

**Blastomycosis Case Report Form**

Unique patient ID (State initials + unique state ID): \_\_\_\_\_

NNDSS State ID: \_\_\_\_\_  Not applicable

NORS ID: \_\_\_\_\_  Not applicable

EIP laboratory ID: \_\_\_\_\_  Not applicable

Form completion data
Name of person completing this form: _____
Institution: _____
Email: _____
Telephone: _____
Date form completed: _____
Date reporting jurisdiction was first notified (if applicable): _____ - _____ - _____ (mm-dd-yyyy)
Date reported to EIP site (if applicable): _____ - _____ - _____ (mm-dd-yyyy)
Date chart abstraction completed (if applicable): _____ - _____ - _____ (mm-dd-yyyy)
Date patient interview completed (if applicable): _____ - _____ - _____ (mm-dd-yyyy)
CRF status: <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable
<i>Date of incident specimen collection (DISC)*: _____ - _____ - _____ (mm-dd-yyyy)</i>
*This is the date of specimen collection for the patient's first positive blastomycosis test

A. Case Surveillance Information
Reporting state/jurisdiction: _____
Reporting county: _____
Case classification status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Not a case <input type="checkbox"/> Unknown

**CHART REVIEW**

B. 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. Assigned sex at birth	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown
3. Gender identity	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender, non-binary, or another gender <input type="checkbox"/> Prefer not to answer/Decline <input type="checkbox"/> Unknown
4. Ethnic origin	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
5. 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"/> Other (specify): _____ <input type="checkbox"/> Unknown  Please specify any additional details noted in the chart about race (e.g., nationality, ethnic group): _____
6. Patient's country of primary residence (e.g., USA)	_____ <input type="checkbox"/> Unknown
7. Patient's state, jurisdiction, or territory of primary residence	_____ <input type="checkbox"/> Unknown

CDC estimates the average public reporting burden for this collection of information as 60 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).

8. Patient's county of primary residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"):	_____ <input type="checkbox"/> Unknown
9. Patient's city of primary residence	_____ <input type="checkbox"/> Unknown
10. Patient's ZIP code of primary residence	_____ <input type="checkbox"/> Unknown
11. Patient's type of health insurance at DISC	<input type="checkbox"/> Private <input type="checkbox"/> Medicare <input type="checkbox"/> Medicaid/state assistance program <input type="checkbox"/> Military <input type="checkbox"/> Indian Health Service <input type="checkbox"/> Incarcerated <input type="checkbox"/> Uninsured <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown

**C. 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 malignancy: _____ <input type="checkbox"/> Solid organ malignancy specify organ: _____ <input type="checkbox"/> Chemotherapy If yes, specify therapy type: _____	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
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): _____	4. Any respiratory viral test in 120 days before or after DISC <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) Date of specimen collection (mm/dd/yyyy): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Influenza Date of specimen collection (mm/dd/yyyy): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown <input type="checkbox"/> Other respiratory virus (specify) _____ Date of specimen collection (mm/dd/yyyy): _____ <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
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"/> Unknown  <input type="checkbox"/> Hematopoietic stem cell transplant (HSCT)	6. Other selected conditions: <input type="checkbox"/> None <input type="checkbox"/> Cardiovascular disease (specify): _____ <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 <input type="checkbox"/> TNF-alpha inhibitors (e.g., infliximab, adalimumab, etanercept) <input type="checkbox"/> Other (specify): _____ _____ <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Liver disease without cirrhosis <input type="checkbox"/> Systemic lupus erythematosus <input type="checkbox"/> Active tuberculosis <input type="checkbox"/> Pregnant <input type="checkbox"/> Pregnant on DISC Gestational age (weeks): _____ Unknown <input type="checkbox"/> Post-partum (gave birth within 6 weeks before DISC)
7. Please list any other potentially relevant clinical information: _____ _____ _____ _____	

**D. Social History**

1. Smoking (select all that apply)	<input type="checkbox"/> Tobacco, current <input type="checkbox"/> Tobacco, previous <input type="checkbox"/> E-nicotine delivery system, current <input type="checkbox"/> E-nicotine
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	delivery system, previous <input type="checkbox"/> None <input type="checkbox"/> Unknown
2. Documented alcohol use disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
3. Cannabis use	<input type="checkbox"/> Yes, with documented use disorder <input type="checkbox"/> Yes, without documented use disorder <input type="checkbox"/> No <input type="checkbox"/> Unknown
4. Other illicit substance use	<input type="checkbox"/> Yes, specify other illicit substance(s): _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown

**E. Laboratory data (specimen and testing data)**

1. Specimen collection date: \_\_\_\_/\_\_\_\_/\_\_\_\_

2. Location of specimen collection:

<input type="checkbox"/> Hospital inpatient	<input type="checkbox"/> Outpatient	<input type="checkbox"/> Long-term care facility (LTCF )
<input type="checkbox"/> Intensive care unit	<input type="checkbox"/> Emergency room	<input type="checkbox"/> Long-term acute care hospital (LTACH)
<input type="checkbox"/> Surgery/OR	<input type="checkbox"/> Clinic/Provider's office	<input type="checkbox"/> Autopsy
<input type="checkbox"/> Radiology	<input type="checkbox"/> Dialysis center	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other inpatient	<input type="checkbox"/> Surgery	<input type="checkbox"/> Unknown
_____	<input type="checkbox"/> Urgent care	
	<input type="checkbox"/> Observational/clinical decision unit	
	<input type="checkbox"/> Other outpatient _____	

**Antigen**

<input type="checkbox"/> Serum	<b>Result:</b> <input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. Below limit of quantification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	<b>Laboratory:</b> <input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> Urine	<b>Result:</b> <input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. Below limit of quantification? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.

**Serology**

<input type="checkbox"/> Serum	<b>Result:</b>	<b>Laboratory where testing was performed:</b>
<input type="checkbox"/> ID IgG	<input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> ID IgM	<input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> CF IgG	<input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> EIA IgG	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> EIA IgM	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> Unknown	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> CSF	<input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> ID IgG	<input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> ID IgM	<input type="checkbox"/> Pos., titer: ____ <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> CF IgG	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> EIA IgG	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> EIA IgM	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.
<input type="checkbox"/> Unknown	<input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.	<input type="checkbox"/> ARUP <input type="checkbox"/> MiraVista <input type="checkbox"/> Mayo <input type="checkbox"/> Quest <input type="checkbox"/> LabCorp <input type="checkbox"/> Other _____ <input type="checkbox"/> Unk.

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Other laboratory methods	
<input type="checkbox"/> Bronchial specimen <input type="checkbox"/> Culture  <input type="checkbox"/> Direct smear/cytology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>B. dermatitidis</i> <input type="checkbox"/> <i>B. gilchristii</i> <input type="checkbox"/> <i>B. helicus</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unknown <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.  <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Sputum <input type="checkbox"/> Culture  <input type="checkbox"/> Direct smear/cytology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>B. dermatitidis</i> <input type="checkbox"/> <i>B. gilchristii</i> <input type="checkbox"/> <i>B. helicus</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unknown <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.  <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Urine <input type="checkbox"/> Culture  <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>B. dermatitidis</i> <input type="checkbox"/> <i>B. gilchristii</i> <input type="checkbox"/> <i>B. helicus</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unknown <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Lung tissue <input type="checkbox"/> Culture  <input type="checkbox"/> Histopathology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>B. dermatitidis</i> <input type="checkbox"/> <i>B. gilchristii</i> <input type="checkbox"/> <i>B. helicus</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unknown <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.  <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.
<input type="checkbox"/> Other specimen _____ <input type="checkbox"/> Culture  <input type="checkbox"/> Histopathology <input type="checkbox"/> Direct smear/cytology <input type="checkbox"/> Molecular test (e.g., PCR) Specify test: _____ <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Result: <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> <i>B. dermatitidis</i> <input type="checkbox"/> <i>B. gilchristii</i> <input type="checkbox"/> <i>B. helicus</i> <input type="checkbox"/> Pending <input type="checkbox"/> Unknown <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.  <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk. <input type="checkbox"/> Pos. <input type="checkbox"/> Neg. <input type="checkbox"/> Unclear <input type="checkbox"/> Unk.

F. Antifungal susceptibility testing			
Date of culture (mm/dd/yyyy)	Species	Drug	MIC
____/____/____	<input type="checkbox"/> <i>B. dermatitidis</i> <input type="checkbox"/> <i>B. gilchristii</i> <input type="checkbox"/> <i>B. helicus</i> <input type="checkbox"/> Unknown	Amphotericin B	
		Anidulafungin (Eraxis)	
		Caspofungin (Cancidas)	
		Fluconazole (Diflucan)	
		Flucytosine (5FC)	
		Ibrexafungerp (Brexafemme)	
		Isavuconazole (Cresemba)	

		Itraconazole (Sporanox)	
		Micafungin (Mycamine)	
		Posaconazole (Noxafil)	
		Voriconazole (Vfend)	

