

State ID: \_\_\_\_\_ Date of Incident Specimen Collection (mm-dd-yyyy): \_\_\_\_-\_\_\_\_-\_\_\_\_ Surveillance Officer Initials \_\_\_\_\_

Form Approved  
OMB No. 092-0978

CANDIDEMIA 2022 CASE REPORT FORM

Patient name: \_\_\_\_\_  
(Last, First, MI)

Medical Record No.: \_\_\_\_\_

Address: \_\_\_\_\_  
(Number, Street, Apt. No.)  
\_\_\_\_\_  
(City, State) \_\_\_\_\_ (Zip Code)

Hospital: \_\_\_\_\_

Acc No. (incident isolate): \_\_\_\_\_

Acc No. (subseq isolate): \_\_\_\_\_

Address type:

- 1  Residential 2  Post office 3  Long-term care facility 4  Corrections 5  Military 6  Homeless 7  Other 8  Insufficient 9  Missing

Phone no.: ( ) \_\_\_\_\_ - \_\_\_\_\_

Check if not a case:

Reason not a case:  Out of catchment area  Duplicate entry  Not candidemia  Unable to verify address  Other (specify): \_\_\_\_\_

SURVEILLANCE OFFICER INFORMATION

Table with 5 columns: 1. Date reported to EIP site; 2. Date review completed; 3. Was case first identified through audit?; 4. Isolate available?; 5. Previous candidemia episode?; 6. CRF status; 7. SO's initials.

DEMOGRAPHICS

8. State ID: \_\_\_\_\_ 10. State: \_\_\_\_\_ 11. County: \_\_\_\_\_

9. Patient ID: \_\_\_\_\_

12. Lab ID where positive culture was identified: \_\_\_\_\_

13. Date of birth (mm-dd-yyyy): \_\_\_\_\_ 14. Age: \_\_\_\_\_ 15. Sex: \_\_\_\_\_

16. Weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz. OR \_\_\_\_\_ kg  Unknown 17. Height: \_\_\_\_\_ ft. \_\_\_\_\_ in. OR \_\_\_\_\_ cm  Unknown 18. BMI: (record only if ht. and/or wt. is not available) \_\_\_\_\_  Unknown

19. Race (check all that apply):  American Indian/Alaska Native  Asian  Black/African American  Native Hawaiian/Pacific Islander  White  Unknown 20. Ethnic origin: 1  Hispanic/Latino 2  Not Hispanic/Latino 9  Unknown

LABORATORY DATA

21. Date of Incident Specimen Collection (DISC) (mm-dd-yyyy): \_\_\_\_-\_\_\_\_-\_\_\_\_

22. Location of Specimen Collection:

- Hospital Inpatient Facility ID: \_\_\_\_\_  ICU  Surgery/OR  Radiology  Other inpatient  Outpatient Facility ID: \_\_\_\_\_  Emergency Room  Clinic/Doctor's office  Dialysis center  Surgery  Observational/clinical decision unit  Other outpatient  LTCF Facility ID: \_\_\_\_\_  LTACH Facility ID: \_\_\_\_\_  Autopsy  Other (specify): \_\_\_\_\_  Unknown

23. Incident Specimen Collection Site (check all that apply): \_\_\_\_\_ 24. Candida species from initial positive blood culture (check all that apply): \_\_\_\_\_

Public reporting burden of this collection of information is estimated to average 40 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).

- Blood, Central Line
- Blood, Peripheral stick
- Blood, not specified
- Other (specify): \_\_\_\_\_
- Unknown

- Candida albicans* (CA)
- Candida glabrata* (CG)
- Candida parapsilosis* (CP)
- Candida tropicalis* (CT)
- Candida dubliniensis* (CD)
- Candida lusitanae* (CL)
- Candida krusei* (CK)
- Candida guilliermondii* (CGM)
- Candida*, other (CO) specify: \_\_\_\_\_
- Candida*, germ tube negative/non albicans (CGN)
- Candida* species (CS)
- Pending

