

1. PATIENT ID: _____	2. STATE ID: _____
3. SPECIMEN ID: _____	4. Date of incident <i>C. diff</i>+ stool collection (DISC): ____/____/____

Form Approved
OMB No. 092-0978

**CLOSTRIDIoidES DIFFICILE INFECTION (CDI) SURVEILLANCE
EMERGING INFECTIONS PROGRAM CASE REPORT**



Patient's Name: _____ Phone No.: _____
 Address: _____
 Address type: _____ Hospital: _____ Chart Number: _____

5. STATE: _____	6a. COUNTY: _____	9. Diagnostic assay for <i>C. diff</i> 9a. EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9b. GDH <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9c. Cytotoxin <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9d. NAAT (<i>C. diff</i> only) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9e. NAAT (GI panel) <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested 9.e.1 If positive, was result suppressed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 9f. Other (specify): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not tested
6b. PLANNING REGION: _____		
7. LABORATORY ID WHERE INCIDENT SPECIMEN IDENTIFIED _____	8. FACILITY ID WHERE PATIENT TREATED _____	

10. DATE OF BIRTH: ____/____/____ <input type="checkbox"/> Unknown	12. SEX AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Transgender	14. RACE: (Check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Unknown
11. AGE: (years) ____	13. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	

15. Was the patient hospitalized on the day of or in the 6 calendar days after the DISC? Yes No Unknown
15a. If YES, Date of Admission: ____/____/____ Unknown

16. Where was the patient located on the 3rd calendar day before the DISC?
 Private Residence Homeless
 LTCF Facility ID: _____ Incarcerated
 Hospital Inpatient Facility ID: _____ Other (specify): _____
16a. Was the patient transferred from this hospital? Yes No Unknown Unknown
 LTACH Facility ID: _____

17. Location of incident <i>C. diff</i>+ stool collection <input type="checkbox"/> Outpatient Facility ID: _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> ICU <input type="checkbox"/> Clinic/doctor's office <input type="checkbox"/> OR <input type="checkbox"/> Dialysis center <input type="checkbox"/> Radiology <input type="checkbox"/> Surgery <input type="checkbox"/> Other inpatient <input type="checkbox"/> Observation/ Clinical decision unit <input type="checkbox"/> Other outpatient <input type="checkbox"/> Hospital Inpatient Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown	18. HCFO classification questions: 18a. Was incident <i>C. diff</i>+ stool collected at least 3 calendar days after the date of hospital admission? <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No 18b. Was incident <i>C. diff</i>+ stool collected in an outpatient setting for a LTCF resident, or in a LTCF or LTACH? <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No 18c. Was the patient admitted from a LTCF or a LTACH? <input type="checkbox"/> Yes (HCFO - go to 18d) <input type="checkbox"/> No (CO - complete CRF) Facility ID: _____ 18d. If HCFO, was this case sampled for full CRF? <input type="checkbox"/> Yes (Complete CRF) <input type="checkbox"/> No (STOP data abstraction here)
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19. Patient Outcome **Unknown**
 Survived **19a. Date of discharge:** ____/____/____ Unknown
 Left against medical advice (AMA)
 Died **19c. Date of death:** ____/____/____ Unknown
19b. If survived, discharged to:
 Private residence
 LTCF Facility ID: _____ Other (specify): _____
 LTACH Facility ID: _____ Unknown

Public reporting burden of this collection of information is estimated to average 38 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 30329; ATTN: PRA (0920-0978).

20. Exposures to healthcare in the 12 weeks before the DISC

20a. Previous hospitalization Yes No Unknown Facility ID: _____
20a.1 If yes, date of discharge closest to DISC:
____/____/_____ Unknown

20b. Overnight stay in LTACH Yes No Unknown Facility ID: _____
20c. Overnight stay in LTCF Yes No Unknown Facility ID: _____

20d. Chronic dialysis Yes No Unknown
20d.1 Type Hemodialysis Peritoneal Unknown

20e. Surgery Yes No Unknown
20f. ER visit Yes No Unknown
20g. Observation/CDU stay Yes No Unknown

21. UNDERLYING CONDITIONS: (Check all that apply) None Unknown

Chronic lung disease <input type="checkbox"/> Cystic fibrosis <input type="checkbox"/> Chronic pulmonary disease	Liver disease <input type="checkbox"/> Chronic liver disease <input type="checkbox"/> Ascites <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Hepatic encephalopathy <input type="checkbox"/> Variceal bleeding <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Treated, in SVR <input type="checkbox"/> Current, chronic	Plegias/Paralysis <input type="checkbox"/> Hemiplegia <input type="checkbox"/> Paraplegia <input type="checkbox"/> Quadriplegia
Chronic metabolic disease <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> With chronic complications	Malignancy <input type="checkbox"/> Malignancy, hematologic <input type="checkbox"/> Malignancy, solid organ (non-metastatic) <input type="checkbox"/> Malignancy, solid organ (metastatic)	Renal disease <input type="checkbox"/> Chronic kidney disease Lowest serum creatinine: _____ mg/DL <input type="checkbox"/> Unknown or not done
Cardiovascular disease <input type="checkbox"/> CVA/Stroke/TIA <input type="checkbox"/> Congenital heart disease <input type="checkbox"/> Congestive heart failure <input type="checkbox"/> Myocardial infarction <input type="checkbox"/> Peripheral vascular disease (PVD)	Neurologic condition <input type="checkbox"/> Cerebral palsy <input type="checkbox"/> Chronic cognitive deficit <input type="checkbox"/> Dementia <input type="checkbox"/> Epilepsy/seizure/seizure disorder <input type="checkbox"/> Multiple sclerosis <input type="checkbox"/> Neuropathy <input type="checkbox"/> Parkinson's disease <input type="checkbox"/> Other (specify): _____	Skin condition <input type="checkbox"/> Burn <input type="checkbox"/> Decubitus/pressure ulcer <input type="checkbox"/> Surgical wound <input type="checkbox"/> Other chronic ulcer or chronic wound <input type="checkbox"/> Other (specify): _____
Gastrointestinal disease <input type="checkbox"/> Diverticular disease <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Peptic ulcer disease <input type="checkbox"/> Short gut syndrome		Other <input type="checkbox"/> Connective tissue disease <input type="checkbox"/> Obesity or morbid obesity <input type="checkbox"/> Pregnancy
Immunocompromised condition <input type="checkbox"/> HIV <input type="checkbox"/> AIDS/CD4 count < 200 <input type="checkbox"/> Primary immunodeficiency <input type="checkbox"/> Transplant, hematopoietic stem cell <input type="checkbox"/> Transplant, solid organ		

22a. Weight _____ lbs _____ oz OR _____ kg Unknown **22b. Height** _____ ft _____ in OR _____ cm Unknown **22c. BMI** _____ Unknown

23. Substance Use

23a. Smoking: None Unknown
 Tobacco E-Nicotine Delivery System Marijuana

23b. Alcohol abuse: Yes No Unknown

23c. Other substances: (Check all that apply) None Unknown

<input type="checkbox"/> Marijuana/cannabinoid (other than smoking)	<input type="checkbox"/> Documented Use Disorder (DUD)/Abuse?	Mode of delivery: (Check all that apply)
<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

During the current hospitalization, did the patient receive medication assisted treatment (MAT) for opioid use disorder?
 Yes No N/A (patient not hospitalized or did not have DUD)

24. Was CDI a primary or contributing reason for patient's admission? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown	25. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Admitted <input type="checkbox"/> Unknown 25a. If YES, what was the POA code assigned to it? <input type="checkbox"/> Y, Yes <input type="checkbox"/> W, Clinically Undetermined <input type="checkbox"/> N, No <input type="checkbox"/> Missing <input type="checkbox"/> U, Unknown <input type="checkbox"/> Not Applicable	26. Was the patient in an ICU on the day of or in the 6 days after the DISC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown 26a. If YES, date of ICU admission: ____/____/____ <input type="checkbox"/> Unknown
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27. Symptoms (in the 6 calendar days before, the day of, or 1 calendar day after the DISC) <i>(Check all that apply)</i> <input type="checkbox"/> "Asymptomatic" documented in medical record <input type="checkbox"/> Diarrhea by definition (unformed or watery stool, ≥ 3/day for ≥ 1 day) <input type="checkbox"/> Diarrhea documented, but unable to determine if it is by definition <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> No diarrhea, nausea, or vomiting documented <input type="checkbox"/> Information not available	28. Fever (in the 2 calendar days before or calendar day of the DISC) <input type="checkbox"/> Fever ≥38°C or ≥100.4°F documented Highest fever documented: _____ °C or _____ °F <input type="checkbox"/> Self-reported fever <input type="checkbox"/> No fever documented <input type="checkbox"/> Information not available
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29. Toxic megacolon and ileus (in the 6 calendar days before, the day of, or the 6 calendar days after the DISC)

