

State ID: \_\_\_\_\_ Date of Initial Culture (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_ Surveillance Office Initials \_\_\_\_\_

**CANDIDEMIA 2017 CASE REPORT FORM**

Patient name: \_\_\_\_\_ Medical Record No.: \_\_\_\_\_  
 (Last, First, MI)  
 Address: \_\_\_\_\_ Hospital: \_\_\_\_\_  
 (Number, Street, Apt. No.)  
 \_\_\_\_\_  
 (City, State) (Zip Code) Acc No. (incident isolate): \_\_\_\_\_  
 Acc No. (subseq isolate): \_\_\_\_\_

.....cut/tear here and retain portion above at EIP site.....

**Check if not a case:**   
**Reason not a case:**  Out of catchment area  Duplicate entry  Not candidemia  Unable to verify address  Other (specify): \_\_\_\_\_

**SURVEILLANCE OFFICER INFORMATION**

<b>1. Date reported to EIP site:</b> □□/□□/□□□□	<b>3. Was case first identified through audit?</b> 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No	<b>5. Previous candidemia episode?</b> 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 5a. If yes, enter state IDs: □□□□□□□□ □□□□□□□□ □□□□□□□□	<b>6. CRF status:</b> 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Pending 4 <input type="checkbox"/> Chart unavailable	<b>7. SO's initials:</b> _____
<b>2. Date review completed:</b> □□/□□/□□□□	<b>4. Isolate available?</b> 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No			

**DEMOGRAPHICS**

**8. State ID:** □□□□□□□□ **9. State:** \_\_\_\_\_ **10. County:** \_\_\_\_\_

**11. Lab ID where positive culture was identified:** □□□□□□

<b>12. Date of birth (mm/dd/yyyy):</b> □□/□□/□□□□	<b>13. Age:</b> □□□ 1 <input type="checkbox"/> days 2 <input type="checkbox"/> mos 3 <input type="checkbox"/> yrs	<b>14. Sex:</b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Check if transgender
<b>15. Race (check all that apply):</b> <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Unknown		<b>16. Ethnic origin:</b> 1 <input type="checkbox"/> Hispanic/Latino 2 <input type="checkbox"/> Not Hispanic/Latino 9 <input type="checkbox"/> Unknown

**LABORATORY DATA**

**17. Date initial positive *Candida* blood culture was drawn (mm/dd/yyyy):** □□/□□/□□□□

<b>18. Source of initial positive <i>Candida</i> blood culture (check all that apply):</b> 1 <input type="checkbox"/> Blood, from CVC 2 <input type="checkbox"/> Blood, from peripheral stick 3 <input type="checkbox"/> Blood, not specified 4 <input type="checkbox"/> Other (specify): _____ 9 <input type="checkbox"/> Unknown	<b>19. <i>Candida</i> species from initial positive blood culture (check all that apply):</b> 1 <input type="checkbox"/> <i>Candida albicans</i> (CA) 6 <input type="checkbox"/> <i>Candida tropicalis</i> (CT) 2 <input type="checkbox"/> <i>Candida glabrata</i> (CG) 7 <input type="checkbox"/> <i>Candida</i> , other (CO) specify: _____ 3 <input type="checkbox"/> <i>Candida krusei</i> (CK) 8 <input type="checkbox"/> <i>Candida</i> , gram tube negative/non albicans (CGN) 4 <input type="checkbox"/> <i>Candida lusitaniae</i> (CL) 9 <input type="checkbox"/> <i>Candida</i> species (CS) 5 <input type="checkbox"/> <i>Candida parapsilosis</i> (CP) 10 <input type="checkbox"/> Pending
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**20. Antifungal susceptibility testing (check here  if no testing done/no test reports available):**

Date of culture	Species	Drug	MIC	Interpretation
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	3 <input type="checkbox"/> CK	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	4 <input type="checkbox"/> CL	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	5 <input type="checkbox"/> CP	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	6 <input type="checkbox"/> CT	Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	7 <input type="checkbox"/> CO	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	8 <input type="checkbox"/> CGN	Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	9 <input type="checkbox"/> CS	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	10 <input type="checkbox"/> Pending			
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	3 <input type="checkbox"/> CK	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
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	9 <input type="checkbox"/> CS	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NS
	10 <input type="checkbox"/> Pending			

**21. Additional non-*Candida* organisms isolated from blood cultures on the same day as initial culture date:** 1  Yes 0  No 9  Unknown

21a. If yes, additional organisms (Enter up to 3 pathogens): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**22. Any subsequent positive *Candida* blood cultures in the 30 days after initial culture date?** 1  Yes 0  No 9  Unknown

22a. If yes, provide dates of all subsequent positive *Candida* blood cultures and select the species:

Date Drawn (mm/dd/yyyy)	Species identified*
<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CK <input type="checkbox"/> CL <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CO: _____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CK <input type="checkbox"/> CL <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CO: _____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CK <input type="checkbox"/> CL <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CO: _____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
<input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CK <input type="checkbox"/> CL <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CO: _____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending

\*Attach additional MIC page if additional *Candida* species (different from original), if another *C. glabrata* (even if original was *C. glabrata*), or if same *Candida* species (if no AFST results available for original)

**23. Documented negative *Candida* blood culture in the 30 days after initial culture date?** 1  Yes 0  No 9  Unknown

23a. If yes, date of first negative *Candida* blood culture: / /

**24. Other known sites of *Candida* infection or colonization in the 7 days before or 3 days after initial culture date?**

1  Yes 0  No 9  Unknown

24a. If yes, source (check all that apply):

- |   |  |  |
|---|--|--|
| 1 <input type="checkbox"/> Peritoneal fluid or abdominal cavity | 4 <input type="checkbox"/> Pleural fluid | 7 <input type="checkbox"/> Skin                        |
| 2 <input type="checkbox"/> Urine                                | 5 <input type="checkbox"/> CSF           | 8 <input type="checkbox"/> Other site (specify): _____ |
| 3 <input type="checkbox"/> Respiratory specimen                 | 6 <input type="checkbox"/> Bone          |  |

**MEDICAL ENCOUNTERS**

**25. Is patient currently hospitalized or was patient hospitalized in the 7 days after initial culture date?** 1  Yes 0  No 9  Unknown

25a. If yes, Treatment hospital ID:   Unknown Date of admission: / /   Unknown Date of discharge: / /   Unknown

**26. Where was the patient located prior to admission? (Check one)**

- |  |   |   |
|--|---|---|
| 1 <input type="checkbox"/> Private residence   | 3 <input type="checkbox"/> LTCF Facility ID: _____  | 6 <input type="checkbox"/> Incarcerated           |
| 2 <input type="checkbox"/> Hospital Inpatient (If transferred from another hospital, facility ID: _____) | 4 <input type="checkbox"/> LTACH Facility ID: _____ | 7 <input type="checkbox"/> Other (specify): _____ |
|  | 5 <input type="checkbox"/> Homeless                 | 9 <input type="checkbox"/> Unknown                |

**27. Patient outcome:** 1  Survived 0  Died 9  Unknown

27a. If survived, Date of last patient encounter: / /   Unknown 27b. If died, Date of death: / /   Unknown

**28. If survived, discharged to:**

- |   |   |
|---|---|
| 0 <input type="checkbox"/> Not applicable (i.e., patient died, or not hospitalized) | 3 <input type="checkbox"/> Long term acute care hospital Facility ID: _____ |
| 1 <input type="checkbox"/> Private residence  | 5 <input type="checkbox"/> Other, specify: _____                            |
| 4 <input type="checkbox"/> Another acute care hospital Facility ID: _____           | 9 <input type="checkbox"/> Unknown  |
| 2 <input type="checkbox"/> Long term care facility Facility ID: _____               |   |

**29. Did the patient require a prior hospitalization in the 90 days before, initial culture date?** 1  Yes 0  No 9  Unknown

**UNDERLYING CONDITIONS**

**30. Underlying conditions (Check all that apply):**  None  Unknown

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Alcohol abuse, current             | <input type="checkbox"/> Congestive Heart Failure                 | <input type="checkbox"/> Neurological Condition              |
| <input type="checkbox"/> Chronic Cognitive Deficit/Dementia | <input type="checkbox"/> Connective Tissue Disease                | <input type="checkbox"/> Obesity or Morbid Obesity           |
| <input type="checkbox"/> Chronic Kidney Disease             | <input type="checkbox"/> CVA/Stroke/TIA                           | <input type="checkbox"/> Pepcid Ulcer Disease                |
| <input type="checkbox"/> Creatinine ≥3                      | <input type="checkbox"/> Cystic Fibrosis                          | <input type="checkbox"/> Peripheral Vascular Disease (PVD)   |
| <input type="checkbox"/> Chronic Liver Disease              | <input type="checkbox"/> Diabetes Mellitus                        | <input type="checkbox"/> Plegias/Paralysis                   |
| <input type="checkbox"/> Cirrhosis                          | <input type="checkbox"/> With Chronic Complications               | <input type="checkbox"/> Hemiplegia                          |
| <input type="checkbox"/> Ascites                            | <input type="checkbox"/> HIV                                      | <input type="checkbox"/> Paraplegia                          |
| <input type="checkbox"/> Hepatic Encephalopathy             | <input type="checkbox"/> AIDS/CD4 count <200                      | <input type="checkbox"/> Quadriplegia                        |
| <input type="checkbox"/> Variceal Bleeding                  | <input type="checkbox"/> Injection Drug Use, Current              | <input type="checkbox"/> Pregnant                            |
| <input type="checkbox"/> Hepatitis C                        | <input type="checkbox"/> Inflammatory Bowel Disease               | <input type="checkbox"/> Primary Immunodeficiency            |
| <input type="checkbox"/> Chronic Pulmonary Disease          | <input type="checkbox"/> Malignancy, Hematologic                  | <input type="checkbox"/> Smoker, Current                     |
| <input type="checkbox"/> Chronic Ulcer or Chronic Wound     | <input type="checkbox"/> Malignancy, Solid Organ (non-metastatic) | <input type="checkbox"/> Transplant, Hematopoietic Stem Cell |
| <input type="checkbox"/> Decubitus/Pressure Ulcer           | <input type="checkbox"/> Malignancy, Solid Organ (metastatic)     | <input type="checkbox"/> Transplant, Solid Organ             |
| <input type="checkbox"/> Surgical Wound                     | <input type="checkbox"/> Myocardial infarction                    |  |
| <input type="checkbox"/> Burn                               |   |  |
| <input type="checkbox"/> Other (specify): _____             |   |  |

