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.)

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

5. STATE: (Residence of Patient) _____

6. COUNTY: (Residence of Patient) _____

7. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED _____

8. FACILITY ID WHERE PATIENT TREATED _____

9. DIAGNOSTIC ASSAY FOR *C. diff*+

9a. EIA	☐ Positive	☐ Negative	☐ Not tested
9b. GDH	☐ Positive	☐ Negative	☐ Not tested
9c. Cytotoxin	☐ Positive	☐ Negative	☐ Not tested
9d. NAAT (*C. diff* only)	☐ Positive	☐ Negative	☐ Not tested
9e. NAAT (GI panel)	☐ Positive	☐ Negative	☐ Not tested
9.e.1 If positive, was result suppressed?	☐ Yes	☐ No	☐ Unknown
9f. Other (specify): _____	☐ Positive	☐ Negative	☐ Not tested

10. DATE OF BIRTH: ___ ___/___ ___/___ ___ ___ ___
☐ Unknown

11. AGE: (years): ___ ___ ___

12. SEX AT BIRTH:
☐ Male ☐ Female ☐ Unknown
☐ Transgender

13. ETHNIC ORIGIN:
☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

14. RACE: (Check all that apply)
☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ 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
☐ LTCF Facility ID: _____
☐ Hospital Inpatient Facility ID: _____
☐ Homeless
☐ Incarcerated
☐ Other *(specify)*: _____
☐ Unknown

16a. Was the patient transferred from this hospital? ☐ Yes ☐ No ☐ Unknown
☐ LTACH Facility ID: _____

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

☐ **Outpatient**
Facility ID: _____
☐ Emergency room
☐ Clinic/doctor's office
☐ Dialysis center
☐ Surgery
☐ Observation/ Clinical decision unit
☐ Other outpatient

☐ **Hospital Inpatient**
Facility ID: _____
☐ ICU
☐ OR
☐ Radiology
☐ Other inpatient

☐ **LTCF**
Facility ID: _____

☐ **LTACH**
Facility ID: _____

☐ **Autopsy**

☐ **Other *(specify)***: _____

☐ **Unknown**

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
☐ Left against medical advice (AMA)

19b. If survived, discharged to:
☐ Private residence
☐ LTCF Facility ID: _____
☐ LTACH Facility ID: _____
☐ Other *(specify)*: _____
☐ Unknown

19c. Date of death: ___ ___/___ ___/___ ___ ___ ___ ☐ Unknown

Public reporting burden of this collection of information is estimated to average 38 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
- ☐Cystic fibrosis
- ☐Chronic pulmonary disease

Chronic metabolic disease
- ☐Diabetes mellitus
  - ☐With chronic complications

Cardiovascular disease
- ☐CVA/Stroke/TIA
- ☐Congenital heart disease
- ☐Congestive heart failure
- ☐Myocardial infarction
- ☐Peripheral vascular disease (PVD)

Gastrointestinal disease
- ☐Diverticular disease
- ☐Inflammatory bowel disease
- ☐Peptic ulcer disease
- ☐Short gut syndrome

Immunocompromised condition
- ☐HIV
  - ☐AIDS/CD4 count < 200
- ☐Primary immunodeficiency
- ☐Transplant, hematopoietic stem cell
- ☐Transplant, solid organ

Liver disease
- ☐Chronic liver disease
  - ☐Ascites
  - ☐Cirrhosis
  - ☐Hepatic encephalopathy
  - ☐Variceal bleeding
- ☐Hepatitis C
  - ☐Treated, in SVR
  - ☐Current, chronic

Malignancy
- ☐Malignancy, hematologic
- ☐Malignancy, solid organ (non-metastatic)
- ☐Malignancy, solid organ (metastatic)

Neurologic condition
- ☐Cerebral palsy
- ☐Chronic cognitive deficit
- ☐Dementia
- ☐Epilepsy/seizure/seizure disorder
- ☐Multiple sclerosis
- ☐Neuropathy
- ☐Parkinson's disease
- ☐Other (specify): _____

Plegias/Paralysis
- ☐Hemiplegia
- ☐Paraplegia
- ☐Quadriplegia

Renal disease
- ☐Chronic kidney disease

  Lowest serum creatinine: _____ mg/DL

  ☐Unknown or not done

Skin condition
- ☐Burn
- ☐Decubitus/pressure ulcer
- ☐Surgical wound
- ☐Other chronic ulcer or chronic wound
- ☐Other (specify): _____

Other
- ☐Connective tissue disease
- ☐Obesity or morbid obesity
- ☐Pregnancy

22a. Weight _____ lbs _____ oz OR _____ kg ☐Unknown

22b. Height _____ ft _____ in OR _____ cm ☐Unknown

22c. BMI _____ ☐Unknown

23. Substance Use

23a. Smoking: ☐None ☐Unknown ☐Tobacco ☐E-Nicotine Delivery System ☐Marijuana

23b. Alcohol abuse: ☐Yes ☐No ☐Unknown

23c. Other substances: (*Check all that apply*) ☐None ☐Unknown

	Documented Use Disorder (DUD)/Abuse?	Mode of delivery: (*Check all that apply*)
☐Marijuana/cannabinoid (other than smoking)	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Opioid, DEA schedule I (e.g., heroin)	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Opioid, NOS	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Cocaine	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Methamphetamine	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Other (specify): _____	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown
☐Unknown substance	☐DUD or Abuse	☐IDU ☐Skin popping ☐non-IDU ☐Unknown

During the current hospitalization, did the patient receive medication assisted treatment (MAT) for opioid use disorder? ☐Yes ☐No ☐N/A (patient not hospitalized or did not have DUD)

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?

☐Y, Yes ☐W, Clinically Undetermined
☐N, No ☐Missing
☐U, Unknown ☐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

27. Symptoms (in the 6 calendar days before, the day of, or 1 calendar day after the date of incident *C. diff*+ stool collection) *(Check all that apply)*

- ☐ "Asymptomatic" documented in medical record
- ☐ Diarrhea by definition (unformed or watery stool, ≥ 3/day for ≥ 1 day)
- ☐ Diarrhea documented, but unable to determine if it is by definition
- ☐ Nausea
- ☐ Vomiting
- ☐ No diarrhea, nausea, or vomiting documented
- ☐ Information not available

28. Toxic megacolon and ileus (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident *C. diff*+ stool collection)

28a. Radiographic findings

- ☐ Toxic megacolon
- ☐ Ileus
- ☐ Both toxic megacolon and ileus
- ☐ Neither toxic megacolon nor ileus
- ☐ Radiology not performed
- ☐ Information not available

28b. Clinical findings

- ☐ Toxic megacolon
- ☐ Ileus
- ☐ Both toxic megacolon and ileus
- ☐ Neither toxic megacolon nor ileus
- ☐ Information not available

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 *C. diff*+ stool collection?

- ☐ Yes ☐ Not Done
- ☐ No ☐ Information not available

30. Colectomy (related to CDI):

- ☐ Yes
- ☐ No
- ☐ Unknown

30a. If YES, Date of Procedure:

__ __ /__ __ /__ __ __ __

☐ Unknown

31. Were other enteric pathogens isolated from stool collected on the date of incident *C. diff*+ stool collection?

- ☐ *Campylobacter*
- ☐ *Norovirus*
- ☐ *Rotavirus*
- ☐ *Salmonella*
- ☐ Shiga Toxin-Producing *E.coli*
- ☐ *Shigella*
- ☐ Other (specify): _____
- ☐ None
- ☐ No other pathogens tested
- ☐ Unknown

32. LABORATORY FINDINGS (in the 6 calendar days before, the day of, or the 6 calendar days after the date of incident *C. diff*+ stool collection):

32a. Albumin ≤2.5g/dl:

- ☐ Yes
- ☐ No
- ☐ Not Done
- ☐ Information not available

32b. White blood cell count ≤ 1,000/µl:

- ☐ Yes
- ☐ No
- ☐ Not Done
- ☐ Information not available

32c. White blood cell count ≥ 15,000/µl:

- ☐ Yes
- ☐ No
- ☐ Not Done
- ☐ Information not available

33. MEDICATIONS TAKEN in the 12 weeks before the date of incident *C. diff*+ stool collection:

33a. Proton pump inhibitor (e.g. Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole)

- ☐ Yes
- ☐ No
- ☐ Unknown

33b. H2 Blockers (e.g. Famotidine, Ranitidine, Cimetidine)

- ☐ Yes
- ☐ No
- ☐ Unknown

33c. Immunosuppressive therapy *(Check all that apply)*

- ☐ Steroids
- ☐ Chemotherapy
- ☐ Other agents *(specify)*: _____
- ☐ None
- ☐ Unknown

33d. Antimicrobial therapy (*Check all that apply*) ☐ None ☐ Unknown

☐ Amikacin	☐ Cefoxitin	☐ Clindamycin	☐ Meropenem	☐ Telavancin
☐ Amoxicillin	☐ Cefpodoxime	☐ Dalbavancin	☐ Meropenem/vaborbactam	☐ Tigecycline
☐ Amoxicillin/clavulanic acid	☐ Ceftaroline	☐ Daptomycin	☐ Metronidazole	☐ Tobramycin
☐ Ampicillin	☐ Ceftazidime	☐ Delafloxacin	☐ Moxifloxacin	☐ Trimethoprim
☐ Ampicillin/sulbactam	☐ Ceftazidime/avibactam	☐ Doripenem	☐ Nitrofurantoin	☐ Trimethoprim/sulfamethoxazole
☐ Azithromycin	☐ Ceftizoxime	☐ Doxycycline	☐ Oritavancin	☐ Vancomycin (IV)
☐ Aztreonam	☐ Ceftolozane/tazobactam	☐ Ertapenem	☐ Penicillin	☐ Other (specify):
☐ Cefazolin	☐ Ceftriaxone	☐ Fosfomycin	☐ Piperacillin/tazobactam	_____
☐ Cefdinir	☐ Cefuroxime	☐ Gentamicin	☐ Polymyxin B	
☐ Cefepime	☐ Cephalexin	☐ Imipenem/cilastatin	☐ Polymyxin E (colistin)	
☐ Cefixime	☐ Ciprofloxacin	☐ Levofloxacin	☐ Rifaximin	
☐ Cefotaxime	☐ Clarithromycin	☐ Linezolid	☐ Tedizolid	

33e. Was patient treated for previous suspected or confirmed CDI in the 12 weeks before the date of incident *C. diff*+ stool collection?

☐ Yes ☐ No ☐ Unknown

33e.1 If YES, which medication was taken *(Check all that apply)*:

☐ Metronidazole ☐ Vancomycin ☐ Fidaxomicin ☐ Other, *(specify)* _____ ☐ Unknown

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)	☐ Metronidazole (PO)	☐ Rifaximin
☐ Vancomycin (Rectal)	☐ Metronidazole (IV)	☐ Nitazoxanide
☐ Vancomycin (Unknown route)	☐ Metronidazole (Unknown route)	☐ Other *(specify)*:
☐ Vancomycin taper (any route)	☐ Fidaxomicin	_____

34a.2 Course 2

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

☐ Vancomycin (PO)	☐ Metronidazole (PO)	☐ Rifaximin
☐ Vancomycin (Rectal)	☐ Metronidazole (IV)	☐ Nitazoxanide
☐ Vancomycin (Unknown route)	☐ Metronidazole (Unknown route)	☐ Other *(specify)*:
☐ Vancomycin taper (any route)	☐ Fidaxomicin	_____

34a.3 Course 3

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

☐ Vancomycin (PO)	☐ Metronidazole (PO)	☐ Rifaximin
☐ Vancomycin (Rectal)	☐ Metronidazole (IV)	☐ Nitazoxanide
☐ Vancomycin (Unknown route)	☐ Metronidazole (Unknown route)	☐ Other *(specify)*:
☐ Vancomycin taper (any route)	☐ Fidaxomicin	_____

34a.4 Course 4

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

☐ Vancomycin (PO)	☐ Metronidazole (PO)	☐ Rifaximin
☐ Vancomycin (Rectal)	☐ Metronidazole (IV)	☐ Nitazoxanide
☐ Vancomycin (Unknown route)	☐ Metronidazole (Unknown route)	☐ Other *(specify)*:
☐ Vancomycin taper (any route)	☐ 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
FIRST positive test for SARS-CoV-2 on or before the DISC:	___ ___/___ ___/___ ___ ___ ___ ☐ Unknown	☐ Antigen ☐ Molecular assay ☐ Serology ☐ Unknown ☐ Other *(specify)*: _____
MOST RECENT positive test for SARS-CoV-2 on or before the DISC:	___ ___/___ ___/___ ___ ___ ___ ☐ Unknown	☐ Antigen ☐ Molecular assay ☐ Serology ☐ Unknown ☐ 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: