





<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, <math>\geq 3</math>/day 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%; vertical-align: top; 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%; vertical-align: top; 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 <math>\leq 2.5g/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 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 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>33. MEDICATIONS TAKEN in the 12 weeks before the date of incident <i>C. diff+</i> stool collection:</b></p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:33%; vertical-align: top; padding: 5px;"> <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> </td> <td style="width:33%; vertical-align: top; padding: 5px;"> <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> </td> <td style="width:33%; vertical-align: top; padding: 5px;"> <p><b>33c. Immunosuppressive therapy</b> <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><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> <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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<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. 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:**

	Specimen collection date	Test type
<b>FIRST positive test for SARS-CoV-2 on or before the DISC:</b>	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Antigen <input type="checkbox"/> Molecular assay <input type="checkbox"/> Serology <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____
<b>MOST RECENT positive test for SARS-CoV-2 on or before the DISC:</b>	____/____/____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Antigen <input type="checkbox"/> Molecular assay <input type="checkbox"/> Serology <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____

**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:** \_\_\_\_\_  
**CDC 2019-nCoV ID:** \_\_\_\_\_

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