



Triazole-resistant *Aspergillus fumigatus* Case Report Form

Form Approved
OMB Control No.: 0920-XXXX
Exp. date: XX/XX/XXXX

_____ THIS SECTION IS COMPLETED BY CDC _____

Unique patient ID (DCIPHER): _____ ARLN specimen ID: _____

ARLN isolate ID: _____ ARLN patient ID: _____

Form completion data

Name of person completing this form: _____

Institution: _____

Email: _____ Telephone: _____

Date form completed (mm-dd-yyyy): _____ Date of incident specimen collection (DISC)* (mm-dd-yyyy): _____

This is the earliest date that a patient had a positive test for triazole-resistant *A. fumigatus

A. Patient demographics

<p>1. Age at DISC (use months or days if patient was aged <2 years):</p> <p>_____ Years</p> <p>_____ Months</p> <p>_____ Days</p> <p>_____ Unknown</p>	<p>2. Sex:</p> <p>Male</p> <p>Female</p> <p>Other (specify): _____</p> <p>_____ Unknown</p>	<p>3. Ethnic origin:</p> <p>Hispanic or Latino</p> <p>Not Hispanic or Latino</p> <p>Unknown</p>
<p>4. Race (select all that apply):</p> <p>American Indian/ Alaska Native</p> <p>Asian</p> <p>Black/African American</p> <p>Native Hawaiian/ Pacific Islander</p> <p>White</p> <p>Unknown</p>	<p>5. Patient's county of residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"):</p> <p>_____</p> <p>_____ Unknown</p>	
<p>6. Patient's state, jurisdiction, or territory of residence:</p> <p>_____</p> <p>_____ Unknown</p>		<p>7. Patient's country of residence (e.g., USA):</p> <p>_____</p> <p>_____ Unknown</p>
<p>8. Healthcare facility name (Note: 'healthcare facility' refers to the facility where the patient's incident specimen was collected):</p> <p>_____</p> <p>_____ Unknown</p>		<p>9. Healthcare facility CMS ID#:</p> <p>_____</p> <p>_____ Unknown</p>
<p>10. Healthcare facility ZIP code:</p> <p>_____</p> <p>_____ Unknown</p>	<p>11. Healthcare facility state, jurisdiction, or territory:</p> <p>_____</p> <p>_____ Unknown</p>	
<p>12. Healthcare facility type:</p> <p>Acute care hospital</p> <p>Long-term acute care hospital (LTACH)</p> <p>Skilled nursing facility with ventilated residents (vSNF)</p> <p>Skilled nursing facility without ventilated residents (SNF)</p> <p>Outpatient</p> <p>Unknown</p> <p>Other: _____</p>		

Public reporting burden of this collection of information is estimated to average 30 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 30333; ATTN: PRA 0920-XXXX.

B. Patient underlying risk factors & medical conditions present during the 2 years before DISC
(unless other timeframe specified)

<p>1. Cancer</p> <p>Yes No Unknown</p>	<p>If yes (select all that apply):</p> <p>Hematologic malignancy, specify type: _____</p> <p>Solid organ malignancy, specify type: _____</p>															
<p>2. HIV-infection</p> <p>Yes No Unknown</p>	<p>If yes, choose one of the below:</p> <p>Ever had CD4 < 200 cells/mm³ within past 6 months?</p> <p>Yes No Unknown</p>															
<p>3. Chronic pulmonary diagnosis:</p> <table border="0"> <tr> <td>Yes</td> <td>No</td> <td>Unknown</td> </tr> <tr> <td>Chronic obstructive pulmonary disease (COPD) or emphysema</td> <td>Pulmonary fibrosis</td> <td></td> </tr> <tr> <td>Bronchiectasis</td> <td>Asthma</td> <td></td> </tr> <tr> <td>Cystic fibrosis</td> <td>Interstitial lung disease</td> <td></td> </tr> <tr> <td>Allergic bronchopulmonary aspergillosis (ABPA)</td> <td>Other chronic pulmonary diagnosis (specify): _____</td> <td></td> </tr> </table>	Yes	No	Unknown	Chronic obstructive pulmonary disease (COPD) or emphysema	Pulmonary fibrosis		Bronchiectasis	Asthma		Cystic fibrosis	Interstitial lung disease		Allergic bronchopulmonary aspergillosis (ABPA)	Other chronic pulmonary diagnosis (specify): _____		
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<p>4. Positive respiratory viral test in 30 days before DISC?</p> <p>Yes No Unknown</p>	<p>If yes, (select all that apply):</p> <p>SARS-CoV-2 (PCR or antigen test), (if yes, select one):</p> <p>Antigen or Unknown test type PCR</p> <p>Influenza</p> <p>Other respiratory virus (specify): _____</p>															
<p>5. Transplant received within 2 years before DISC?</p> <p>Yes No Unknown</p>	<p>If yes, specify:</p> <p>Solid organ transplant (specify):</p> <table border="0"> <tr> <td>Lung</td> <td>Liver</td> </tr> <tr> <td>Heart</td> <td>Skin graft</td> </tr> <tr> <td>Kidney</td> <td>Other: _____</td> </tr> <tr> <td>Pancreas</td> <td></td> </tr> </table> <p>Hematopoietic stem cell transplant (HSCT)</p>	Lung	Liver	Heart	Skin graft	Kidney	Other: _____	Pancreas								
Lung	Liver															
Heart	Skin graft															
Kidney	Other: _____															
Pancreas																
<p>6. Other selected conditions:</p> <p>Yes No Unknown</p>	<p>If yes, specify:</p> <table border="0"> <tr> <td>Diabetes mellitus</td> <td>Cirrhosis</td> </tr> <tr> <td>End stage renal disease/dialysis</td> <td>Medications/therapies that weaken the immune system (specify):</td> </tr> <tr> <td>Autoimmune disease(s) or inherited immunodeficiency(-ies), (specify):</td> <td></td> </tr> <tr> <td><div style="border: 1px solid black; height: 40px; width: 100%;"></div></td> <td><div style="border: 1px solid black; height: 40px; width: 100%;"></div></td> </tr> </table>	Diabetes mellitus	Cirrhosis	End stage renal disease/dialysis	Medications/therapies that weaken the immune system (specify):	Autoimmune disease(s) or inherited immunodeficiency(-ies), (specify):		<div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>							
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<p>7. Other potentially relevant clinical information?</p> <p>Yes No Unknown</p>	<p>If yes, specify:</p> <div style="border: 1px solid black; height: 80px; width: 100%;"></div>															

