Form Approved

OMB Control No.: 0920-XXXX

Exp. date: XX/XX/XXXX

**Triazole-resistant *Aspergillus fumigatus* case report form**

Unique patient ID (DCIPHER): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARLN specimen ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ARLN isolate ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ARLN patient ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Form completion data** | | |
| Name of person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date form completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *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* | | |
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| **A. Patient demographics** | | |
| 1. Age at DISC:  (use months or days if patient was aged <2 years) | \_\_\_\_\_\_\_\_ □ years □ months □ days □ unknown | |
| 2. Sex | □ Male □ Female □ other (specify): \_\_\_\_\_\_\_\_\_\_ □ unknown | |
| 3. Ethnic origin | □ Hispanic or Latino □ not Hispanic or Latino □ unknown | |
| 4. Race (select all that apply) | □ American Indian/Alaska Native □ Asian □ Black/African American  □ Native Hawaiian/Pacific Islander □ White  □ Unknown | |
| 5. Patient's county of residence | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown | |
| 6. Patient’s state, jurisdiction, or territory of residence | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown | |
| 7. Patient’s country of residence (e.g., USA) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown | |
| 8. Healthcare facility name  (Note: ‘healthcare facility’ refers to the facility where the patient’s incident specimen was collected) | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown | |
| 9. Healthcare facility CMS ID # | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown | |

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.

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| **A. Patient Demographics (continued)** | |
| 10. Healthcare facility ZIP code | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown |
| 11. Healthcare facility state, jurisdiction, or territory | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ unknown |
| 12. Healthcare facility type | □ acute care hospital  □ long-term acute care hospital (LTACH)  □ skilled nursing facility *with* ventilated residents (vSNF)  □ skilled nursing facility *without* ventilated residents (SNF)  □ outpatient  □ unknown  □ other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **B. Patient underlying risk factors & medical conditions present during the 2 years before DISC (unless other timeframe specified)** | |
| 1. Cancer□ Yes □ No □ Unknown  □ Hematologic malignancy  specify type: \_\_\_\_\_\_\_\_\_\_\_\_\_  □ Solid organ malignancy  specify type:\_\_\_\_\_\_\_\_\_\_\_\_ | 3. Chronic pulmonary diagnosis□ Yes □ No □ Unknown  □ Chronic obstructive pulmonary disease (COPD) or emphysema  □ Bronchiectasis  □ Cystic fibrosis  □ Allergic bronchopulmonary aspergillosis (ABPA)  □ Pulmonary fibrosis  □ Asthma  □ Interstitial Lung Disease  □ Other chronic pulmonary diagnosis (specify):\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. HIV-infection □ Yes □ No □ Unknown  If yes, choose one of the below  *Ever* had CD4 < 200 cells/mm3 within past 6 months  □ Yes □ No □ Unknown |
| 4. Positive respiratory viral test in **30 days before DISC** □ Yes □ No □ Unknown  If yes, (select all that apply):  □ SARS-CoV-2 (PCR or antigen test)  □ antigen □ PCR □ unknown test type  □ Influenza  □ Other respiratory virus (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 5. Transplant received within 2 years before DISC  □ Yes □ No □ Unknown    □ Solid organ transplant:  □ Lung □ Heart □ Kidney □ Pancreas □ Liver □ Skin Graft □Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Hematopoietic stem cell transplant (HSCT) |
| 6. Other selected conditions: □ Yes □ No □ Unknown  □ Diabetes mellitus  □ End stage renal disease/dialysis  □ Autoimmune disease(s) or inherited immunodeficiency(-ies)  (specify) : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Medications/therapies that weaken the immune system (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Cirrhosis | 7. Other potentially relevant clinical information?  □ Yes (specify below) □ No □ Unknown  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |

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| **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*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ *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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 3. Died within 30 days after DISC? | □ no  □ yes, date of death \_\_\_\_\_\_\_ - \_\_\_\_\_\_\_- \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm-dd-yyyy)  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. | | | |
| Select one of the following to complete each row of the table | | | | |
| Amphotericin B lipid complex (ABLC)  Liposomal Amphotericin B (L-AmB)  Amphotericin B coloidal dispersion (ABCD)  Anidulafungin (ANF) | | Caspofungin (CAS)  Fluconazole (FLC)\*  Flucytosine (5FC)  Isavuconazole (ISA) | Itraconazole (ITC)  Micafungin (MFG)  Posaconazole (PSC)  Voriconazole (VRC) | Other drug (specify):  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Unknown drug (UNK)  \*Indicates not mold-active |

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| **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 *Aspergillus*  □ Treatment for non-*Aspergillus* infection |
|  | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Start date unknown  □ Start date was >60 days before DISC | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Still on treatment at time CRF completed  □ Stop date unknown | □ Prophylaxis  □ Treatment for *Aspergillus*  □ Treatment for non-*Aspergillus* infection |
|  | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Start date unknown  □ Start date was >60 days before DISC | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Still on treatment at time CRF completed  □ Stop date unknown | □ Prophylaxis  □ Treatment for *Aspergillus*  □ Treatment for non-*Aspergillus* infection |
|  | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Start date unknown  □ Start date was >60 days before DISC | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Still on treatment at time CRF completed  □ Stop date unknown | □ Prophylaxis  □ Treatment for *Aspergillus*  □ Treatment for non-*Aspergillus* infection |
|  | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Start date unknown  □ Start date was >60 days before DISC | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Still on treatment at time CRF completed  □ Stop date unknown | □ Prophylaxis  □ Treatment for *Aspergillus*  □ Treatment for non-*Aspergillus* infection |
|  | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Start date unknown  □ Start date was >60 days before DISC | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Still on treatment at time CRF completed  □ Stop date unknown | □ Prophylaxis  □ Treatment for *Aspergillus*  □ Treatment for non-*Aspergillus* infection |
|  | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Start date unknown  □ Start date was >60 days before DISC | \_\_\_ \_\_\_ - \_\_\_ \_\_\_ - \_\_\_ \_\_\_ \_\_\_ \_\_\_  □ Still on treatment at time CRF completed  □ Stop date unknown | □ Prophylaxis  □ Treatment for *Aspergillus*  □ Treatment for non-*Aspergillus* infection |

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| **F. Supplemental patient interview form:**  Note that “you” in these questions refers to the patient. | |
| 1. Person interviewed | □ Patient □ Someone other than the patient, (specify relationship to patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. What was your job or occupation before [DISC]? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Unemployed □ Retired □ N/A  □ Refused □ Unknown |
| 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”)  List state(s), territory(-ies), jurisdiction(s), country(-ies) | □ Yes □ No □ Unknown  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Did you perform any of the following activities during the 90 days before [DISC] | |  |  | | --- | --- | | Gardening | □ Yes □ No □ Unknown | | Handling compost | □ Yes □ No □ Unknown | | Handling a fungicide product | □ Yes □ No □ Unknown | | Spending time on a farm | □ Yes □ No □ Unknown | |  |  | |  |  | | If patient spent time on a farm in 90 days before DISC, describe location, type of crop(s) grown (if applicable), and activities performed on farm: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*  *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  | |  |  | |

**Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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