

Patient ID: \_\_\_\_\_ Specimen ID: \_\_\_\_\_  
 Patient's Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Chart Number: \_\_\_\_\_  
 \_\_\_\_\_ Hospital: \_\_\_\_\_

Form Approved  
 OMB No. 0920-0978  
 Expires 05/31/2021

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



<b>1. STATE:</b> <small>(Residence of Patient)</small>	<b>2. COUNTY:</b> <small>(Residence of Patient)</small>	<b>3. STATE ID:</b>	<b>4a. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED</b>	<b>4b. FACILITY ID WHERE PATIENT TREATED</b>
_____	_____	_____	_____	_____
<b>5. DATE OF BIRTH:</b> ____/____/____	<b>6. AGE:</b> _____	<b>7a. SEX:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>7b. ETHNIC ORIGIN:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	<b>7c. RACE: (Check all that apply)</b> <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
<b>8a. DATE OF INCIDENT C. diff+ STOOL COLLECTION</b> ____/____/____	<b>8b. Positive diagnostic assay for C. diff+: (Check all that apply)</b> <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): _____		<b>8c. Location of incident C. diff+ stool collection (Check one)</b> <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	
<b>9. Was patient hospitalized on the date of or in the 6 calendar days after incident C. diff+ stool collection?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If YES, Date of Admission: ____/____/____				
<b>10. Where was the patient on the 3<sup>rd</sup> calendar day before the date of incident C. diff+ stool collection? (Check one)</b> <input type="checkbox"/> Hospital inpatient      Facility ID: _____ <input type="checkbox"/> LTACH      Facility ID: _____ <input type="checkbox"/> LTCF      Facility ID: _____ <input type="checkbox"/> Private residence <input type="checkbox"/> Incarcerated <input type="checkbox"/> Homeless <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			<b>11. HCFO classification questions:</b> <b>a. Was incident C. diff+ stool collected at least 3 calendar days after the date of hospital admission?</b> <input type="checkbox"/> Yes (HCFO - go to 11d.) <input type="checkbox"/> No <b>b. Was incident C. diff+ stool collected at an outpatient setting for a LTCF resident, or in a LTCF or LTACH?</b> <input type="checkbox"/> Yes (HCFO - go to 11d.) <input type="checkbox"/> No <b>c. Was the patient admitted from a LTCF or a LTACH?</b> <input type="checkbox"/> Yes (HCFO - go to 11d.) <input type="checkbox"/> No (CO - Complete CRF) Facility ID: _____ <b>d. If HCFO, was this case sampled for full CRF based on sampling frame (1:10)?</b> <input type="checkbox"/> Yes (Complete CRF) <input type="checkbox"/> No (STOP data abstraction here!)	
<b>12. Was CDI a primary or contributing reason for patient's admission?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown			<b>14. Exclusion criteria for CA-CDI: (Check all that apply)</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Hospitalized (overnight) in the 12 weeks before the date of incident C. diff+ stool collection. Date of most recent discharge: ____/____/____ <input type="checkbox"/> Unknown Facility ID _____ <input type="checkbox"/> Overnight stay in LTACH in the 12 weeks before the date of incident C. diff+ stool collection. Facility ID _____ <input type="checkbox"/> Residence in LTCF in the 12 weeks before the date of incident C. diff+ stool collection. Facility ID _____	
<b>13. Were other enteric pathogens isolated from stool collected on the date of incident C. diff+ stool collection?</b> <input type="checkbox"/> <i>Campylobacter</i> <input type="checkbox"/> None <input type="checkbox"/> Norovirus <input type="checkbox"/> <i>Salmonella</i> <input type="checkbox"/> No other pathogens tested <input type="checkbox"/> Rotavirus <input type="checkbox"/> Shiga Toxin-Producing <i>E. coli</i> <input type="checkbox"/> Unknown <input type="checkbox"/> <i>Shigella</i> <input type="checkbox"/> Other (specify): _____				
<b>15. Exposures to Healthcare in the 12 weeks before the date of incident C. diff+ stool collection:</b>				
<b>a. Chronic Hemodialysis</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>b. Surgical procedure</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>c. ER visit</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>d. Observation/CDU stay</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				

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><b>25. CRF status:</b></p> <p><input type="checkbox"/> Complete</p> <p><input type="checkbox"/> Incomplete</p> <p><input type="checkbox"/> Chart unavailable after 3 requests</p>	<p><b>26. Previous unique CDI episode</b> (&gt;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><b>27. Initials of S.O:</b></p> <p>_____</p>	<p><b>28. Identified through audit</b></p> <p><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
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**29. COMMENTS:** \_\_\_\_\_

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