29a. Radiographic findings <input type="checkbox"/> Toxic megacolon <input type="checkbox"/> Ileus <input type="checkbox"/> Both toxic megacolon and ileus <input type="checkbox"/> Neither toxic megacolon nor ileus <input type="checkbox"/> Radiology not performed <input type="checkbox"/> Information not available	29b. Clinical findings <input type="checkbox"/> Toxic megacolon <input type="checkbox"/> Ileus <input type="checkbox"/> Both toxic megacolon and ileus <input type="checkbox"/> Neither toxic megacolon nor ileus <input type="checkbox"/> Information not available
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30. Was pseudomembranous colitis listed in the surgical pathology, endoscopy, or autopsy report in the 6 calendar days before, the day of, or the 6 calendar days after the DISC? <input type="checkbox"/> Yes <input type="checkbox"/> Not Done <input type="checkbox"/> No <input type="checkbox"/> Information not available	31. Colectomy (related to CDI): 31a. If YES, Date of Procedure: <input type="checkbox"/> Yes _____ / _____ / _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Unknown
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32. Were other enteric pathogens isolated from stool collected on the DISC? <input type="checkbox"/> Astrovirus <input type="checkbox"/> Sapovirus <input type="checkbox"/> <i>Campylobacter</i> <input type="checkbox"/> Shiga Toxin-Producing <i>E.coli</i> <input type="checkbox"/> Enteroaggregative <i>E. coli</i> (EAEC) <input type="checkbox"/> <i>Shigella</i> <input type="checkbox"/> Enteropathogenic <i>E. coli</i> (EPEC) <input type="checkbox"/> <i>Yersinia enterocolitica</i> <input type="checkbox"/> Enterotoxigenic <i>E. coli</i> (ETEC) <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Norovirus <input type="checkbox"/> Rotavirus <input type="checkbox"/> <i>Salmonella</i> <input type="checkbox"/> None <input type="checkbox"/> No other pathogens tested <input type="checkbox"/> Unknown	33. LABORATORY FINDINGS (in the 6 calendar days before, the day of, or the 6 calendar days after the DISC) <table border="1" style="width:100%; border-collapse: collapse; margin-top: 5px;"> <tr> <td style="width:50%; padding: 5px;"> 33a. Albumin ≤ 2.5g/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available </td> <td style="width:50%; padding: 5px;"> 33c. White blood cell count ≥ 15,000/μl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available </td> </tr> <tr> <td style="width:50%; padding: 5px;"> 33b. White blood cell count ≤ 1,000/μl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available </td> <td style="width:50%; padding: 5px;"> 33d. Serum creatinine > 1.5 mg/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available </td> </tr> </table>	33a. Albumin ≤ 2.5g/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available	33c. White blood cell count ≥ 15,000/μl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available	33b. White blood cell count ≤ 1,000/μl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available	33d. Serum creatinine > 1.5 mg/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available
33a. Albumin ≤ 2.5g/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available	33c. White blood cell count ≥ 15,000/μl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available				
33b. White blood cell count ≤ 1,000/μl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available	33d. Serum creatinine > 1.5 mg/dl: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Done <input type="checkbox"/> Information not available				

34. MEDICATIONS taken in the 12 weeks before the DISC:

34a. Proton pump inhibitor (e.g. Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	34b. H2 Blockers (e.g. Famotidine, Ranitidine, Cimetidine) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	34c. Immunosuppressive therapy <i>(Check all that apply)</i> <input type="checkbox"/> Steroids <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Other agents (<i>specify</i>): _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown
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34d. Antimicrobial therapy <i>(Check all that apply)</i> <input type="checkbox"/> Yes, name unknown <input type="checkbox"/> None <input type="checkbox"/> Unknown				
<input type="checkbox"/> Amikacin	<input type="checkbox"/> Cefotaxime	<input type="checkbox"/> Clindamycin	<input type="checkbox"/> Meropenem	<input type="checkbox"/> Telavancin
<input type="checkbox"/> Amoxicillin	<input type="checkbox"/> Cefoxitin	<input type="checkbox"/> Dalbavancin	<input type="checkbox"/> Meropenem/vaborbactam	<input type="checkbox"/> Tigecycline
<input type="checkbox"/> Amoxicillin/clavulanic acid	<input type="checkbox"/> Cefpodoxime	<input type="checkbox"/> Daptomycin	<input type="checkbox"/> Metronidazole	<input type="checkbox"/> Tobramycin
<input type="checkbox"/> Ampicillin	<input type="checkbox"/> Ceftaroline	<input type="checkbox"/> Delafloxacin	<input type="checkbox"/> Moxifloxacin	<input type="checkbox"/> Trimethoprim
<input type="checkbox"/> Ampicillin/sulbactam	<input type="checkbox"/> Ceftazidime	<input type="checkbox"/> Doripenem	<input type="checkbox"/> Nitrofurantoin	<input type="checkbox"/> Trimethoprim/sulfamethoxazole
<input type="checkbox"/> Azithromycin	<input type="checkbox"/> Ceftazidime/avibactam	<input type="checkbox"/> Doxycycline	<input type="checkbox"/> Omadacycline	<input type="checkbox"/> Vancomycin (IV)
<input type="checkbox"/> Aztreonam	<input type="checkbox"/> Ceftizoxime	<input type="checkbox"/> Eravacycline	<input type="checkbox"/> Oritavancin	<input type="checkbox"/> Vancomycin (PO for prophylaxis)
<input type="checkbox"/> Cefadroxil	<input type="checkbox"/> Ceftolozane/tazobactam	<input type="checkbox"/> Ertapenem	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Other (<i>specify</i>): _____
<input type="checkbox"/> Cefazolin	<input type="checkbox"/> Ceftriaxone	<input type="checkbox"/> Fosfomycin	<input type="checkbox"/> Piperacillin/tazobactam	
<input type="checkbox"/> Cefdinir	<input type="checkbox"/> Cefuroxime	<input type="checkbox"/> Gentamicin	<input type="checkbox"/> Polymyxin B	
<input type="checkbox"/> Cefepime	<input type="checkbox"/> Cephalixin	<input type="checkbox"/> Imipenem/cilastatin	<input type="checkbox"/> Polymyxin E (colistin)	
<input type="checkbox"/> Cefiderocol	<input type="checkbox"/> Ciprofloxacin	<input type="checkbox"/> Levofloxacin	<input type="checkbox"/> Rifaximin	
<input type="checkbox"/> Cefixime	<input type="checkbox"/> Clarithromycin	<input type="checkbox"/> Linezolid	<input type="checkbox"/> Tedizolid	

