

1. PATIENT ID: _____	2. STATE ID: _____
3. SPECIMEN ID: _____	4. DATE OF INCIDENT <i>C. diff</i>+ STOOL COLLECTION: ____/____/____

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

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



Patient's Name: _____ (Last, First, M.I.) Phone No.: () _____ - _____

Address: _____ (Number, Street, Apt. No.) Chart Number: _____

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

5. STATE: (Residence of Patient)	6. COUNTY: (Residence of Patient)	7. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED	8. FACILITY ID WHERE PATIENT TREATED	9. POSITIVE DIAGNOSTIC ASSAY FOR <i>C. diff</i> <i>(Check all that apply)</i> <input type="checkbox"/> EIA <input type="checkbox"/> Cytotoxin <input type="checkbox"/> Unknown <input type="checkbox"/> Culture <input type="checkbox"/> NAAT <input type="checkbox"/> GDH <input type="checkbox"/> Other (<i>specify</i>): _____
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10. DATE OF BIRTH: ____/____/____ <input type="checkbox"/> Unknown	11. AGE: (Years) _____	12. SEX AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender	13. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	14. RACE: (<i>Check all that apply</i>) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown
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15. Was patient hospitalized on the date of or in the 6 calendar days after the date of incident *C. diff*+ stool collection? Yes No Unknown

15a. If YES, Date of Admission: ____/____/____ Unknown

16. Where was the patient located on the 3rd calendar day before the date of incident *C. diff*+ stool collection?

<input type="checkbox"/> Private Residence	<input type="checkbox"/> Homeless
<input type="checkbox"/> LTCF Facility ID: _____	<input type="checkbox"/> Incarcerated
<input type="checkbox"/> Hospital Inpatient Facility ID: _____	<input type="checkbox"/> Other (<i>specify</i>): _____

16a. Was patient transferred from this hospital? Yes No Unknown Unknown

LTACH Facility ID: _____

17. Location of incident *C. diff*+ stool collection

<input type="checkbox"/> Outpatient Facility ID: _____	<input type="checkbox"/> Hospital Inpatient Facility ID: _____	<input type="checkbox"/> LTCF Facility ID: _____
<input type="checkbox"/> Emergency room	<input type="checkbox"/> ICU	<input type="checkbox"/> LTACH Facility ID: _____
<input type="checkbox"/> Clinic/doctor's office	<input type="checkbox"/> OR	<input type="checkbox"/> Autopsy
<input type="checkbox"/> Dialysis center	<input type="checkbox"/> Radiology	<input type="checkbox"/> Other (<i>specify</i>): _____
<input type="checkbox"/> Surgery	<input type="checkbox"/> Other inpatient	<input type="checkbox"/> Unknown
<input type="checkbox"/> Observation/ Clinical decision unit		
<input type="checkbox"/> Other outpatient		

18. HCFO classification questions:

18a. Was incident *C. diff*+ stool collected at least 3 calendar days after the date of hospital admission?
 Yes (HCFO - go to 18d) No

18b. Was incident *C. diff*+ stool collected in an outpatient setting for a LTCF resident, or in a LTCF or LTACH?
 Yes (HCFO - go to 18d) No

18c. Was the patient admitted from a LTCF or a LTACH?
 Yes (HCFO - go to 18d) No (CO - complete CRF)
Facility ID: _____

18d. If HCFO, was this case sampled for full CRF?
 Yes (Complete CRF) No (STOP data abstraction here!)

1 2 3 4 5 6 7 8 9 10

19. Patient Outcome Unknown

Survived Died

19a. Date of discharge: ____/____/____ Unknown **19c. Date of death:** ____/____/____ Unknown

Left against medical advice (AMA)

19b. If survived, discharged to:

Private residence

LTCF Facility ID: _____

LTACH Facility ID: _____

Other (*specify*): _____

Unknown

Public reporting burden of this collection of information is estimated to average 35 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).

20. Exposures to healthcare in the 12 weeks before the date of incident C. diff+ stool collection

20a. Previous hospitalization Yes No Unknown Facility ID: _____
20a.1 If yes, date of discharge closest to date of incident C. diff+ stool collection:
____/____/____ Unknown

20b. Overnight stay in LTACH Yes No Unknown Facility ID: _____
20c. Overnight stay in LTCF Yes No Unknown Facility ID: _____

20d. Chronic dialysis Yes No Unknown
20d.1 Type Hemodialysis Peritoneal Unknown

20e. Surgery Yes No Unknown
20f. ER visit Yes No Unknown
20g. Observation/CDU stay Yes No Unknown

21. UNDERLYING CONDITIONS: (Check all that apply) None Unknown

Chronic lung disease <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Chronic pulmonary disease	Liver disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Ascites <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Variceal bleeding <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Treated, in SVR <input type="checkbox"/> Current, chronic	Plegias/Paralysis <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia
Chronic metabolic disease <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> With chronic complications	Malignancy <input type="checkbox"/> Malignancy, hematologic <input type="checkbox"/> Malignancy, solid organ (non-metastatic) <input type="checkbox"/> Malignancy, solid organ (metastatic)	Renal disease <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____mg/dl
Cardiovascular disease <input type="checkbox"/> CVA/Stroke/TIA <input type="checkbox"/> Congenital heart disease <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Peripheral vascular disease (PVD)	Neurologic condition <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Chronic cognitive deficit <input type="checkbox"/> Dementia <input type="checkbox"/> Epilepsy/seizure/seizure disorder <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other (specify): _____	Skin condition <input type="checkbox"/> Burn <input type="checkbox"/> Decubitus/pressure ulcer <input type="checkbox"/> Surgical wound <input type="checkbox"/> Other chronic ulcer or chronic wound <input type="checkbox"/> Other (specify): _____
Gastrointestinal disease <input type="checkbox"/> Diverticular disease <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Short gut syndrome		Other <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Obesity or morbid obesity <input type="checkbox"/> Pregnancy
Immunocompromised condition <input type="checkbox"/> HIV <input type="checkbox"/> AIDS/CD4 count < 200 <input type="checkbox"/> Primary immunodeficiency <input type="checkbox"/> Transplant, hematopoietic stem cell <input type="checkbox"/> Transplant, solid organ		

22a. Weight _____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unknown	22b. Height _____ ft _____ in OR _____ cm <input type="checkbox"/> Unknown	22c. BMI _____ <input type="checkbox"/> Unknown
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23. Substance Use

23a. Smoking: <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-Nicotine Delivery System <input type="checkbox"/> Marijuana	23b. Alcohol abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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23c. Other substances: (Check all that apply) None Unknown

<input type="checkbox"/> Marijuana/cannabinoid (other than smoking)	Documented Use Disorder (DUD)/Abuse? <input type="checkbox"/> DUD or Abuse	Mode of delivery: (Check all that apply)
<input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin)	<input type="checkbox"/> DUD or Abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	<input type="checkbox"/> DUD or Abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Cocaine or methamphetamine	<input type="checkbox"/> DUD or Abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> DUD or Abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown substance	<input type="checkbox"/> DUD or Abuse	<input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown

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

25. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?
 Yes No Not Admitted Unknown

25a. If YES, what was the POA code assigned to it?

<input type="checkbox"/> Y, Yes	<input type="checkbox"/> W, Clinically Undetermined
<input type="checkbox"/> N, No	<input type="checkbox"/> Missing
<input type="checkbox"/> U, Unknown	<input type="checkbox"/> Not Applicable

26. Was the patient in an ICU on the day of or in the 6 days after the date of incident C. diff+ stool collection?
 Yes No Unknown

26a. If YES, date of ICU admission:
____/____/____
 Unknown

