Form Approved
OMB No. 0920-1385
Exp. Date: 3/31/26

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 *A. fumigatus*

A. Patient demographics	
1. Age at DISC: (use months or days if patient was aged <2 years)	_____ ◻ Years ◻ Months ◻ Days ◻ Unknown
2.Assigned sex at birth	◻ Male ◻ Female ◻ Unknown
3. Gender identity	◻ Male ◻ Female ◻ Transgender, non-binary, or another gender ◻ Prefer not to answer/Decline ◻ Unknown
4. Ethnic origin	◻ Hispanic or Latino ◻ Not Hispanic or Latino ◻ Unknown
5. Race (select all that apply)	◻ American Indian/Alaska Native ◻ Asian ◻ Black/African American ◻ Native Hawaiian/Pacific Islander ◻ White ◻ Unknown
6. Patient's county of residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"):	_____ ◻ Unknown
7. Patient's state, jurisdiction, or territory of residence	_____ ◻ Unknown
8. Patient's country of residence (e.g., USA)	_____ ◻ Unknown
9. Healthcare facility name (Note: 'healthcare facility' refers to the facility where the patient's incident specimen was collected)	_____ ◻ Unknown
10. Healthcare facility CMS ID #	_____ ◻ Unknown

CDC estimates the average public reporting burden for this collection of information as 30 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information 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 CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS H21-8, Atlanta, Georgia 30333; ATTN: PRA (0920-1385).

A. Patient Demographics (continued)	
11. Healthcare facility ZIP code	_____ □ Unknown
12. Healthcare facility state, jurisdiction, or territory	_____ □ Unknown
13. Healthcare facility type	□ Acute care hospital (ACH) □ Long-term acute care hospital (LTACH) □ Skilled nursing facility *with* ventilated residents (vSNF) □ Skilled nursing facility *without* ventilated residents (SNF) □ Outpatient □ Unknown □ Other _____

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:_____ □ Chemotherapy If yes, specify: _____	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/mm^3 within past 6 months □ Yes □ No □ Unknown	
4. Positive respiratory viral test in 120 **days before or after 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 □ Cardiovascular disease (specify): _____ □ Diabetes mellitus □ End stage renal disease/dialysis □ Autoimmune disease(s) or inherited immunodeficiency(-ies) (specify): _____ □ Medications/therapies that weaken the immune system □ TNF-alpha inhibitors (e.g., infliximab, adalimumab, etanercept) □ Other (specify): _____ □ Cirrhosis □ Liver disease without cirrhosis □ Systemic lupus erythematosus □ Active tuberculosis □ Pregnant □ Pregnant on DISC Gestational age (weeks):_____ Unknown	7. Other potentially relevant clinical information? □ Yes (specify below) □ No □ Unknown _____ _____ _____ _____ _____

□ Post-partum (gave birth within 6 weeks before DISC)	

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

D. Antifungal treatment: Did the patient receive antifungal drugs during the 60 days before to 30 days after the DISC? ◻ Yes ◻ No ◻ Unknown
(If yes, please complete the table below for each drug received).

Select 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) Ibrexafungerp (IBR)	Isavuconazole (ISA) Itraconazole (ITC) Micafungin (MFG) Posaconazole (PSC) Voriconazole (VRC)	Other drug (specify): ______________________ Unknown drug (UNK)

Drug Abbrev	**b. First date given** (*mm-dd-yyyy*)	**c. Last date given** (*mm-dd-yyyy*)	**d. Indication**	**e. Therapeutic drug monitoring (TDM)**
	___ ___ - ___ ___ - ___ ___ ___ ___ ◻ 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	◻ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: ◻ No
	___ ___ - ___ ___ - ___ ___ ___ ___ ◻ 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	◻ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: ◻ No
	___ ___ - ___ ___ - ___ ___ ___ ___ ◻ 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	◻ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: ◻ No
	___ ___ - ___ ___ - ___ ___ ___ ___ ◻ 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	◻ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: ◻ No
	___ ___ - ___ ___ - ___ ___ ___ ___ ◻ 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	◻ Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: ◻ No

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 ◻ Student ◻ Retired ◻ N/A

	□ Refused to answer □ Unknown
3. What was your industry before [DISC]?	_____ □ Unemployed □ Student □ 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") 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 (agriculture) □ Yes □ No □ Unknown Handling a fungicide product (home gardening) 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: _____

_____
_____
_____
_____
_____
_____
_____