34e. Was patient treated for suspected or confirmed CDI in the 12 weeks before the DISC?
 Yes No Unknown

34f.1 If YES, which medication was taken (Check all that apply):
 Metronidazole Vancomycin Fidaxomicin Other, (specify) _____ Unknown

35. Treatment for incident CDI No treatment Unknown treatment

35a.1 Course 1
Start Date: ____/____/____ Unknown **Stop Date:** ____/____/____ Unknown **OR Duration (days)** ____ Unknown
 Vancomycin (PO) Metronidazole (PO) Rifaximin
 Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
 Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
 Vancomycin taper (any route) Fidaxomicin

35a.2 Course 2
Start Date: ____/____/____ Unknown **Stop Date:** ____/____/____ Unknown **OR Duration (days)** ____ Unknown
 Vancomycin (PO) Metronidazole (PO) Rifaximin
 Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
 Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
 Vancomycin taper (any route) Fidaxomicin

35a.3 Course 3
Start Date: ____/____/____ Unknown **Stop Date:** ____/____/____ Unknown **OR Duration (days)** ____ Unknown
 Vancomycin (PO) Metronidazole (PO) Rifaximin
 Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
 Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
 Vancomycin taper (any route) Fidaxomicin

35a.4 Course 4
Start Date: ____/____/____ Unknown **Stop Date:** ____/____/____ Unknown **OR Duration (days)** ____ Unknown
 Vancomycin (PO) Metronidazole (PO) Rifaximin
 Vancomycin (Rectal) Metronidazole (IV) Nitazoxanide
 Vancomycin (Unknown route) Metronidazole (Unknown route) Other (specify): _____
 Vancomycin taper (any route) Fidaxomicin

35b. **Probiotics (specify):** _____

35c. **Stool transplant Date:** ____/____/____ Unknown

<p>36. Did the patient have a positive test(s) for SARS-CoV-2 (molecular assay, antigen, or other viral test; excluding serology) in the 90 days before or day of the DISC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>36a. Specimen collection dates for positive tests in the 90 days before or day of DISC</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:50%; border-right: 1px solid black; vertical-align: top;"> <p>36a.1. First positive test: ____/____/____ <input type="checkbox"/> Date Unknown</p> </td> <td style="width:50%; vertical-align: top;"> <p>36a.2 Most recent positive test: ____/____/____ <input type="checkbox"/> Date Unknown</p> </td> </tr> </table>		<p>36a.1. First positive test: ____/____/____ <input type="checkbox"/> Date Unknown</p>	<p>36a.2 Most recent positive test: ____/____/____ <input type="checkbox"/> Date Unknown</p>
	<p>36a.1. First positive test: ____/____/____ <input type="checkbox"/> Date Unknown</p>	<p>36a.2 Most recent positive test: ____/____/____ <input type="checkbox"/> Date Unknown</p>		

37. COVID-NET Case IDs: _____

<p>38. Previous unique CDI episode (>8 weeks before the DISC): <input type="checkbox"/> Yes <input type="checkbox"/> No 38a. If YES, previous STATEID: _____</p>	<p>39. Any recurrent C. diff+ episodes following this incident C. diff+ episode? <input type="checkbox"/> Yes <input type="checkbox"/> No 39a. If YES, Date of first recurrent specimen: ____/____/____</p>	<p>40. CRF status: <input type="checkbox"/> Complete <input type="checkbox"/> Incomplete <input type="checkbox"/> Chart unavailable after 3 requests</p>	<p>41. Initials of S.O: _____</p>	<p>42. Date of abstraction: ____/____/____</p>
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Comments: