

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**



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
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	
9. Was patient hospitalized on the date of or in the 6 calendar days after incident C. diff+ stool collection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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) <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			11. HCFO classification questions: a. Was incident C. diff+ stool collected at least 3 calendar days after the date of hospital admission? <input type="checkbox"/> Yes (HCFO - go to 11d.) <input type="checkbox"/> No b. Was incident C. diff+ stool collected at an outpatient setting for a LTCF resident, or in a LTCF or LTACH? <input type="checkbox"/> Yes (HCFO - go to 11d.) <input type="checkbox"/> No c. Was the patient admitted from a LTCF or a LTACH? <input type="checkbox"/> Yes (HCFO - go to 11d.) <input type="checkbox"/> No (CO - Complete CRF) Facility ID: _____ d. If HCFO, was this case sampled for full CRF based on sampling frame (1:10)? <input type="checkbox"/> Yes (Complete CRF) <input type="checkbox"/> No (STOP data abstraction here!)	
12. Was CDI a primary or contributing reason for patient's admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown			14. Exclusion criteria for CA-CDI: (Check all that apply) <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 _____	
13. Were other enteric pathogens isolated from stool collected on the date of incident C. diff+ stool collection? <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): _____				
15. Exposures to Healthcare in the 12 weeks before the date of incident C. diff+ stool collection: a. Chronic Hemodialysis b. Surgical procedure c. ER visit d. Observation/CDU stay <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <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).

<p>16. Patient outcome <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Survived <input type="checkbox"/> Died</p> <p>If survived: If died:</p> <p>Date of discharge: ___/___/___ Date of death: ___/___/___</p> <p>Discharged to:</p> <p><input type="checkbox"/> LTACH Facility ID: _____</p> <p><input type="checkbox"/> LTCF Facility ID: _____</p> <p><input type="checkbox"/> Private residence</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> Unknown</p>		<p>17a. Colectomy (related to CDI): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If YES, Date of Procedure ___/___/___</p> <hr/> <p>17b. ICU Admission (in the 2 calendar days before, the day of, or the 6 calendar days after the date of incident <i>C. diff</i>+ stool collection):</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If YES, Date of ICU Admission ___/___/___</p> <hr/> <p>17c. Any additional positive stool test for <i>C. diff</i> ≥ 2 and ≤ 8 weeks after the date of incident <i>C. diff</i>+ stool collection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If YES, Date of first recurrent specimen ___/___/___</p>
<p>18. RADIOGRAPHIC FINDINGS (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident <i>C. diff</i>+ stool collection):</p> <p><input type="checkbox"/> Toxic megacolon <input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Ileus <input type="checkbox"/> Radiology not performed</p> <p><input type="checkbox"/> Both toxic megacolon and ileus <input type="checkbox"/> Information not available</p>		<p>19. Was pseudomembranous colitis listed in the surgical pathology, endoscopy, or autopsy report in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident <i>C. diff</i>+ stool collection?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> No <input type="checkbox"/> Information not available</p>
<p>20.1 LABORATORY FINDINGS (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident <i>C. diff</i>+ stool collection):</p> <p>a. Albumin ≤ 2.5g/dl:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> Information not available</p> <p>b. White blood cell count ≤ 1,000/μl:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> Information not available</p> <p>c. White blood cell count ≥ 15,000/μl:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> Information not available</p>	<p>20.2 Clinical findings</p> <p>d. Symptoms (in the 6 calendar days before, the day of, or 1 calendar day after the date of incident <i>C. diff</i>+ stool collection) (Check all that apply)</p> <p><input type="checkbox"/> Diarrhea by definition (unformed or watery stool, ≥ 3/day for ≥ 1 day) <input type="checkbox"/> "Asymptomatic" documented in medical record</p> <p><input type="checkbox"/> Diarrhea documented, but unable to determine if it is by definition <input type="checkbox"/> No diarrhea, nausea, or vomiting documented</p> <p><input type="checkbox"/> Nausea <input type="checkbox"/> Information not available</p> <p><input type="checkbox"/> Vomiting</p> <p>e. Other findings (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident <i>C. diff</i>+ stool collection)</p> <p><input type="checkbox"/> Toxic megacolon <input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Ileus <input type="checkbox"/> Information not available</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p>	
<p>21. UNDERLYING CONDITIONS: (Check all that apply) <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> AIDS <input type="checkbox"/> Dementia <input type="checkbox"/> Primary Immunodeficiency</p> <p><input type="checkbox"/> Chronic Cognitive Deficit <input type="checkbox"/> Diabetes <input type="checkbox"/> Short Gut Syndrome</p> <p><input type="checkbox"/> Chronic Kidney Disease <input type="checkbox"/> Diverticular Disease <input type="checkbox"/> Solid Organ Transplant</p> <p><input type="checkbox"/> Chronic Liver Disease <input type="checkbox"/> Hemiplegia/Paraplegia <input type="checkbox"/> Stem Cell Transplant</p> <p><input type="checkbox"/> Chronic Pulmonary Disease <input type="checkbox"/> HIV <input type="checkbox"/> Solid Tumor (non metastatic)</p> <p><input type="checkbox"/> Congenital Heart Disease <input type="checkbox"/> Inflammatory Bowel Disease <input type="checkbox"/> Hematologic Malignancy</p> <p><input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Myocardial Infarct <input type="checkbox"/> Metastatic Solid Tumor</p> <p><input type="checkbox"/> Connective Tissue Disease <input type="checkbox"/> Peptic Ulcer Disease <input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> CVA/Stroke <input type="checkbox"/> Peripheral Vascular Disease</p>		
<p>22. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown If YES, what was the POA code assigned to it?</p> <p style="margin-left: 300px;"><input type="checkbox"/> Y, Yes <input type="checkbox"/> U, Unknown <input type="checkbox"/> Missing</p> <p style="margin-left: 300px;"><input type="checkbox"/> N, No <input type="checkbox"/> W, Clinically Undetermined <input type="checkbox"/> Not Applicable</p>		

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: _____