C. Patient diagnosis and outcomes

1. According to treating clinicians, which clinical syndrome(s) related to *Aspergillus* did the patient have?

Invasive pulmonary aspergillosis (IPA)

Other disease/syndrome(s) related to *A. fumigatus*: _____

OR

Aspergillus was not believed to be causing clinical illness or is not mentioned in medical records

Unknown

2. Was the patient hospitalized at an acute care hospital in the 30 days before to 30 days after DISC?

Yes

No

Unknown

If yes, dates of admission of hospitalization most proximal to DISC:

Admission date (mm-dd-yyyy): _____ Discharge date: (mm-dd-yyyy): _____

Still hospitalized

If yes, received ICU-level care in the 14 days before DISC?

Yes

No

Unknown

Received ICU-level care in the 14 days after DISC?

Yes

No

Unknown

Discharge ICD-10 diagnosis code(s):

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3. Died within 30 days after DISC?

No

Yes, date of death:

Cause(s) of death:

Unknown

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D. Antifungal treatment

Please use the table below to indicate antifungal drugs that the patient received during the 60 days before to 30 days after the DISC. Indicate one of the following to complete each row of the table.

Amphotericin B lipid complex (**ABLC**)
Liposomal Amphotericin B (**L-AmB**)
Amphotericin B colloidal dispersion (**ABCD**)
Anidulafungin (**ANF**)
Caspofungin (**CAS**)
Fluconazole (not mold-active) (**FLC**)

Flucytosine (**5FC**)
Isavuconazole (**ISA**)
Itraconazole (**ITC**)
Micafungin (**MFG**)
Posaconazole (**PSC**)
Voriconazole (**VRC**)

Other drug (**OTH**) (specify):

Unknown drug (**UNK**)

a. Drug Abbrev	b. First date given (mm-dd-yyyy)	c. Last date given (mm-dd-yyyy)	d. Indication
_____	_____ Start date unknown Start date was >60 days before DISC	_____ Still on treatment at time CRF completed Stop date unknown	Prophylaxis Treatment for <i>Aspergillus</i> Treatment for non- <i>Aspergillus</i> infection
_____	_____ Start date unknown Start date was >60 days before DISC	_____ Still on treatment at time CRF completed Stop date unknown	Prophylaxis Treatment for <i>Aspergillus</i> Treatment for non- <i>Aspergillus</i> infection
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F. Supplemental patient interview form (Note that "you" in these questions refers to the patient.)

<p>1. Person interviewed</p> <p>Patient Someone other than the patient, (specify relationship to patient): _____</p>	<p>2. What was your job or occupation before [DISC]?</p> <p>_____</p> <p>Unemployed Refused to answer Retired Unknown N/A</p>																
<p>3. Did you travel outside of [healthcare facility state] within 3 months before [DISC]? (note: if healthcare facility is in a different state from patient's residence, then please count time spent in the patient's home state as "travel")</p> <p>Yes No Unknown</p> <p>If yes, list state(s), territory(-ies), jurisdiction(s), country(-ies): _____</p>																	
<p>4. Did you perform any of the following activities during the 90 days before [DISC]</p> <table border="0"> <tr> <td>Gardening</td> <td>Yes</td> <td>No</td> <td>Unknown</td> </tr> <tr> <td>Handling compost</td> <td>Yes</td> <td>No</td> <td>Unknown</td> </tr> <tr> <td>Handling a fungicide product</td> <td>Yes</td> <td>No</td> <td>Unknown</td> </tr> <tr> <td>Spending time on a farm</td> <td>Yes</td> <td>No</td> <td>Unknown</td> </tr> </table> <p>If you spent time on a farm in the 90 days before [DISC], describe location, type of crop(s) grown (if applicable), and activities performed on farm: _____</p>		Gardening	Yes	No	Unknown	Handling compost	Yes	No	Unknown	Handling a fungicide product	Yes	No	Unknown	Spending time on a farm	Yes	No	Unknown
Gardening	Yes	No	Unknown														
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Additional comments: