

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

**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: _____
_____ <small>(City)</small>	_____ <small>(State)</small>
_____ <small>(Zip Code)</small>	
Hospital: _____	

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

10. DATE OF BIRTH: ____/____/____ <input type="checkbox"/> Unknown	12. SEX AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender	14. RACE: (Check all that apply) <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
11. AGE: (years): _____	13. ETHNIC ORIGIN: <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 3rd 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: _____

17. Location of incident <i>C. diff+</i> stool collection	18. HCFO classification questions:
<input type="checkbox"/> Outpatient 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	18a. Was incident <i>C. diff+</i> stool collected at least 3 calendar days after the date of hospital admission? <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No 18b. Was incident <i>C. diff+</i> stool collected in an outpatient setting for a LTCF resident, or in a LTCF or LTACH? <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No 18c. Was the patient admitted from a LTCF or a LTACH? <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No (CO - complete CRF) Facility ID: _____ 18d. If HCFO, was this case sampled for full CRF? <input type="checkbox"/> Yes (Complete CRF) <input type="checkbox"/> No (STOP data abstraction here!)
<input type="checkbox"/> Hospital Inpatient Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient	18e. HCFO classification questions: <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
<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	19. Patient Outcome <input type="checkbox"/> Unknown <input type="checkbox"/> Survived <input type="checkbox"/> Died 19a. Date of discharge: ____/____/____ <input type="checkbox"/> Unknown <input type="checkbox"/> Left against medical advice (AMA) 19b. If survived, discharged to: <input type="checkbox"/> Private residence <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> 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>Chronic lung disease</p> <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Chronic pulmonary disease <p>Chronic metabolic disease</p> <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> With chronic complications <p>Cardiovascular disease</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>Gastrointestinal disease</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>Immunocompromised condition</p> <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	<p>Liver disease</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 <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Treated, in SVR <input type="checkbox"/> Current, chronic <p>Malignancy</p> <input type="checkbox"/> Malignancy, hematologic <input type="checkbox"/> Malignancy, solid organ (non-metastatic) <input type="checkbox"/> Malignancy, solid organ (metastatic) <p>Neurologic condition</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>Plegias/Paralysis</p> <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia <p>Renal disease</p> <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____ mg/DL <input type="checkbox"/> Unknown or not done <p>Skin condition</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>Other</p> <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Obesity or morbid obesity <input type="checkbox"/> Pregnancy
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22a. Weight	22b. Height	22c. BMI
_____ lbs _____ oz OR _____ kg <input type="checkbox"/> Unknown	_____ ft _____ in OR _____ cm <input type="checkbox"/> Unknown	_____ <input type="checkbox"/> Unknown

23. Substance Use

<p>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</p>	<p>23b. Alcohol abuse: <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> <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>Mode of delivery: (Check all that apply)</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>During the current hospitalization, did the patient receive medication assisted treatment (MAT) for opioid use disorder?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (patient not hospitalized or did not have DUD)
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<p>24. Was CDI a primary or contributing reason for patient's admission?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown	<p>25. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown <p>25a. If YES, what was the POA code assigned to it?</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>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?</p> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <p>26a. If YES, date of ICU admission:</p> ____/____/____ <input type="checkbox"/> Unknown
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<p>27. 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) <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>28. Toxic megacolon and ileus (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>28a. Radiographic findings</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>28b. Clinical findings</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>28a. Radiographic findings</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>28b. Clinical findings</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>29. 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>30. Colectomy (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>31. Were other enteric pathogens isolated from stool collected on the date of incident <i>C. diff</i>+ stool collection?</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>32. 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>32a. Albumin $\leq 2.5g/dl$:</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>32b. White blood cell count $\leq 1,000/\mu l$:</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>32c. White blood cell count $\geq 15,000/\mu l$:</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>33. MEDICATIONS TAKEN in the 12 weeks before the date of incident <i>C. diff</i>+ stool collection:</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; padding: 5px;"> <p>33a. Proton pump inhibitor (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> </td> <td style="width:33%; padding: 5px;"> <p>33b. H2 Blockers (e.g. Famotidine, Ranitidine, Cimetidine)</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown</p> </td> <td style="width:33%; padding: 5px;"> <p>33c. Immunosuppressive therapy <i>(Check all that apply)</i></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> </td> </tr> </table>		<p>33a. Proton pump inhibitor (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>33b. H2 Blockers (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>33c. Immunosuppressive therapy <i>(Check all that apply)</i></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>																																																									
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Antimicrobial therapy <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> <td><input 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<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>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?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>33e.1 If YES, which medication was taken <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

- Vancomycin (PO), Vancomycin (Rectal), Vancomycin (Unknown route), Vancomycin taper (any route), Metronidazole (PO), Metronidazole (IV), Metronidazole (Unknown route), Fidaxomicin, Rifaximin, Nitazoxanide, Other (specify):

34a.2 Course 2

Start Date: ___/___/___ Unknown Stop Date: ___/___/___ Unknown OR Duration (days) ___ Unknown

- Vancomycin (PO), Vancomycin (Rectal), Vancomycin (Unknown route), Vancomycin taper (any route), Metronidazole (PO), Metronidazole (IV), Metronidazole (Unknown route), Fidaxomicin, Rifaximin, Nitazoxanide, Other (specify):

34a.3 Course 3

Start Date: ___/___/___ Unknown Stop Date: ___/___/___ Unknown OR Duration (days) ___ Unknown

- Vancomycin (PO), Vancomycin (Rectal), Vancomycin (Unknown route), Vancomycin taper (any route), Metronidazole (PO), Metronidazole (IV), Metronidazole (Unknown route), Fidaxomicin, Rifaximin, Nitazoxanide, Other (specify):

34a.4 Course 4

Start Date: ___/___/___ Unknown Stop Date: ___/___/___ Unknown OR Duration (days) ___ Unknown

- Vancomycin (PO), Vancomycin (Rectal), Vancomycin (Unknown route), Vancomycin taper (any route), Metronidazole (PO), Metronidazole (IV), Metronidazole (Unknown route), Fidaxomicin, Rifaximin, Nitazoxanide, Other (specify):

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. Did the patient have a POSITIVE test(s) for SARS-CoV-2 (molecular assay, serology or other confirmatory test) on or before the DISC?

- Yes, No, Unknown

40a. If YES, complete table below:

Table with 3 columns: Test description, Specimen collection date, Test type. Rows for FIRST and MOST RECENT positive tests.

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: _____