**25. Antifungal susceptibility testing (check here  if no testing done/no test reports available):**

Date of culture	Species	Drug	MIC	Interpretation
		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	1 <input type="checkbox"/> CA	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	2 <input type="checkbox"/> CG	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	3 <input type="checkbox"/> CP	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	4 <input type="checkbox"/> CT	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	5 <input type="checkbox"/> CD	Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	6 <input type="checkbox"/> CL	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	7 <input type="checkbox"/> CK	Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	8 <input type="checkbox"/> CGM	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	9 <input type="checkbox"/> CO			
	10 <input type="checkbox"/> CGN			
	11 <input type="checkbox"/> CS			
	12 <input type="checkbox"/> Pending			
		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	1 <input type="checkbox"/> CA	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	2 <input type="checkbox"/> CG	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	3 <input type="checkbox"/> CP	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	4 <input type="checkbox"/> CT	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	5 <input type="checkbox"/> CD	Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	6 <input type="checkbox"/> CL	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	7 <input type="checkbox"/> CK	Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	8 <input type="checkbox"/> CGM	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	9 <input type="checkbox"/> CO			
	10 <input type="checkbox"/> CGN			
	11 <input type="checkbox"/> CS			
	12 <input type="checkbox"/> Pending			

**26. Any subsequent positive *Candida* blood cultures in the 29 days after, not including the DISC?** 1 Yes 0 No 9 Unknown

26a. If yes, provide dates of all subsequent positive *Candida* blood cultures and select the species:

Date Drawn (mm-dd-yyyy)	Species identified*
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending

\*Attach additional MIC page if additional *Candida* species (different from original), if another *C. glabrata* (even if original was *C. glabrata*), or if same *Candida* species (if no AFST results available for original)

**27. Documented negative *Candida* blood culture on the day of or in the 29 days after the DISC (in which no blood cultures after this negative culture were positive in the 29 days after the DISC)?** 1 Yes 0 No 9 Unknown

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27a. If yes, date of negative blood culture: \_\_\_\_-\_\_\_\_-\_\_\_\_\_

28. On the day of or in the 6 days before the DISC, was the patient known to be colonized with or being managed as if they were colonized with a multi-drug resistant organism (MDRO) (e.g., on contact precautions)? MDROs include CRE, CRPA, CRAB, MRSA, and VRE.

1  Yes 0  No 9  Unknown

28a. If yes, specify organisms (Enter up to 3 pathogens): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

29. Additional non-*Candida* organisms isolated from blood cultures on the day of or in the 6 days before the DISC:

1  Yes 0  No 9  Unknown

29a. If yes, additional organisms (Enter up to 3 pathogens): \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

30. Infection with *Clostridioides difficile* on the day of or in the 89 days before or 29 days after the DISC:

1  Yes 0  No 9  Unknown

30a. If yes, date of first *C. diff* diagnosis: \_\_\_\_-\_\_\_\_-\_\_\_\_\_  Unknown

31. Did the patient have any of the following types of infection/colonization related to their *Candida* infection? (check all that apply):

None  Unknown

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> Abdominal                    | <input type="checkbox"/> Candiduria                                | <input type="checkbox"/> Pulmonary                                   | <input type="checkbox"/> Endocarditis                            |
| <input type="checkbox"/> Hepatobiliary or pancreatic  | <input type="checkbox"/> Esophagitis                               | <input type="checkbox"/> Abscess                                     | <input type="checkbox"/> Septic emboli (specify location): _____ |
| <input type="checkbox"/> GI tract                     | <input type="checkbox"/> Oral/thrush                               | <input type="checkbox"/> Respiratory specimen with <i>Candida</i>    | <input type="checkbox"/> Other (specify): _____                  |
| <input type="checkbox"/> Abscess (specify): _____     | <input type="checkbox"/> Osteomyelitis                             | <input type="checkbox"/> CNS involvement (meningitis, brain abscess) |  |
| <input type="checkbox"/> Peritonitis/peritoneal fluid | <input type="checkbox"/> Skin lesions/wounds                       |  |  |
| <input type="checkbox"/> Splenic                      | <input type="checkbox"/> Eyes (endophthalmitis or chorioretinitis) |  |  |

#### MEDICAL ENCOUNTERS

32. Was the patient hospitalized on the day of or in the 6 days after the DISC? 1  Yes 0  No 9  Unknown

32a. If yes, Date of first admission: \_\_\_\_-\_\_\_\_-\_\_\_\_\_  Unknown

Hospital ID: \_\_\_\_\_  Unknown

32b. Was the patient transferred during this hospitalization?

1  Yes 0  No 9  Unknown

If yes, enter up to two transfers:

Date of transfer: \_\_\_\_-\_\_\_\_-\_\_\_\_\_  Unknown Date of second transfer: \_\_\_\_-\_\_\_\_-\_\_\_\_\_  Unknown

Hospital ID: \_\_\_\_\_  Unknown Hospital ID: \_\_\_\_\_  Unknown

32c. Where was the patient located prior to admission or, if not hospitalized, where was the patient located on the 3rd calendar day before the DISC? (Check one)

- |   |                                     |   |
|---|-------------------------------------|---|
| 1 <input type="checkbox"/> Private residence  | 4 <input type="checkbox"/> LTACH    | 6 <input type="checkbox"/> Incarcerated           |
| 2 <input type="checkbox"/> Hospital inpatient | Facility ID: _____                  | 7 <input type="checkbox"/> Other (specify): _____ |
| Facility ID: _____                            | 5 <input type="checkbox"/> Homeless | 9 <input type="checkbox"/> Unknown                |
| 3 <input type="checkbox"/> LTCF               |                                     |   |
| Facility ID: _____                            |                                     |   |

33. Was the patient in an ICU in the 14 days before, not including the DISC?

1  Yes 0  No 9  Unknown

34. Was the patient in an ICU on the day of incident specimen collection or in the 13 days after the DISC?

1  Yes 0  No 9  Unknown

35. Did the patient receive invasive mechanical ventilation in the 30 days before the DISC, not including the DISC?

1  Yes 0  No 9  Unknown

36. Did the patient receive dialysis or renal replacement therapy (RRT) in the 30 days before the DISC, not including the DISC?

1  Yes 0  No 9  Unknown

37. Patient outcome: 1  Survived 9  Unknown 2  Died

Date of discharge: \_\_\_\_\_  Unknown Date of death: \_\_\_\_\_  Unknown  
 Left against medical advice (AMA)

37a. Discharged to:  
 0  Not applicable (i.e. patient died, or not hospitalized) 5  Other (specify): \_\_\_\_\_  
 1  Private residence 6  Homeless  
 2  LTCF Facility ID: \_\_\_\_\_ 7  Incarcerated  
 3  LTACH Facility ID: \_\_\_\_\_ 9  Unknown

**38. Did the patient have any of the following classes or specific ICD-10 codes, including any sub-codes for this hospitalization?**

(Check all that apply):  None  Unknown

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> B37 (candidiasis)<br>Specify sub-code: _____ | <input type="checkbox"/> B48 (other mycoses, not classified elsewhere)<br><input type="checkbox"/> B49 (unspecified mycoses)<br><input type="checkbox"/> T80.211 (BSI due to central venous catheter) | <input type="checkbox"/> A41.9 (sepsis, unspecified organism)<br><input type="checkbox"/> R65.2 (severe sepsis)<br><input type="checkbox"/> Other <i>Candida</i> -related code<br>Specify code: _____ |
| <input type="checkbox"/> P37.5 (neonatal candidiasis)                 |   |   |

39. Previous Hospitalization in the 90 days before, not including the DISC: 1  Yes 0  No 9  Unknown

39a. If yes, date of discharge: \_\_\_\_-\_\_\_\_-\_\_\_\_  Unknown  
 Facility ID: \_\_\_\_\_

40. Overnight stay in LTACH in the 90 days before, not including the DISC: 1  Yes 0  No 9  Unknown

Facility ID: \_\_\_\_\_

41. Overnight stay in LTCF in the 90 days before, not including the DISC: 1  Yes 0  No 9  Unknown

Facility ID: \_\_\_\_\_

**UNDERLYING CONDITIONS**

42. Underlying conditions (Check all that apply):  None  Unknown

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>Chronic Lung Disease</b><br><input type="checkbox"/> Cystic Fibrosis<br><input type="checkbox"/> Chronic Pulmonary disease   | <input type="checkbox"/> <b>Liver Disease</b><br><input type="checkbox"/> Chronic Liver Disease<br><input type="checkbox"/> Ascites<br><input type="checkbox"/> Cirrhosis<br><input type="checkbox"/> Hepatic Encephalopathy<br><input type="checkbox"/> Variceal Bleeding<br><input type="checkbox"/> Hepatitis B, chronic<br><input type="checkbox"/> Hepatitis C<br><input type="checkbox"/> Treated, in SVR<br><input type="checkbox"/> Current, chronic<br><input type="checkbox"/> Hepatitis B, acute | <input type="checkbox"/> <b>Plegias/Paralysis</b><br><input type="checkbox"/> Hemiplegia<br><input type="checkbox"/> Paraplegia<br><input type="checkbox"/> Quadriplegia  |
| <input type="checkbox"/> <b>Chronic Metabolic Disease</b><br><input type="checkbox"/> Diabetes Mellitus<br><input type="checkbox"/> With Chronic Complications   | <input type="checkbox"/> <b>Malignancy</b><br><input type="checkbox"/> Malignancy, Hematologic<br><input type="checkbox"/> Malignancy, Solid Organ (non-metastatic)<br><input type="checkbox"/> Malignancy, Solid Organ (metastatic)  | <input type="checkbox"/> <b>Renal Disease</b><br><input type="checkbox"/> Chronic Kidney Disease<br>Lowest serum creatinine: _____ mg/DL<br><input type="checkbox"/> Unknown or not done  |
| <input type="checkbox"/> <b>Cardiovascular Disease</b><br><input type="checkbox"/> CVA/Stroke/TIA<br><input type="checkbox"/> Congenital Heart disease<br><input type="checkbox"/> Congestive Heart Failure<br><input type="checkbox"/> Myocardial infarction<br><input type="checkbox"/> Peripheral Vascular Disease (PVD)    | <input type="checkbox"/> <b>Neurologic Condition</b><br><input type="checkbox"/> Cerebral palsy<br><input type="checkbox"/> Chronic Cognitive Deficit<br><input type="checkbox"/> Dementia<br><input type="checkbox"/> Epilepsy/seizure/seizure disorder<br><input type="checkbox"/> Multiple sclerosis<br><input type="checkbox"/> Neuropathy<br><input type="checkbox"/> Parkinson's disease<br><input type="checkbox"/> Other (specify): _____   | <input type="checkbox"/> <b>Skin Condition</b><br><input type="checkbox"/> Burn<br><input type="checkbox"/> Decubitus/Pressure Ulcer<br><input type="checkbox"/> Surgical Wound<br><input type="checkbox"/> Other chronic ulcer or chronic wound<br><input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> <b>Gastrointestinal Disease</b><br><input type="checkbox"/> Diverticular disease<br><input type="checkbox"/> Inflammatory Bowel Disease<br><input type="checkbox"/> Peptic Ulcer Disease<br><input type="checkbox"/> Short gut syndrome   |   | <input type="checkbox"/> <b>Other</b><br><input type="checkbox"/> Connective tissue disease<br><input type="checkbox"/> Obesity or morbid obesity<br><input type="checkbox"/> Pregnant  |
| <input type="checkbox"/> <b>Immunocompromised Condition</b><br><input type="checkbox"/> HIV infection<br><input type="checkbox"/> AIDS/CD4 count <200<br><input type="checkbox"/> Primary Immunodeficiency<br><input type="checkbox"/> Transplant, Hematopoietic Stem Cell<br><input type="checkbox"/> Transplant, Solid Organ |   |   |

**SOCIAL HISTORY**

43. Smoking (Check all that apply):

44. Alcohol Abuse:

<input type="checkbox"/> None	<input type="checkbox"/> Tobacco	1 <input type="checkbox"/> Yes
<input type="checkbox"/> Unknown	<input type="checkbox"/> E-nicotine delivery system	0 <input type="checkbox"/> No
	<input type="checkbox"/> Marijuana	9 <input type="checkbox"/> Unknown

**45. Other Substances** (Check all that apply):  None  Unknown

**Documented Use Disorder (DUD/Abuse):** **Mode of Delivery** (Check all that apply):

<input type="checkbox"/> Marijuana (other than smoking)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Opioid, NOS	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Cocaine	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Methamphetamine	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Other (specify): _____	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown
<input type="checkbox"/> Unknown substance	<input type="checkbox"/> DUD or abuse	<input type="checkbox"/> IDU	<input type="checkbox"/> Skin popping	<input type="checkbox"/> Non-IDU	<input type="checkbox"/> Unknown

**46. During the current hospitalization, did the patient receive medication-assisted treatment (MAT) for opioid use disorder?**

1  Yes    0  No    8  N/A (patient not hospitalized or did not have DUD)    9  Unknown

**OTHER CONDITIONS**

**47. For cases ≤ 1 year of age:** Gestational age at birth: \_\_\_\_\_ wks    9  Unknown    AND    Birth weight: \_\_\_\_\_ gms    9  Unknown

**48. Chronic Dialysis:**  Not on chronic dialysis     Unknown    46a. If Hemodialysis, type of vascular access:

Type:  Hemodialysis     Peritoneal     AV fistula/graft     Hemodialysis central line     Unknown

**49. Surgeries in the 90 days before, not including the DISC:**

Abdominal surgery (specify): \_\_\_\_\_

If yes: 1  Open abdomen    0  Laparoscopic    9  Unknown

Non-abdominal surgery (specify): \_\_\_\_\_

No surgery

**50. Pancreatitis in the 90 days before, not including the DISC:**

1  Yes

0  No

9  Unknown

**51. Chronic Urinary Tract Problems/Abnormalities:**    51a. If yes, did the patient have any urinary tract procedures in the 90 days before, not including the DISC?

1  Yes    0  No    9  Unknown    1  Yes    0  No    9  Unknown

**52. Was the patient neutropenic in the 2 calendar days before, not including the DISC?**

1  Yes    0  No    9  Unknown (no WBC days -2 or 0, or no differential)

**53. Did the patient have a CVC in the 2 calendar days before, not including the DISC?**

1  Yes    2  No    3  Had CVC but can't find dates    9  Unknown

If yes, check here if central line in place for > 2 calendar days:

53a. If yes, CVC type: (Check all that apply)

<input type="checkbox"/> Non-tunneled CVCs	<input type="checkbox"/> Implantable ports	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Tunneled CVCs	<input type="checkbox"/> Peripherally inserted central catheter (PICC)	<input type="checkbox"/> Unknown

53b. Were all CVCs removed or changed on the day of or in the 6 days after the DISC?

1  Yes    3  CVC removed, but can't find dates    9  Unknown

2  No    5  Died or discharged before indwelling catheter replaced

**54. Did the patient have a midline catheter in the 2 calendar days before, not including the DISC?**

1  Yes    0  No    9  Unknown

**55. Did the patient have any of the following indwelling devices or other devices present in the 2 calendar days before, not including the DISC?**  None  Unknown

<input type="checkbox"/> Urinary Catheter/Device	<input type="checkbox"/> Respiratory	<input type="checkbox"/> Gastrointestinal
<input type="checkbox"/> Indwelling urethral	<input type="checkbox"/> ET/NT	<input type="checkbox"/> Abdominal drain (specify): _____
<input type="checkbox"/> Suprapubic	<input type="checkbox"/> Tracheostomy	<input type="checkbox"/> Gastrostomy
	<input type="checkbox"/> Invasive mechanical ventilation	

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**56. Did the patient have a positive SARS-CoV-2 test result (molecular assay, serology, or other confirmatory test) from a specimen collected in the 90 days before the DISC or on the DISC?**

1  Yes    0  No    9  Unknown

56a. If yes, date of specimen collection for initial positive SARS-CoV-2 test:

Date: \_\_\_\_\_ 9  Date Unknown

56b. If yes, EIP COVID-NET Case ID: \_\_\_\_\_ 9  Unknown     Out of EIP COVID-NET catchment area

**57. Did the patient receive systemic antibacterial medication in the 14 days before, not including the DISC?**

1  Yes    0  No    9  Unknown

**58. Did the patient receive any systemic steroids in the 30 days before, not including the DISC?**

1  Yes    0  No    9  Unknown

58a. If yes, what was the reason steroids were administered? (check all that apply)

- Steroid(s) given as an outpatient medication
- Steroid(s) given during hospitalization associated with candidemia episode prior to Candida DISC
- Steroid(s) given as part of treatment/management for COVID-19

**59. Did the patient receive total parenteral nutrition (TPN) in the 14 days before, not including the DISC?**

1  Yes    0  No    9  Unknown

**60. Did the patient receive any of the following immunomodulatory drugs in the 30 days before the DISC, not including the DISC? (check all that apply)**

None     Tocilizumab     Sarilumab     Baricitinib     Unknown

60a. If yes were any of the immunomodulatory drugs given as part of treatment/management for COVID-19?

1  Yes    0  No    9  Unknown

**61. Did the patient receive systemic antifungal medication on the day of or in the 13 days before the DISC?**

1  Yes (if Yes, fill out question 60)    0  No    9  Unknown

**62. Was the patient administered systemic antifungal medication after, not including the DISC?**

1  Yes (if Yes, fill out question 60)    0  No    9  Unknown

**63. If antifungal medication was not given to treat current candidemia infection, what was the reason?**

- 1  Patient died before culture result available to clinicians
- 2  Comfort care only measures were instituted
- 3  Patient discharged before culture result available to clinician
- 4  Medical records indicated culture result not clinically significant or contaminated
- 5  Other reason documented in medical records, specify: \_\_\_\_\_
- 6  Patient refused treatment against medical advice
- 9  Unknown

-----IF ANY ANTIFUNGAL MEDICATION WAS GIVEN, COMPLETE NEXT PAGE. -----

**OTHER**

**64. Does the chart indicate that the incident specimen was considered a contaminant or was considered to not be indicative of true of infection?**

1  Yes    0  No    9  Unknown

**65. Was the patient under the care of an infectious disease physician on the day of the DISC or within the 6 days after the DISC?**

1  Yes    0  No    9  Unknown

**ANTIFUNGAL MEDICATION TABLES**

Drug abbreviations (**NOTE: Please use abbreviation when entering data**):

- |   |                              |                            |
|---|------------------------------|----------------------------|
| Amphotericin – any IV formulation (Amphotec, Amphocil, Fungizone, Abelcet, Ambiosome, etc.)=AMBIV | Fluconazole (Diflucan)=FLC   | Other=OTH                  |
| Anidulafungin (Eraxis)=ANF  | Flucytosine (5FC)=5FC        | Posaconazole (Noxafil)=PSC |
| Caspofungin (Cancidas)=CAS  | Isavuconazole (cresemba)=ISU | UNKNOWN DRUG=UNK           |
|   | Itraconazole (Sporanox)=ITC  | Voriconazole (Vfend)=VRC   |
|   | Micafungin (Mycamine)=MFG    |                            |

60. ANTIFUNGAL MEDICATION						
a. Drug Abbrev	b. First date given (mm-dd-yyyy)	c. Date start unknown	d. Last date given (mm-dd-yyyy)	e. Date stop unknown	f. Indication	g. Reason for stopping (if applicable)*
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	

\*Reasons for stopping antifungal treatment include: (1) completion of treatment; (2) started on different antifungal; (3) hospital discharge; (4) withdrawal of care/transition to comfort care only; (5) death; (6) other; (7) no additional records/lost to follow-up; (8) not applicable, no therapy given; and (9) unknown.

-----END OF CHART REVIEW FORM-----

**AFST results for additional *Candida* isolates**

Antifungal susceptibility testing (check here  if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	3 <input type="checkbox"/> CP	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	4 <input type="checkbox"/> CT	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	5 <input type="checkbox"/> CD	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	6 <input type="checkbox"/> CL	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	7 <input type="checkbox"/> CK	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	8 <input type="checkbox"/> CGM	Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	9 <input type="checkbox"/> CO	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	10 <input type="checkbox"/> CGN	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	11 <input type="checkbox"/> CS	Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	12 <input type="checkbox"/> Pending	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	3 <input type="checkbox"/> CP	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	4 <input type="checkbox"/> CT	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	5 <input type="checkbox"/> CD	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	6 <input type="checkbox"/> CL	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	7 <input type="checkbox"/> CK	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	8 <input type="checkbox"/> CGM	Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	9 <input type="checkbox"/> CO	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	10 <input type="checkbox"/> CGN	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	11 <input type="checkbox"/> CS	Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	12 <input type="checkbox"/> Pending	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND

Antifungal susceptibility testing (check here  if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	3 <input type="checkbox"/> CP	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	4 <input type="checkbox"/> CT	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	5 <input type="checkbox"/> CD	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
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	7 <input type="checkbox"/> CK	Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	8 <input type="checkbox"/> CGM	Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	9 <input type="checkbox"/> CO	Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
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	11 <input type="checkbox"/> CS	Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	12 <input type="checkbox"/> Pending	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	1 <input type="checkbox"/> CA	Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	2 <input type="checkbox"/> CG	Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	3 <input type="checkbox"/> CP	Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
	4 <input type="checkbox"/> CT	Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
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	12 <input type="checkbox"/> Pending	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND