

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

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: _____  Date of incident specimen collection (DISC)*: ____ - ____ - ____ (mm-dd-yyyy) *This is the earliest date that a patient had a positive test for triazole-resistant <i>A. fumigatus</i>

A. Patient demographics	
1. Age at DISC: (use months or days if patient was aged <2 years)	_____ <input type="checkbox"/> years <input type="checkbox"/> months <input type="checkbox"/> days <input type="checkbox"/> unknown
2. Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> other (specify): _____ <input type="checkbox"/> unknown
3. Ethnic origin	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> not Hispanic or Latino <input type="checkbox"/> unknown
4. Race (select all that apply)	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown
5. Patient's county of residence	_____ <input type="checkbox"/> unknown
6. Patient's state, jurisdiction, or territory of residence	_____ <input type="checkbox"/> unknown
7. Patient's country of residence (e.g., USA)	_____ <input type="checkbox"/> unknown
8. Healthcare facility name  (Note: 'healthcare facility' refers to the facility where the patient's incident specimen was collected)	_____ <input type="checkbox"/> unknown
9. Healthcare facility CMS ID #	_____ <input type="checkbox"/> 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.

A. Patient Demographics (continued)	
10. Healthcare facility ZIP code	_____ <input type="checkbox"/> unknown
11. Healthcare facility state, jurisdiction, or territory	_____ <input type="checkbox"/> unknown
12. Healthcare facility type	<input type="checkbox"/> acute care hospital <input type="checkbox"/> long-term acute care hospital (LTACH) <input type="checkbox"/> skilled nursing facility <i>with</i> ventilated residents (vSNF) <input type="checkbox"/> skilled nursing facility <i>without</i> ventilated residents (SNF) <input type="checkbox"/> outpatient <input type="checkbox"/> unknown <input type="checkbox"/> other _____

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

C. Patient diagnosis and outcomes	
<p>1. According to treating clinicians, which clinical syndrome(s) related to <i>Aspergillus</i> did the patient have?</p>	<p><input type="checkbox"/> Invasive pulmonary aspergillosis (IPA)</p> <p><input type="checkbox"/> Other disease/syndrome(s) related to <i>A. fumigatus</i>: _____</p> <p><input type="checkbox"/> <i>Aspergillus</i> was <b>not</b> believed to be causing clinical illness or is not mentioned in medical records</p> <p><input type="checkbox"/> unknown</p>
<p>2. Was the patient hospitalized at an acute care hospital in the 30 days before to 30 days after DISC?</p>	<p><input type="checkbox"/> yes   <input type="checkbox"/> no   <input type="checkbox"/> unknown</p> <p><i>If yes, dates of admission of hospitalization most proximal to DISC,</i></p> <p>Admission date: _____ - _____ - _____ (mm-dd-yyyy)</p> <p>Discharge date: _____ - _____ - _____ (mm-dd-yyyy)   <input type="checkbox"/> still hospitalized</p> <p><i>If yes,</i></p> <p>Received ICU-level care in the 14 days <i>before</i> DISC?:   <input type="checkbox"/> yes   <input type="checkbox"/> no   <input type="checkbox"/> unknown</p> <p>Received ICU-level care in the 14 days <i>after</i> DISC?:   <input type="checkbox"/> yes   <input type="checkbox"/> no   <input type="checkbox"/> unknown</p> <p>Discharge ICD-10 diagnosis code(s): _____</p>
<p>3. Died within 30 days after DISC?</p>	<p><input type="checkbox"/> no</p> <p><input type="checkbox"/> yes, date of death _____ - _____ - _____ (mm-dd-yyyy)</p> <p>Cause(s) of death _____</p> <p><input type="checkbox"/> unknown</p>

**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)	Caspofungin (CAS)	Itraconazole (ITC)	Other drug (specify):
Liposomal Amphotericin B (L-AmB)	Fluconazole (FLC)*	Micafungin (MFG)	_____
Amphotericin B colloidal dispersion (ABCD)	Flucytosine (5FC)	Posaconazole (PSC)	Unknown drug (UNK)
Anidulafungin (ANF)	Isavuconazole (ISA)	Voriconazole (VRC)	*Indicates not mold-active

Drug Abbrev	b. First date given (mm-dd-yyyy)	c. Last date given (mm-dd-yyyy)	d. Indication
	<p>_____ - _____ - _____</p> <p><input type="checkbox"/> Start date unknown</p> <p><input type="checkbox"/> Start date was &gt;60 days before DISC</p>	<p>_____ - _____ - _____</p> <p><input type="checkbox"/> Still on treatment at time CRF completed</p> <p><input type="checkbox"/> Stop date unknown</p>	<p><input type="checkbox"/> Prophylaxis</p> <p><input type="checkbox"/> Treatment for <i>Aspergillus</i></p> <p><input type="checkbox"/> Treatment for non-<i>Aspergillus</i> infection</p>
	<p>_____ - _____ - _____</p> <p><input type="checkbox"/> Start date unknown</p> <p><input type="checkbox"/> Start date was &gt;60 days before DISC</p>	<p>_____ - _____ - _____</p> <p><input type="checkbox"/> Still on treatment at time CRF completed</p> <p><input type="checkbox"/> Stop date unknown</p>	<p><input type="checkbox"/> Prophylaxis</p> <p><input type="checkbox"/> Treatment for <i>Aspergillus</i></p> <p><input type="checkbox"/> Treatment for non-<i>Aspergillus</i> infection</p>
	<p>_____ - _____ - _____</p> <p><input type="checkbox"/> Start date unknown</p> <p><input type="checkbox"/> Start date was &gt;60 days before DISC</p>	<p>_____ - _____ - _____</p> <p><input type="checkbox"/> Still on treatment at time CRF completed</p> <p><input type="checkbox"/> Stop date unknown</p>	<p><input type="checkbox"/> Prophylaxis</p> <p><input type="checkbox"/> Treatment for <i>Aspergillus</i></p> <p><input type="checkbox"/> Treatment for non-<i>Aspergillus</i> infection</p>
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F. Supplemental patient interview form:									
Note that "you" in these questions refers to the patient.									
1. Person interviewed	<input type="checkbox"/> Patient <input type="checkbox"/> Someone other than the patient, (specify relationship to patient): _____								
2. What was your job or occupation before [DISC]?	_____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> N/A <input type="checkbox"/> Refused <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  _____ _____								
4. Did you perform any of the following activities during the 90 days before [DISC]	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">Gardening</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Handling compost</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Handling a fungicide product</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</td> </tr> <tr> <td>Spending time on a farm</td> <td><input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Unknown</td> </tr> </table> <p>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:</p> <p>_____</p> <p>-----</p> <p>-----</p>	Gardening	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Handling compost	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Handling a fungicide product	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Spending time on a farm	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Additional comments: \_\_\_\_\_

\_\_\_\_\_