

1. PATIENT ID: \_\_\_\_\_ 2. STATE ID: \_\_\_\_\_  
3. SPECIMEN ID: \_\_\_\_\_ 4. DATE OF INCIDENT *C. diff+* STOOL COLLECTION: \_\_\_/\_\_\_/\_\_\_\_

Form Approved  
OMB No. 092-0978

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



Patient's Name: \_\_\_\_\_ Phone No.: ( ) \_\_\_\_\_ - \_\_\_\_\_  
(Last, First, M.I.)  
Address: \_\_\_\_\_ Chart Number: \_\_\_\_\_  
(Number, Street, Apt. No.)  
\_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) Hospital: \_\_\_\_\_

<b>5. STATE:</b> (Residence of Patient)	<b>6. COUNTY:</b> (Residence of Patient)	<b>9. POSITIVE DIAGNOSTIC ASSAY FOR <i>C. diff+</i></b> <b>9a. EIA</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested <b>9b. GDH</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested <b>9c. Cytotoxin</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested <b>9d. NAAT (<i>C. diff</i> only)</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested <b>9e. NAAT (GI panel)</b> <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested <b>9e.1 If positive, was result suppressed?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>9f. Other (specify):</b> _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested
<b>7. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED</b>	<b>8. FACILITY ID WHERE PATIENT TREATED</b>	

<b>10. DATE OF BIRTH:</b> ____/____/____ <input type="checkbox"/> Unknown	<b>12. SEX AT BIRTH:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender	<b>14. RACE: (Check all that apply)</b> <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
<b>11. AGE: (years):</b> _____	<b>13. ETHNIC ORIGIN:</b> <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	

**15. Was the patient hospitalized on the day 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?**  
 Private Residence  Homeless  
 LTCF Facility ID: \_\_\_\_\_  Incarcerated  
 Hospital Inpatient Facility ID: \_\_\_\_\_  Other (specify): \_\_\_\_\_  
**16a. Was the patient transferred from this hospital?**  Yes  No  Unknown  Unknown  
 LTACH Facility ID: \_\_\_\_\_

<b>17. Location of incident <i>C. diff+</i> stool collection</b> <input type="checkbox"/> <b>Outpatient</b> Facility ID: _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> Clinic/doctor's office <input type="checkbox"/> Dialysis center <input type="checkbox"/> Surgery <input type="checkbox"/> Observation/ Clinical decision unit <input type="checkbox"/> Other outpatient <input type="checkbox"/> <b>Hospital Inpatient</b> Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient <input type="checkbox"/> <b>LTCF</b> Facility ID: _____ <input type="checkbox"/> <b>LTACH</b> Facility ID: _____ <input type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> <b>Other (specify):</b> _____ <input type="checkbox"/> <b>Unknown</b>	<b>18. HCFO classification questions:</b> <b>18a. Was incident <i>C. diff+</i> stool collected at least 3 calendar days after the date of hospital admission?</b> <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No <b>18b. Was incident <i>C. diff+</i> stool collected in an outpatient setting for a LTCF resident, or in a LTCF or LTACH?</b> <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No <b>18c. Was the patient admitted from a LTCF or a LTACH?</b> <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No (CO - complete CRF) Facility ID: _____ <b>18d. If HCFO, was this case sampled for full CRF?</b> <input type="checkbox"/> Yes (Complete CRF) <input type="checkbox"/> No (STOP data abstraction here!) 1 2 3 4 5 6 7 8 9 10
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**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

**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

<p><b>Chronic lung disease</b></p> <p><input type="checkbox"/> Cystic fibrosis  <input type="checkbox"/> Chronic pulmonary disease</p> <p><b>Chronic metabolic disease</b></p> <p><input type="checkbox"/> Diabetes mellitus  <input type="checkbox"/> With chronic complications</p> <p><b>Cardiovascular disease</b></p> <p><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)</p> <p><b>Gastrointestinal disease</b></p> <p><input type="checkbox"/> Diverticular disease  <input type="checkbox"/> Inflammatory bowel disease  <input type="checkbox"/> Peptic ulcer disease  <input type="checkbox"/> Short gut syndrome</p> <p><b>Immunocompromised condition</b></p> <p><input type="checkbox"/> HIV  <input type="checkbox"/> AIDS/CD4 count &lt; 200  <input type="checkbox"/> Primary immunodeficiency  <input type="checkbox"/> Transplant, hematopoietic stem cell  <input type="checkbox"/> Transplant, solid organ</p>	<p><b>Liver disease</b></p> <p><input type="checkbox"/> Chronic liver disease  <input type="checkbox"/> Ascites  <input type="checkbox"/> Cirrhosis  <input type="checkbox"/> Hepatic encephalopathy  <input type="checkbox"/> Variceal bleeding</p> <p><input type="checkbox"/> Hepatitis C  <input type="checkbox"/> Treated, in SVR  <input type="checkbox"/> Current, chronic</p> <p><b>Malignancy</b></p> <p><input type="checkbox"/> Malignancy, hematologic  <input type="checkbox"/> Malignancy, solid organ (non-metastatic)  <input type="checkbox"/> Malignancy, solid organ (metastatic)</p> <p><b>Neurologic condition</b></p> <p><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): _____</p>	<p><b>Plegias/Paralysis</b></p> <p><input type="checkbox"/> Hemiplegia  <input type="checkbox"/> Paraplegia  <input type="checkbox"/> Quadriplegia</p> <p><b>Renal disease</b></p> <p><input type="checkbox"/> Chronic kidney disease          Lowest serum creatinine: _____ mg/DL  <input type="checkbox"/> Unknown or not done</p> <p><b>Skin condition</b></p> <p><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): _____</p> <p><b>Other</b></p> <p><input type="checkbox"/> Connective tissue disease  <input type="checkbox"/> Obesity or morbid obesity  <input type="checkbox"/> Pregnancy</p>
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<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**

<p><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</p>	<p><b>23b. Alcohol abuse:</b> <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown</p>
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**23c. Other substances: (Check all that apply)**  None  Unknown

<p>Documented Use Disorder (DUD)/Abuse?</p> <p><input type="checkbox"/> Marijuana/cannabinoid (other than smoking) <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Opioid, DEA schedule I (e.g., heroin) <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Opioid, NOS <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Cocaine <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Methamphetamine <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> DUD or Abuse  <input type="checkbox"/> Unknown substance <input type="checkbox"/> DUD or Abuse</p>	<p>Mode of delivery: (Check all that apply)</p> <p><input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown  <input type="checkbox"/> IDU <input type="checkbox"/> Skin popping <input type="checkbox"/> non-IDU <input type="checkbox"/> Unknown</p>	<p>During the current hospitalization, did the patient receive medication assisted treatment (MAT) for opioid use disorder?  <input type="checkbox"/> Yes <input type="checkbox"/> No  <input type="checkbox"/> N/A (patient not hospitalized or did not have DUD)</p>
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<p><b>24. 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</p>	<p><b>25. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown</p> <p><b>25a. If YES, what was the POA code assigned to it?</b></p> <p><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</p>	<p><b>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?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>26a. If YES, date of ICU admission:</b>          ____/____/____  <input type="checkbox"/> Unknown</p>
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<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) <i>(Check all that apply)</i></p> <p><input type="checkbox"/> "Asymptomatic" documented in medical record</p> <p><input type="checkbox"/> Diarrhea by definition (unformed or watery stool, ≥ 3/day for ≥ 1 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>																																																										
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<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      <input type="checkbox"/> Unknown</p>																																																												
<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 ≤2.5g/dl:</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 ≤ 1,000/μl:</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 ≥ 15,000/μl:</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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Antimicrobial therapy</b> <i>(Check all that apply)</i>    <input type="checkbox"/> None    <input type="checkbox"/> Unknown</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Amikacin</td> <td><input type="checkbox"/> Cefoxitin</td> <td><input type="checkbox"/> Clindamycin</td> <td><input type="checkbox"/> Meropenem</td> <td><input type="checkbox"/> Telavancin</td> </tr> <tr> <td><input type="checkbox"/> Amoxicillin</td> <td><input type="checkbox"/> Cefpodoxime</td> <td><input type="checkbox"/> Dalbavancin</td> <td><input type="checkbox"/> Meropenem/vaborbactam</td> <td><input type="checkbox"/> Tigecycline</td> </tr> <tr> <td><input type="checkbox"/> Amoxicillin/clavulanic acid</td> <td><input type="checkbox"/> Ceftaroline</td> <td><input type="checkbox"/> Daptomycin</td> <td><input type="checkbox"/> Metronidazole</td> <td><input type="checkbox"/> Tobramycin</td> </tr> <tr> <td><input type="checkbox"/> Ampicillin</td> <td><input type="checkbox"/> Ceftazidime</td> 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Azithromycin	<input type="checkbox"/> Ceftizoxime	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Oritavancin	<input type="checkbox"/> Vancomycin (IV)	<input type="checkbox"/> Aztreonam	<input type="checkbox"/> Ceftolozane/tazobactam	<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"/> Cephalixin	<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	
<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"/> Ceftaroline	<input type="checkbox"/> Daptomycin	<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Tobramycin																																																									
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Ceftazidime	<input type="checkbox"/> Delafloxacin	<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> Trimethoprim																																																									
<input type="checkbox"/> Ampicillin/sulbactam	<input type="checkbox"/> Ceftazidime/avibactam	<input type="checkbox"/> Doripenem	<input type="checkbox"/> Nitrofurantoin	<input type="checkbox"/> Trimethoprim/sulfamethoxazole																																																									
<input type="checkbox"/> Azithromycin	<input type="checkbox"/> Ceftizoxime	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Oritavancin	<input type="checkbox"/> Vancomycin (IV)																																																									
<input type="checkbox"/> Aztreonam	<input type="checkbox"/> Ceftolozane/tazobactam	<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"/> Cephalixin	<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> <i>(Check all that apply)</i>:</p> <p><input type="checkbox"/> Metronidazole    <input type="checkbox"/> Vancomycin    <input type="checkbox"/> Fidaxomicin    <input type="checkbox"/> Other, (specify) _____    <input type="checkbox"/> Unknown</p>																																																													

**34. Treatment for incident CDI**  No treatment  Unknown treatment

**34a.1 Course 1**

**Start Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **Stop Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **OR Duration (days)** \_\_\_\_  Unknown

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vancomycin (PO)              | <input type="checkbox"/> Metronidazole (PO)            | <input type="checkbox"/> Rifaximin              |
| <input type="checkbox"/> Vancomycin (Rectal)          | <input type="checkbox"/> Metronidazole (IV)            | <input type="checkbox"/> Nitazoxanide           |
| <input type="checkbox"/> Vancomycin (Unknown route)   | <input type="checkbox"/> Metronidazole (Unknown route) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Vancomycin taper (any route) | <input type="checkbox"/> Fidaxomicin                   |   |

**34a.2 Course 2**

**Start Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **Stop Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **OR Duration (days)** \_\_\_\_  Unknown

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vancomycin (PO)              | <input type="checkbox"/> Metronidazole (PO)            | <input type="checkbox"/> Rifaximin              |
| <input type="checkbox"/> Vancomycin (Rectal)          | <input type="checkbox"/> Metronidazole (IV)            | <input type="checkbox"/> Nitazoxanide           |
| <input type="checkbox"/> Vancomycin (Unknown route)   | <input type="checkbox"/> Metronidazole (Unknown route) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Vancomycin taper (any route) | <input type="checkbox"/> Fidaxomicin                   |   |

**34a.3 Course 3**

**Start Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **Stop Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **OR Duration (days)** \_\_\_\_  Unknown

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vancomycin (PO)              | <input type="checkbox"/> Metronidazole (PO)            | <input type="checkbox"/> Rifaximin              |
| <input type="checkbox"/> Vancomycin (Rectal)          | <input type="checkbox"/> Metronidazole (IV)            | <input type="checkbox"/> Nitazoxanide           |
| <input type="checkbox"/> Vancomycin (Unknown route)   | <input type="checkbox"/> Metronidazole (Unknown route) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Vancomycin taper (any route) | <input type="checkbox"/> Fidaxomicin                   |   |

**34a.4 Course 4**

**Start Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **Stop Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown **OR Duration (days)** \_\_\_\_  Unknown

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Vancomycin (PO)              | <input type="checkbox"/> Metronidazole (PO)            | <input type="checkbox"/> Rifaximin              |
| <input type="checkbox"/> Vancomycin (Rectal)          | <input type="checkbox"/> Metronidazole (IV)            | <input type="checkbox"/> Nitazoxanide           |
| <input type="checkbox"/> Vancomycin (Unknown route)   | <input type="checkbox"/> Metronidazole (Unknown route) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Vancomycin taper (any route) | <input type="checkbox"/> Fidaxomicin                   |   |

**34b.**  Probiotics (specify): \_\_\_\_\_

**34c.**  Stool transplant Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  Unknown

**35. Previous unique CDI episode**  
(>8 weeks before the date of incident *C. diff*+ stool collection):

- Yes  
 No

**35a. If YES, previous STATEID:**  
\_\_\_\_\_

**36. Any recurrent *C. diff*+ episodes following this incident *C. diff*+ episode?**

- Yes  
 No

**36a. If YES, Date of first recurrent specimen:**  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**37. CRF status:**

- Complete  
 Incomplete  
 Chart unavailable after 3 requests

**38. Initials of S.O:**  
\_\_\_\_\_

**39. Date of abstraction:**  
\_\_\_\_/\_\_\_\_/\_\_\_\_

**40. Was the patient tested for SARS-CoV-2 (molecular assay, serology or other confirmatory test) on or before the DISC?**

- Yes  
 No  
 Unknown

**40a. If YES, date of test:**

\_\_\_\_/\_\_\_\_/\_\_\_\_  
 Unknown

**40b. If YES, what type of test was used?**

- Molecular assay  
 Serology  
 Method Unknown  
 Other (specify): \_\_\_\_\_

**40c. If YES, test result**

- Positive  
 Negative  
 Indeterminate

**41a. COVID-NET Case ID**  
\_\_\_\_\_

**41b. NNDSS IDs (please provide at least one of the following when applicable):**

**Local Case ID:** \_\_\_\_\_

**Local Record ID:** \_\_\_\_\_

**State case identifier:** \_\_\_\_\_

**Legacy case identifier:** \_\_\_\_\_

**Comments:**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_