**OTHER CONDITIONS**

31. For cases ≤ 1 year of age: Gestational age at birth: \_\_\_\_\_ wks 9 Unknown AND Birth weight: \_\_\_\_\_ gms 9 Unknown

32. Infection with *Clostridium difficile* in the 90 days before or 30 days after initial culture date:

1 Yes 0 No 9 Unknown

32a. If yes, date of first *C. diff* diagnosis: // Unknown

33. Surgeries in the 90 days before initial culture date:

- Abdominal surgery
- Non-abdominal surgery (specify): \_\_\_\_\_
- No surgery

34. Pancreatitis in the 90 days before initial culture date:

- 1 Yes
- 0 No

35. Was the patient neutropenic\* 2 days before, the day before, or on the day of initial culture date?

1 Yes 0 No 9 Unknown (no WBC days -2 or 0, or no differential)

35a. If yes, date of neutropenia (mm/dd/yyyy): //

\*Neutropenia: ANC ≤ 500 OR calculated as: WBC count \* (% polys + % bands) ≤ 500

Laboratory-calculated ANC: \_\_\_\_\_ \* (% \_\_\_\_\_ + % \_\_\_\_\_) = \_\_\_\_\_

36. Was the patient ever in an ICU in the 14 days before initial culture date?

1 Yes 0 No 9 Unknown

37. Was the patient ever in an ICU in the 14 days after initial culture date?

1 Yes 0 No 9 Unknown

38. Did the patient have a CVC 2 days before, the day before, or on the day of initial culture date?

1 Yes 2 No 3 Had CVC but can't find dates 9 Unknown

38a. If yes, CVC type: (Check all that apply)

- 1 Nontunneled CVCs
- 2 Tunneled CVCs
- 3 Implantable ports
- 4 Peripherally inserted central catheter (PICC)
- 5 Other (specify): \_\_\_\_\_
- 6 Other (specify): \_\_\_\_\_
- 7 Unknown
- 8 Unknown
- 9 Unknown

38b. Were CVCs removed or changed in the 7 days after initial culture date?

- 1 Yes
- 2 No
- 3 CVC removed, but can't find dates
- 4 Died or discharged before indwelling catheter replaced
- 5 Died or discharged before indwelling catheter replaced
- 6 Unknown
- 7 Unknown
- 8 Unknown
- 9 Unknown

39. Did the patient have a midline catheter 2 days before, the day before, or on the day of initial culture date?

1 Yes 0 No 9 Unknown

**MEDICATIONS**

40. Did the patient receive systemic antibacterial medication in the 14 days before initial culture date?

1 Yes 0 No 9 Unknown

41. Did the patient receive total parenteral nutrition (TPN) in the 14 days before initial culture date?

1 Yes 0 No 9 Unknown

42. Did the patient receive systemic antifungal medication during hospitalization, including the 14 days before initial culture date (even if a different hospitalization)?

1 Yes (if Yes, fill out question 45) 0 No 9 Unknown

43. Was the patient prescribed systemic antifungal medication to treat candidemia, or was medication ongoing, at hospital discharge?

