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

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 *(Please do not write the word "County"; for example, write "Cook" instead of "Cook County")*:

_____
- ☐ 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

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: _____

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)

1. Cancer

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes *(select all that apply)*:

- ☐ Hematologic malignancy, specify type: _____
- ☐ Solid organ malignancy, specify type: _____

2. HIV-infection

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, choose one of the below:

***Ever* had CD4 < 200 cells/mm^3 within past 6 months?**

- ◯ Yes
- ◯ No
- ◯ Unknown

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)*: _____

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), *(if yes, select one)*:
  - ☐ Antigen ***or*** ☐ Unknown test type
  - ☐ PCR
- ☐ Influenza
- ☐ Other respiratory virus *(specify)*: _____

5. Transplant received within 2 years before DISC?

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, specify:

- ☐ Solid organ transplant *(specify)*:
  - ☐ Lung
  - ☐ Heart
  - ☐ Kidney
  - ☐ Pancreas
  - ☐ Liver
  - ☐ Skin graft
  - ☐ Other: _____
- ☐ Hematopoietic stem cell transplant (HSCT)

6. Other selected conditions:

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, specify:

- ☐ Diabetes mellitus
- ☐ End stage renal disease/dialysis
- ☐ Autoimmune disease(s) or inherited immunodeficiency(-ies), *(specify)*:
- ☐ Cirrhosis
- ☐ Medications/therapies that weaken the immune system *(specify)*:

7. Other potentially relevant clinical information?

- ◯ Yes
- ◯ No
- ◯ Unknown

If yes, specify:

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):

3. Died within 30 days after DISC?

○ No
○ Yes, date of death: __________

Cause(s) of death:
☐ Unknown

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 coloidal 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 *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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______	______ ○ 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 to answer
- ○ 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")

○ Yes ○ No ○ Unknown

If yes, list state(s), territory(-ies), jurisdiction(s), country(-ies):

______

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 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:

Additional comments: