

1. PATIENT ID: _____	2. STATE ID: _____
3. SPECIMEN ID: _____	4. Date of incident <i>C. diff</i>+ stool collection (DISC): ____/____/____

Form Approved
OMB No. 092-0978

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



Patient's Name: _____ Phone No.: _____
 Address: _____
 Address type: _____ Hospital: _____ Chart Number: _____

5. STATE: <small>(Residence of Patient)</small>	6. COUNTY: <small>(Residence of Patient)</small>	9. 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 9.e.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: <i>(Check all that apply)</i> <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 DISC? Yes No Unknown
15a. If YES, Date of Admission: ____/____/____ Unknown

16. Where was the patient located on the 3rd calendar day before the DISC?
 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 <input type="checkbox"/> Outpatient Facility ID: _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> ICU <input type="checkbox"/> Clinic/doctor's office <input type="checkbox"/> OR <input type="checkbox"/> Dialysis center <input type="checkbox"/> Radiology <input type="checkbox"/> Surgery <input type="checkbox"/> Other inpatient <input type="checkbox"/> Observation/ Clinical decision unit <input type="checkbox"/> Other outpatient <input type="checkbox"/> Hospital Inpatient Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	18. HCFO classification questions: 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)
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19. Patient Outcome Unknown
 Survived **19a. Date of discharge:** ____/____/____ Unknown
 Left against medical advice (AMA)
 Died **19c. Date of death:** ____/____/____ Unknown
19b. If survived, discharged to:
 Private residence
 LTCF Facility ID: _____ Other (specify): _____
 LTACH Facility ID: _____ 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).

<p>27. Symptoms (in the 6 calendar days before, the day of, or 1 calendar day after the DISC) <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. Fever (in the 2 calendar days before or calendar day of the DISC)</p> <p><input type="checkbox"/> Fever $\geq 38^{\circ}\text{C}$ or $\geq 100.4^{\circ}\text{F}$ documented</p> <p style="text-align: center;">Highest fever documented: _____ $^{\circ}\text{C}$ or _____ $^{\circ}\text{F}$</p> <p><input type="checkbox"/> Self-reported fever</p> <p><input type="checkbox"/> No fever documented</p> <p><input type="checkbox"/> Information not available</p>
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29. Toxic megacolon and ileus (in the 6 calendar days before, the day of, or the 6 calendar days after the DISC)

<p>29a. Radiographic findings</p> <p><input type="checkbox"/> Toxic megacolon <input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Ileus <input type="checkbox"/> Radiology not performed</p> <p><input type="checkbox"/> Both toxic megacolon and ileus <input type="checkbox"/> Information not available</p>	<p>29b. Clinical findings</p> <p><input type="checkbox"/> Toxic megacolon <input type="checkbox"/> Neither toxic megacolon nor ileus</p> <p><input type="checkbox"/> Ileus <input type="checkbox"/> Information not available</p> <p><input type="checkbox"/> Both toxic megacolon and ileus</p>
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<p>30. 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 DISC?</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>31. Colectomy (related to CDI): 31a. If YES, Date of Procedure:</p> <p><input type="checkbox"/> Yes _____ / _____ / _____</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Unknown <input type="checkbox"/> Unknown</p>
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<p>32. Were other enteric pathogens isolated from stool collected on the DISC?</p> <p><input type="checkbox"/> Astrovirus <input type="checkbox"/> Sapovirus</p> <p><input type="checkbox"/> <i>Campylobacter</i> <input type="checkbox"/> Shiga Toxin-Producing <i>E.coli</i></p> <p><input type="checkbox"/> Enteroaggregative <i>E. coli</i> (EAEC) <input type="checkbox"/> <i>Shigella</i></p> <p><input type="checkbox"/> Enteropathogenic <i>E. coli</i> (EPEC) <input type="checkbox"/> <i>Yersinia enterocolitica</i></p> <p><input type="checkbox"/> Enterotoxigenic <i>E. coli</i> (ETEC) <input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> Norovirus</p> <p><input type="checkbox"/> Rotavirus</p> <p><input type="checkbox"/> <i>Salmonella</i> <input type="checkbox"/> None</p> <p><input type="checkbox"/> _____ <input type="checkbox"/> No other pathogens tested</p> <p><input type="checkbox"/> _____ <input type="checkbox"/> Unknown</p>	<p>33. LABORATORY FINDINGS (in the 6 calendar days before, the day of, or the 6 calendar days after the DISC)</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; vertical-align: top;"> <p>33a. Albumin $\leq 2.5\text{g/dl}$:</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> </td> <td style="width:50%; vertical-align: top;"> <p>33c. White blood cell count $\geq 15,000/\mu\text{l}$:</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> </td> </tr> <tr> <td style="width:50%; vertical-align: top;"> <p>33b. White blood cell count $\leq 1,000/\mu\text{l}$:</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> </td> <td style="width:50%; vertical-align: top;"> <p>33d. Serum creatinine $> 1.5\text{ mg/dl}$:</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> </td> </tr> </table>	<p>33a. Albumin $\leq 2.5\text{g/dl}$:</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>33c. White blood cell count $\geq 15,000/\mu\text{l}$:</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>33b. White blood cell count $\leq 1,000/\mu\text{l}$:</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>33d. Serum creatinine $> 1.5\text{ mg/dl}$:</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>
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<p>33b. White blood cell count $\leq 1,000/\mu\text{l}$:</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>33d. Serum creatinine $> 1.5\text{ mg/dl}$:</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>				

34. MEDICATIONS taken in the 12 weeks before the DISC:

<p>34a. 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>34b. 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>34c. Immunosuppressive therapy (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>
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34d. Antimicrobial therapy (Check all that apply) Yes, name unknown None Unknown

<input type="checkbox"/> Amikacin	<input type="checkbox"/> Cefotaxime	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Meropenem	<input type="checkbox"/> Telavancin
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Cefoxitin	<input type="checkbox"/> Dalbavancin	<input type="checkbox"/> Meropenem/vaborbactam	<input type="checkbox"/> Tigecycline
<input type="checkbox"/> Amoxicillin/clavulanic acid	<input type="checkbox"/> Cefpodoxime	<input type="checkbox"/> Daptomycin	<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Tobramycin
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Ceftaroline	<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"/> Omadacycline	<input type="checkbox"/> Vancomycin (IV)
<input type="checkbox"/> Aztreonam	<input type="checkbox"/> Ceftizoxime	<input type="checkbox"/> Eravacycline	<input type="checkbox"/> Oritavancin	<input type="checkbox"/> Vancomycin (PO for prophylaxis)
<input type="checkbox"/> Cefadroxil	<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"/> Fosfomycin	<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"/> Cefiderocol	<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Rifaximin	
<input type="checkbox"/> Cefixime	<input type="checkbox"/> Clarithromycin	<input type="checkbox"/> Linezolid	<input type="checkbox"/> Tedizolid	

