check one) <input type="checkbox"/> Hospital inpatient Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> Emergency Room <input type="checkbox"/> Outpatient <input type="checkbox"/> Observation Unit/CDU <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
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9. Was patient hospitalized on the date of or in the 6 calendar days after incident C. diff+ stool collection?
 Yes No Unknown

If YES, Date of Admission: ____/____/____

10. Where was the patient on the 3rd calendar day before the date of incident C. diff+ stool collection? (Check one)

Hospital inpatient Facility ID: _____
 LTACH Facility ID: _____
 LTCF Facility ID: _____
 Private residence
 Incarcerated
 Homeless
 Other (specify): _____
 Unknown

11. HCFO classification questions:

a. Was incident C. diff+ stool collected at least 3 calendar days after the date of hospital admission?
 Yes (HCFO - go to 11d.) No

b. Was incident C. diff+ stool collected at an outpatient setting for a LTCF resident, or in a LTCF or LTACH?
 Yes (HCFO - go to 11d.) No

c. Was the patient admitted from a LTCF or a LTACH?
 Yes (HCFO - go to 11d.) No (CO - Complete CRF)

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

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

13. Were other enteric pathogens isolated from stool collected on the date of incident C. diff+ stool collection?

Campylobacter None Norovirus
 Salmonella No other pathogens tested Rotavirus
 Shiga Toxin-Producing *E. coli* Unknown
 Shigella Other (specify): _____

14. Exclusion criteria for CA-CDI: (Check all that apply) None Unknown

Hospitalized (overnight) in the 12 weeks before the date of incident C. diff+ stool collection.
 Date of most recent discharge: ____/____/____
 Facility ID _____

Overnight stay in LTACH in the 12 weeks before the date of incident C. diff+ stool collection.
 Facility ID _____

Residence in LTCF in the 12 weeks before the date of incident C. diff+ stool collection.
 Facility ID _____

15. Exposures to Healthcare in the 12 weeks before the date of incident C. diff+ stool collection:

a. Chronic Hemodialysis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	b. Surgical procedure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	c. ER visit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	d. Observation/CDU stay <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Public reporting burden of this collection of information is estimated to average 30 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).

23. MEDICATIONS TAKEN in the 12 weeks before the date of incident C. diff+ stool collection:

a. Proton pump inhibitor Yes No Unknown

b. H2 Blockers Yes No Unknown

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

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

Amikacin Cefazolin Ceftriaxone Doxycycline Metronidazole Tetracycline

Amoxicillin Cefdinir Cefuroxime Ertapenem Moxifloxacin Tigecycline

Amoxicillin/Clavulanic Acid Cefepime Cephalexin Gentamicin Nitrofurantoin Tobramycin

Ampicillin Cefotaxime Ciprofloxacin Imipenem Penicillin Trimethoprim -Sulfamethoxazole

Amp/sulb Cefoxitin Clarithromycin Levofloxacin Piperacillin-Tazobactam Vancomycin (IV)

Azithromycin Cefpodoxime Clindamycin Linezolid Rifampin Other (specify): _____

Aztreonam Ceftazidime Daptomycin Meropenem Rifaximin

e. Was patient treated for previous suspected or confirmed CDI in the 12 weeks before the date of incident C. diff+ stool collection?

Yes No Unknown

If YES, which medication was taken (Check all that apply):

Metronidazole Vancomycin Fidaxomicin Other, (specify) _____ Unknown

24. Treatment for incident CDI No treatment Unknown treatment

Probiotics (specify): _____

Stool transplant Date: ____/____/____

Course 1 **Start Date:** ____/____/____ **Stop Date:** ____/____/____ **OR** **Duration (days)** _____

- Vancomycin (PO) Metronidazole (PO) Rifaximin
- Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
- Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
- Vancomycin taper (any route) Fidaxomicin

Course 2 **Start Date:** ____/____/____ **Stop Date:** ____/____/____ **OR** **Duration (days)** _____

- Vancomycin (PO) Metronidazole (PO) Rifaximin
- Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
- Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
- Vancomycin taper (any route) Fidaxomicin

Course 3 **Start Date:** ____/____/____ **Stop Date:** ____/____/____ **OR** **Duration (days)** _____

- Vancomycin (PO) Metronidazole (PO) Rifaximin
- Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
- Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
- Vancomycin taper (any route) Fidaxomicin

Course 4 **Start Date:** ____/____/____ **Stop Date:** ____/____/____ **OR** **Duration (days)** _____

- Vancomycin (PO) Metronidazole (PO) Rifaximin
- Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
- Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
- Vancomycin taper (any route) Fidaxomicin

- SURVEILLANCE OFFICE USE ONLY -

<p>25. CRF status:</p> <p><input type="checkbox"/> Complete</p> <p><input type="checkbox"/> Incomplete</p> <p><input type="checkbox"/> Chart unavailable after 3 requests</p>	<p>26. Previous unique CDI episode (>8 weeks before the date of incident C. diff+ stool collection):</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, Previous STATEID: _____</p>	<p>27. Initials of S.O:</p> <p>_____</p>	<p>28. Identified through audit</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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29. COMMENTS: _____