1 Yes (if Yes, fill out question 46) 0 No 9 Unknown

44. If antifungal medication was not given to treat current candidemia infection, what was the reason?

- 1 Patient died before culture result available to clinicians
- 2 Comfort care only measures were instituted
- 3 Patient discharged before culture result available to clinician
- 4 Medical records indicated culture result not clinically significant
- 5 Other reason documented in medical records, specify: \_\_\_\_\_
- 6 Unknown

-----IF ANY ANTIFUNGAL MEDICATION WAS GIVEN, COMPLETE NEXT PAGE. OTHERWISE END OF CHART REVIEW FORM-----

**ANTIFUNGAL MEDICATION TABLES**

Drug abbreviations (**NOTE: Please use abbreviation when entering data**):

Amphotericin – any IV formulation (Amphotec, Amphocil, Fungizone, Abelcet, AmBiosome, etc.)=AMBIV  
 Amphotericin – any inhaled formulation ( )=AMBINH  
 Anidulafungin (Eraxis)=ANF  
 Caspofungin (Cancidas)=CAS

Fluconazole (Diflucan)=FLC  
 Flucytosine (5FC)=5FC  
 Isavuconazole (cresemba)=ISU  
 Itraconazole (Sporanox)=ITC  
 Micafungin (Mycamine)=MFG

Other=OTH  
 Posaconazole (Noxafil)=PSC  
 UNKNOWN DRUG=UNK  
 Voriconazole (Vfend)=VRC

**45. ANTIFUNGAL MEDICATION DURING HOSPITALIZATION, INCLUDING THE 14 DAYS BEFORE INITIAL CULTURE DATE (EVEN IF A DIFFERENT HOSPITALIZATION)**

a. Drug Abbrev	b. First date given (mm/dd/yyyy)	c. Date start unknown	d. Last date given (mm/dd/yyyy)	e. Date stop unknown	f. Indication (Check if for prophylaxis)	g. Reason for stopping*
	□□/□□/□□□□	□	□□/□□/□□□□	□	<input type="checkbox"/> Prophylaxis	
	□□/□□/□□□□	□	□□/□□/□□□□	□	<input type="checkbox"/> Prophylaxis	
	□□/□□/□□□□	□	□□/□□/□□□□	□	<input type="checkbox"/> Prophylaxis	

\*Reasons for stopping antifungal treatment include: (1) completion of treatment; (2) started on different antifungal; (3) hospital discharge; (4) withdrawal of care/transition to comfort care only; (5) death; (6) other; (7) no additional records/lost to follow-up; (8) not applicable, no therapy given; and (9) unknown.

\*\*If a medication is given before initial culture date and the patient continues taking that medication after initial culture date, then put initial culture date as last date given for Q46 and as first date given for Q47.

**46. ANTIFUNGAL MEDICATION ONGOING OR PRESCRIBED AT DISCHARGE**

a. Drug Abbrev	b. Prescription start date*(mm/dd/yyyy)	c. Date start unknown	d. Prescription end date (mm/dd/yyyy)	e. Date stop unknown	f. Total duration of post-discharge treatment (days)
	□□/□□/□□□□	□	□□/□□/□□□□	□	
	□□/□□/□□□□	□	□□/□□/□□□□	□	
	□□/□□/□□□□	□	□□/□□/□□□□	□	

\*Put discharge date as prescription start date if only given, for example, the prescription name x14.

-----END OF CHART REVIEW FORM-----

**AFST results for additional *Candida* isolates**

Antifungal susceptibility testing (check here  if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation				
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	3 <input type="checkbox"/> CK	Caspofungin (Cancidas)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	4 <input type="checkbox"/> CL	Fluconazole (Diflucan)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	5 <input type="checkbox"/> CP	Flucytosine (5FC)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	6 <input type="checkbox"/> CT	Itraconazole (Sporanox)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	7 <input type="checkbox"/> CO	Micafungin (Mycamine)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	8 <input type="checkbox"/> CGN	Posaconazole (Noxafil)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	9 <input type="checkbox"/> CS	Voriconazole (Vfend)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	10 <input type="checkbox"/> Pending			<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
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	9 <input type="checkbox"/> CS	Voriconazole (Vfend)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	10 <input type="checkbox"/> Pending			<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS

Antifungal susceptibility testing (check here  if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation				
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
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	9 <input type="checkbox"/> CS	Voriconazole (Vfend)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	10 <input type="checkbox"/> Pending			<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	3 <input type="checkbox"/> CK	Caspofungin (Cancidas)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	4 <input type="checkbox"/> CL	Fluconazole (Diflucan)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	5 <input type="checkbox"/> CP	Flucytosine (5FC)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	6 <input type="checkbox"/> CT	Itraconazole (Sporanox)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	7 <input type="checkbox"/> CO	Micafungin (Mycamine)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	8 <input type="checkbox"/> CGN	Posaconazole (Noxafil)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	9 <input type="checkbox"/> CS	Voriconazole (Vfend)		<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS
	10 <input type="checkbox"/> Pending			<input type="checkbox"/> S	<input type="checkbox"/> SDD	<input type="checkbox"/> I	<input type="checkbox"/> R	<input type="checkbox"/> NS