

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

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

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



Patient's Name: _____ <small>(Last, First, M.I.)</small>	Phone No.: (     ) _____ - _____
Address: _____ <small>(Number, Street, Apt. No.)</small>	Chart Number: _____
_____ (City) _____ (State) _____ (Zip Code)	Hospital: _____

<b>5. STATE:</b> <small>(Residence of Patient)</small>	<b>6. COUNTY:</b> <small>(Residence of Patient)</small>	<b>7. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED</b>	<b>8. FACILITY ID WHERE PATIENT TREATED</b>	<b>9. POSITIVE DIAGNOSTIC ASSAY FOR <i>C. diff</i></b> <small>(Check all that apply)</small> <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 (specify): _____
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<b>10. DATE OF BIRTH:</b> ____/____/____ <input type="checkbox"/> Unknown	<b>11. AGE:</b> <small>(Years)</small> ____	<b>12. SEX AT BIRTH:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender	<b>13. ETHNIC ORIGIN:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	<b>14. RACE:</b> <small>(Check all that apply)</small> <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 3<sup>rd</sup> 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 (specify): _____

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

<b>Chronic lung disease</b> <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Chronic pulmonary disease	<b>Liver disease</b> <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	<b>Plegias/Paralysis</b> <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia
<b>Chronic metabolic disease</b> <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> With chronic complications	<b>Malignancy</b> <input type="checkbox"/> Malignancy, hematologic <input type="checkbox"/> Malignancy, solid organ (non-metastatic) <input type="checkbox"/> Malignancy, solid organ (metastatic)	<b>Renal disease</b> <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____mg/dl
<b>Cardiovascular disease</b> <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)	<b>Neurologic condition</b> <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): _____	<b>Skin condition</b> <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): _____
<b>Gastrointestinal disease</b> <input type="checkbox"/> Diverticular disease <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Short gut syndrome		<b>Other</b> <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Obesity or morbid obesity <input type="checkbox"/> Pregnancy
<b>Immunocompromised condition</b> <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		

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

<b>23a. Smoking:</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-Nicotine Delivery System <input type="checkbox"/> Marijuana	<b>23b. Alcohol abuse:</b> <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"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown
<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
<input type="checkbox"/> N, No	<input type="checkbox"/> Undetermined
<input type="checkbox"/> U, Unknown	<input type="checkbox"/> Missing
	<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

<p><b>27. Symptoms</b> (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"/> "Asymptomatic" documented in medical record</p> <p><input type="checkbox"/> Diarrhea by definition (unformed or watery stool, <math>\geq 3/\text{day}</math> for <math>\geq 1</math> day)</p> <p><input type="checkbox"/> Diarrhea documented, but unable to determine if it is by definition</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> No diarrhea, nausea, or vomiting documented</p> <p><input type="checkbox"/> Information not available</p>	<p><b>28. Toxic megacolon and ileus</b> (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> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; padding: 5px;"> <p><b>28a. Radiographic findings</b></p> <p><input type="checkbox"/> Toxic megacolon</p> <p><input type="checkbox"/> Ileus</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p> <p><input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Radiology not performed</p> <p><input type="checkbox"/> Information not available</p> </td> <td style="width:50%; padding: 5px;"> <p><b>28b. Clinical findings</b></p> <p><input type="checkbox"/> Toxic megacolon</p> <p><input type="checkbox"/> Ileus</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p> <p><input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Information not available</p> </td> </tr> </table>	<p><b>28a. Radiographic findings</b></p> <p><input type="checkbox"/> Toxic megacolon</p> <p><input type="checkbox"/> Ileus</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p> <p><input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Radiology not performed</p> <p><input type="checkbox"/> Information not available</p>	<p><b>28b. Clinical findings</b></p> <p><input type="checkbox"/> Toxic megacolon</p> <p><input type="checkbox"/> Ileus</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p> <p><input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Information not available</p>
<p><b>28a. Radiographic findings</b></p> <p><input type="checkbox"/> Toxic megacolon</p> <p><input type="checkbox"/> Ileus</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p> <p><input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Radiology not performed</p> <p><input type="checkbox"/> Information not available</p>	<p><b>28b. Clinical findings</b></p> <p><input type="checkbox"/> Toxic megacolon</p> <p><input type="checkbox"/> Ileus</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p> <p><input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Information not available</p>		

<p><b>29. Was pseudomembranous colitis listed in the surgical pathology, endoscopy, or autopsy report</b> 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><b>30. Colectomy</b> (related to CDI):</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p> <p><b>30a. If YES, date of procedure:</b>      ___/___/___</p> <p><input type="checkbox"/> Unknown</p>
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<p><b>31. Were other enteric pathogens isolated from stool collected on the date of incident <i>C. diff+</i> stool collection?</b></p> <p><input type="checkbox"/> <i>Campylobacter</i></p> <p><input type="checkbox"/> <i>Norovirus</i></p> <p><input type="checkbox"/> <i>Rotavirus</i></p> <p><input type="checkbox"/> <i>Salmonella</i></p> <p><input type="checkbox"/> Shiga Toxin-Producing <i>E.coli</i></p> <p><input type="checkbox"/> <i>Shigella</i></p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> No other pathogens tested</p> <p><input type="checkbox"/> Unknown</p>	<p><b>32. Laboratory findings</b> 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><b>32a. Albumin <math>\leq 2.5\text{g/dl}</math>:</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> Information not available</p> <p><b>32b. White blood cell count <math>\leq 1,000/\mu\text{l}</math>:</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> Information not available</p> <p><b>32c. White blood cell count <math>\geq 15,000/\mu\text{l}</math>:</b></p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Not Done</p> <p><input type="checkbox"/> Information not available</p>
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<b>33. Medications taken in the 12 weeks before the date of incident <i>C. diff+</i> stool collection:</b>		
<p><b>33a. Proton pump inhibitor</b> (e.g. Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>	<p><b>33b. H2 Blockers</b> (e.g. Famotidine, Ranitidine, Cimetidine)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p>	<p><b>33c. Immunosuppressive therapy</b> (Check all that apply)</p> <p><input type="checkbox"/> Steroids</p> <p><input type="checkbox"/> Chemotherapy</p> <p><input type="checkbox"/> Other agents (specify): _____</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Unknown</p>

<p><b>33d. Antimicrobial therapy</b> (Check all that apply)    <input type="checkbox"/> None    <input type="checkbox"/> Unknown</p>				
<input type="checkbox"/> Amikacin	<input type="checkbox"/> Cefoxitin	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Meropenem	<input type="checkbox"/> Telavancin
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Cefpodoxime	<input type="checkbox"/> Dalbavancin	<input type="checkbox"/> Meropenem/vaborbactam	<input type="checkbox"/> Tigecycline
<input type="checkbox"/> Amoxicillin/clavulanic acid	<input type="checkbox"/> Ceftriaxone	<input type="checkbox"/> Daptomycin	<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Tobramycin
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Cefuroxime	<input type="checkbox"/> Delafloxacin	<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> Trimethoprim
<input type="checkbox"/> Ampicillin/sulbactam	<input type="checkbox"/> Ceftazidime	<input type="checkbox"/> Doripenem	<input type="checkbox"/> Nitrofurantoin	<input type="checkbox"/> Trimethoprim/sulfamethoxazole
<input type="checkbox"/> Azithromycin	<input type="checkbox"/> Ceftazidime/avibactam	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Oritavancin	<input type="checkbox"/> Vancomycin (IV)
<input type="checkbox"/> Aztreonam	<input type="checkbox"/> Ceftizoxime	<input type="checkbox"/> Ertapenem	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Cefazolin	<input type="checkbox"/> Ceftriaxone	<input type="checkbox"/> Fosfomicin	<input type="checkbox"/> Piperacillin/tazobactam	
<input type="checkbox"/> Cefdinir	<input type="checkbox"/> Cefuroxime	<input type="checkbox"/> Gentamicin	<input type="checkbox"/> Polymyxin B	
<input type="checkbox"/> Cefepime	<input type="checkbox"/> Cephalexin	<input type="checkbox"/> Imipenem/cilastatin	<input type="checkbox"/> Polymyxin E (colistin)	
<input type="checkbox"/> Cefixime	<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Rifaximin	
<input type="checkbox"/> Cefotaxime	<input type="checkbox"/> Clarithromycin	<input type="checkbox"/> Linezolid	<input type="checkbox"/> Tedizolid	

<p><b>33e. Was patient treated for previous suspected or confirmed CDI in the 12 weeks before the date of incident <i>C. diff+</i> stool collection?</b></p> <p><input type="checkbox"/> Yes      <input type="checkbox"/> No      <input type="checkbox"/> Unknown</p> <p><b>33e.1 If YES, which medication was taken</b> (Check all that apply):</p> <p><input type="checkbox"/> Metronidazole    <input type="checkbox"/> Vancomycin    <input type="checkbox"/> Fidaxomicin    <input type="checkbox"/> Other, (specify) _____    <input type="checkbox"/> Unknown</p>
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