G. Patient symptoms, diagnosis, and outcomes	
1. Acute signs/symptoms on or within 60 days before DISC?	<input type="checkbox"/> Yes <input type="checkbox"/> No acute signs or symptoms <input type="checkbox"/> Unknown
1a. Symptoms experienced on or within 60 days before DISC (select all that apply).	<b>Pulmonary:</b> <input type="checkbox"/> Cough <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of Breath  <b>Other respiratory infection symptoms:</b> <input type="checkbox"/> Sore throat <input type="checkbox"/> Chest pain <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Stiff neck <input type="checkbox"/> Headache <input type="checkbox"/> Joint or bone pain or body aches <input type="checkbox"/> Weight loss without trying <input type="checkbox"/> Muscle pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting  <b>Dermal:</b> <input type="checkbox"/> Rash or other skin problems (( <input type="checkbox"/> Erythema nodosum <input type="checkbox"/> Erythema multiforme <input type="checkbox"/> Other (specify) _____))  <b>Neurologic:</b> <input type="checkbox"/> Confusion <input type="checkbox"/> Seizures  <b>Radiologic findings:</b> <input type="checkbox"/> Abnormal findings on chest imaging (e.g., pulmonary infiltrates, cavitation, nodules, or lesions) <input type="checkbox"/> Peripheral lymphadenopathy <input type="checkbox"/> Bone or joint abnormality (e.g., osteomyelitis, pathologic fracture) <input type="checkbox"/> Meningitis, encephalitis, or focal brain lesion <input type="checkbox"/> Abscess, granuloma, or lesion in other system  <input type="checkbox"/> No acute signs/symptoms <input type="checkbox"/> Other (specify) _____
2. Date of earliest symptom onset?	_____/_____/_____ (mm/dd/yyyy) <input type="checkbox"/> If exact date unknown, approximate date of onset: _____ <input type="checkbox"/> No acute signs/symptoms <input type="checkbox"/> Unknown
3. Was the patient part of an outbreak of suspected fungal infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
4. Did the patient request to be tested for blastomycosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
5. According to treating clinicians, which clinical syndrome(s) related to <i>Blastomyces</i> did the patient have on or within 60 days after DISC?	<input type="checkbox"/> Acute pulmonary blastomycosis <input type="checkbox"/> Chronic pulmonary blastomycosis <input type="checkbox"/> Acute respiratory distress syndrome (ARDS) <input type="checkbox"/> Cutaneous blastomycosis <input type="checkbox"/> Blastomycosis meningitis Treated with a ventriculoperitoneal (VP) shunt? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Focal blastomycosis (specify site): _____ <input type="checkbox"/> Unknown
6. What other clinical diagnoses did the patient have on or within 60 days before DISC? (select all that apply)	<input type="checkbox"/> Coccidioidomycosis <input type="checkbox"/> Cryptococcosis <input type="checkbox"/> Histoplasmosis <input type="checkbox"/> Other fungal infection (specify): _____ <input type="checkbox"/> Community-acquired pneumonia <input type="checkbox"/> Bacterial pneumonia <input type="checkbox"/> Viral pneumonia <input type="checkbox"/> Cancer <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Influenza <input type="checkbox"/> COVID-19 <input type="checkbox"/> Other infection/disease not listed (specify): _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown
7. Site of <i>Blastomyces</i> infection based on clinical impression on or within 60 days after DISC (select all that apply)	<input type="checkbox"/> Lung <input type="checkbox"/> Skin <input type="checkbox"/> Bone <input type="checkbox"/> Joint <input type="checkbox"/> Central nervous system <input type="checkbox"/> No site identified <input type="checkbox"/> Other (specify) _____ <input type="checkbox"/> Unknown
8. Was the patient hospitalized at an acute care hospital in the 60 days before to 60 days after DISC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, dates of admission of hospitalization most proximal to DISC,  Admission date: ____/____/_____ (mm/dd/yyyy)

	Discharge date: ____/____/____ (mm/dd/yyyy) <input type="checkbox"/> Still hospitalized  <i>If yes,</i>  Received ICU-level care in the 14 days <i>before</i> DISC?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  Received ICU-level care in the 14 days <i>after</i> DISC?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  Discharge ICD-10 diagnosis code(s): _____
9. Died within 60 days after DISC?	<input type="checkbox"/> No  <input type="checkbox"/> Yes, date of death ____ / ____ / ____ (mm/dd/yyyy) Cause(s) of death _____ If yes, did death occur in hospital? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> unknown  <input type="checkbox"/> Unknown
10. Did the patient have any outpatient, urgent care, and/or emergency department visits in the 60 days before to 60 days after DISC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, how many visits? ____ (if more than one, fill out information below for each visit)  Date of visit: ____/____/____ (mm/dd/yyyy) If date of visit is after DISC, was the visit related to blastomycosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Setting: <input type="checkbox"/> Primary care <input type="checkbox"/> Urgent care <input type="checkbox"/> Emergency department <input type="checkbox"/> Specialty care: Pulmonology <input type="checkbox"/> Specialty care: Infectious Disease <input type="checkbox"/> Other (specify): _____ Chief complaint: _____ <input type="checkbox"/> Not listed <input type="checkbox"/> Unknown Was blastomycosis noted as a possible diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did the visit involve fever or recent onset of respiratory symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
11. Was a chest x-ray taken within 60 days before to 60 days after DISC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, were any of the chest x-rays abnormal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of first abnormal chest x-ray: ____/____/____ (mm/dd/yyyy) For first abnormal chest x-ray, select all that apply; <input type="checkbox"/> Air space density <input type="checkbox"/> Air space opacity <input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitory lesions <input type="checkbox"/> Granuloma <input type="checkbox"/> Pulmonary infiltrate <input type="checkbox"/> Interstitial infiltrate <input type="checkbox"/> Lobar infiltrate <input type="checkbox"/> Nodule <input type="checkbox"/> Report not available <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown
12. Was a chest CT scan taken within 90 days before to 60 days after DISC?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, were any of the chest CT scans abnormal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of first abnormal chest CT scan: ____/____/____ (mm/dd/yyyy) For first abnormal chest CT scan, select all that apply; <input type="checkbox"/> Air space density <input type="checkbox"/> Air space opacity <input type="checkbox"/> Consolidation <input type="checkbox"/> Cavitory lesions <input type="checkbox"/> Granuloma <input type="checkbox"/> Pulmonary infiltrate <input type="checkbox"/> Interstitial infiltrate <input type="checkbox"/> Lobar infiltrate <input type="checkbox"/> Nodule <input type="checkbox"/> Report not available <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown

H. Vital Status	
1. Has the patient died?	<input type="checkbox"/> No  <input type="checkbox"/> Yes, date of death ____ / ____ / ____ (mm/dd/yyyy) Cause(s) of death _____ If yes, did death occur in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <input type="checkbox"/> Unknown

I. Antifungal Treatment				
1. Did the patient receive antifungal drugs during the <u>90 days before to 60 days after</u> the DISC? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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 (FLC) Flucytosine (5FC) Ibrexafungerp (IBR) Isavuconazole (ISA) Itraconazole (ITC)		Micafungin (MFG) Posaconazole (PSC) Voriconazole (VRC) Other drug (OTH), specify: _____ Unknown drug (UNK)
Drug abbrev.	First date given (mm/dd/yyyy)	Last date given (mm/dd/yyyy)	Indication	Therapeutic Drug Monitoring (TDM)
	___/___/_____	___/___/_____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Blastomyces</i> <input type="checkbox"/> Treatment for non- <i>Blastomyces</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: TDM level:  Date of second TDM: TDM level:  <input type="checkbox"/> No
	___/___/_____	___/___/_____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Blastomyces</i> <input type="checkbox"/> Treatment for non- <i>Blastomyces</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: TDM level:  Date of second TDM: TDM level:  <input type="checkbox"/> No
	___/___/_____	___/___/_____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Blastomyces</i> <input type="checkbox"/> Treatment for non- <i>Blastomyces</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: TDM level:  Date of second TDM: TDM level:  <input type="checkbox"/> No
	___/___/_____	___/___/_____	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Blastomyces</i> <input type="checkbox"/> Treatment for non- <i>Blastomyces</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: TDM level:  Date of second TDM: TDM level:  <input type="checkbox"/> No

## PATIENT INTERVIEW

J. Supplemental Patient Interview Form	
Note that the "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. Were you told that you had a positive lab result for blastomycosis before our call today?	<input type="checkbox"/> Yes If yes, what type of healthcare setting told you? <input type="checkbox"/> Emergency room <input type="checkbox"/> Urgent care <input type="checkbox"/> Primary care <input type="checkbox"/> Hospital <input type="checkbox"/> Pharmacy <input type="checkbox"/> Public health official <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> No If no, were you told that you had a negative lab result for blastomycosis before our call today? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Unsure If unsure, were you told that you had a negative lab result for blastomycosis before our call today? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
3. Is your home located in an urban, suburban, or rural area?	<input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural, wooded <input type="checkbox"/> Rural, farmland <input type="checkbox"/> Don't know
4. Do you live on or near a wetland?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

<p>5. Do you live near a lake, river, stream, or pond?</p>	<p><input type="checkbox"/> Yes          If yes, how far away? <input type="checkbox"/> 0-300 ft <input type="checkbox"/> &gt;300 ft- &lt;1 mile <input type="checkbox"/> &gt;1 mile          Name of body of water: _____</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Don't know</p>
<p>6. In the 12 weeks before testing positive for blastomycosis or symptom onset, did you travel out of your home county or state?</p>	<p><input type="checkbox"/> Yes, specify city/state/dates: _____          _____          _____</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Don't know</p>
<p>7. In the 12 weeks before testing positive for blastomycosis or symptom onset, which of the following outdoor activities did you participate in within an area known to have the fungus that causes blastomycosis (select all that apply)?</p>	<p><input type="checkbox"/> Hunting  <input type="checkbox"/> Fishing  <input type="checkbox"/> Swimming  <input type="checkbox"/> Boating  <input type="checkbox"/> Visiting a lake or river  <input type="checkbox"/> Camping  <input type="checkbox"/> Hiking  <input type="checkbox"/> Mountain biking  <input type="checkbox"/> Off-road/ATV  <input type="checkbox"/> Clearing/cutting wood  <input type="checkbox"/> Gathering natural products (berries, mushrooms, firewood)  <input type="checkbox"/> Gardening/landscaping              If yes, exposure to: <input type="checkbox"/> Mulch <input type="checkbox"/> Topsoil <input type="checkbox"/> Compost  <input type="checkbox"/> Leaf blowing  <input type="checkbox"/> Collecting/transporting yard waste  <input type="checkbox"/> Live/hike near a beaver dam  <input type="checkbox"/> Live/hike near an excavation site  <input type="checkbox"/> Exposed to rotten wood/vegetation  <input type="checkbox"/> Outdoor sports, specify  <input type="checkbox"/> Other outdoor activity, specify  <input type="checkbox"/> None  <input type="checkbox"/> Don't know</p>
<p>8. Has anyone else in the household been diagnosed with blastomycosis in the past 6 months?</p>	<p><input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Don't know</p>
<p>9. Do you have any pets that have been diagnosed with blastomycosis in the past 6 months?</p>	<p><input type="checkbox"/> Yes          If yes, what kind? <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other          If yes, what breed? _____</p> <p><input type="checkbox"/> No  <input type="checkbox"/> Don't know</p>
<p>10. In the 12 weeks before testing positive for blastomycosis, what kind of work did you do? If you did more than one type of job in the 12 weeks before you were tested, please tell us about each one:</p>	<p>_____ <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown</p>
<p>11. In the 12 weeks before testing positive for blastomycosis, what kind of industry did you work in? If you worked in more than one industry in the 12 weeks before you were tested, please tell us about each one:</p>	<p>_____ <input type="checkbox"/> Student <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Not applicable <input type="checkbox"/> Unknown</p>
<p>12. How often did you work, travel, or volunteer outdoors in the 12 weeks before testing positive for blastomycosis?</p>	<p><input type="checkbox"/> Every day  <input type="checkbox"/> Most days  <input type="checkbox"/> Some days  <input type="checkbox"/> Rarely  <input type="checkbox"/> Never  <input type="checkbox"/> N/A  <input type="checkbox"/> Don't know</p>
<p>13. In the 12 weeks before testing positive for blastomycosis, how often did you wear a respirator like an N95 or KN95 or a mask at work?</p>	<p><input type="checkbox"/> Every day  <input type="checkbox"/> Most days  <input type="checkbox"/> Some days  <input type="checkbox"/> Rarely  <input type="checkbox"/> Never  <input type="checkbox"/> N/A  <input type="checkbox"/> Don't know</p>



14. Did you miss school or work because of blastomycosis?	<input type="checkbox"/> Yes, number of days _____ <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Don't know
15. Had you ever heard of blastomycosis before you were diagnosed or told of your positive result?	<input type="checkbox"/> Yes If yes, where did you hear about it? (check all that apply) <input type="checkbox"/> Healthcare provider <input type="checkbox"/> Internet <input type="checkbox"/> Family member, friend, coworker <input type="checkbox"/> Radio <input type="checkbox"/> Television <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Don't know <input type="checkbox"/> No <input type="checkbox"/> Don't know
16. How do you think people get blastomycosis? (check all that apply)	<input type="checkbox"/> From another person <input type="checkbox"/> From animals <input type="checkbox"/> From food <input type="checkbox"/> From bug bites <input type="checkbox"/> From water <input type="checkbox"/> From the environment <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Don't know

**Additional comments:**

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