



- 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	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	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
	7 <input type="checkbox"/> CK	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
	8 <input type="checkbox"/> CGM	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
	9 <input type="checkbox"/> CO	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
	10 <input type="checkbox"/> CGN	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
	11 <input type="checkbox"/> CS	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
	12 <input type="checkbox"/> Pending	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
		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
		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	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	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
	7 <input type="checkbox"/> CK	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
	8 <input type="checkbox"/> CGM	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
	9 <input type="checkbox"/> CO	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
	10 <input type="checkbox"/> CGN	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
	11 <input type="checkbox"/> CS	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
	12 <input type="checkbox"/> Pending	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
		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

**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

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

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  
 B37 (candidiasis)  B48 (other mycoses, not classified elsewhere)  A41.9 (sepsis, unspecified organism)  
 Specify sub-code: \_\_\_\_\_  B49 (unspecified mycoses)  R65.2 (severe sepsis)  
 P37.5 (neonatal candidiasis)  T80.211 (BSI due to central venous catheter)  Other *Candida*-related code  
 Specify code: \_\_\_\_\_

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

- |  |  |  |
|--|--|--|
| <p><input type="checkbox"/> <b>Chronic Lung Disease</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cystic Fibrosis</li> <li><input type="checkbox"/> Chronic Pulmonary disease</li> </ul> <p><input type="checkbox"/> <b>Chronic Metabolic Disease</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Diabetes Mellitus</li> <li><input type="checkbox"/> With Chronic Complications</li> </ul> <p><input type="checkbox"/> <b>Cardiovascular Disease</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> CVA/Stroke/TIA</li> <li><input type="checkbox"/> Congenital Heart disease</li> <li><input type="checkbox"/> Congestive Heart Failure</li> <li><input type="checkbox"/> Myocardial infarction</li> <li><input type="checkbox"/> Peripheral Vascular Disease (PVD)</li> </ul> <p><input type="checkbox"/> <b>Gastrointestinal Disease</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Diverticular disease</li> <li><input type="checkbox"/> Inflammatory Bowel Disease</li> <li><input type="checkbox"/> Peptic Ulcer Disease</li> <li><input type="checkbox"/> Short gut syndrome</li> </ul> <p><input type="checkbox"/> <b>Immunocompromised Condition</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> HIV infection</li> <li><input type="checkbox"/> AIDS/CD4 count &lt;200</li> <li><input type="checkbox"/> Primary Immunodeficiency</li> <li><input type="checkbox"/> Transplant, Hematopoietic Stem Cell</li> <li><input type="checkbox"/> Transplant, Solid Organ</li> </ul> | <p><input type="checkbox"/> <b>Liver Disease</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Liver Disease</li> <li><input type="checkbox"/> Ascites</li> <li><input type="checkbox"/> Cirrhosis</li> <li><input type="checkbox"/> Hepatic Encephalopathy</li> <li><input type="checkbox"/> Variceal Bleeding</li> <li><input type="checkbox"/> Hepatitis B, chronic</li> <li><input type="checkbox"/> Hepatitis C</li> <li><input type="checkbox"/> Treated, in SVR</li> <li><input type="checkbox"/> Current, chronic</li> <li><input type="checkbox"/> Hepatitis B, acute</li> </ul> <p><input type="checkbox"/> <b>Malignancy</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Malignancy, Hematologic</li> <li><input type="checkbox"/> Malignancy, Solid Organ (non-metastatic)</li> <li><input type="checkbox"/> Malignancy, Solid Organ (metastatic)</li> </ul> <p><input type="checkbox"/> <b>Neurologic Condition</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cerebral palsy</li> <li><input type="checkbox"/> Chronic Cognitive Deficit</li> <li><input type="checkbox"/> Dementia</li> <li><input type="checkbox"/> Epilepsy/seizure/seizure disorder</li> <li><input type="checkbox"/> Multiple sclerosis</li> <li><input type="checkbox"/> Neuropathy</li> <li><input type="checkbox"/> Parkinson's disease</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul> | <p><input type="checkbox"/> <b>Plegias/Paralysis</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Hemiplegia</li> <li><input type="checkbox"/> Paraplegia</li> <li><input type="checkbox"/> Quadriplegia</li> </ul> <p><input type="checkbox"/> <b>Renal Disease</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Chronic Kidney Disease</li> <li>Lowest serum creatinine: _____ mg/DL</li> <li><input type="checkbox"/> Unknown or not done</li> </ul> <p><input type="checkbox"/> <b>Skin Condition</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Burn</li> <li><input type="checkbox"/> Decubitus/Pressure Ulcer</li> <li><input type="checkbox"/> Surgical Wound</li> <li><input type="checkbox"/> Other chronic ulcer or chronic wound</li> <li><input type="checkbox"/> Other (specify): _____</li> </ul> <p><input type="checkbox"/> <b>Other</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Connective tissue disease</li> <li><input type="checkbox"/> Obesity or morbid obesity</li> <li><input type="checkbox"/> Pregnant</li> </ul> |
|--|--|--|

**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:**

1  Yes    0  No    9  Unknown

**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

**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	

**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  
 Anidulafungin (Eraxis)=ANF  
 Caspofungin (Cancidas)=CAS

Fluconazole (Diflucan)=FLC  
 Flucytosine (5FC)=5FC  
 Isavuconazole (cresemba)=ISU  
 Itraconazole (Sporanox)=ITC  
 Micafungin (Mycamine)=MFG

Other=OTH  
 Posaconazole (Noxafil)=PSC  
 UNKNOWN DRUG=UNK  
 Voriconazole (Vfend)=VRC

**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
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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

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

Date of culture	Species	Drug	MIC	Interpretation
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	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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