

**Candida auris Case Report Form**

Unique Case ID: \_\_\_\_\_

Prior Case ID from same patient:

Patient ID:

NNDSS State ID: \_\_\_\_\_ | | ARLN specimen ID: \_\_\_\_\_

Form completion data
Name of person completing this form: _____ Institution: _____ Email: _____ Telephone: _____ Date form completed: _____  Date chart abstraction completed if applicable: ____-____-____ (mm-dd-yyyy) CRF status: <input type="checkbox"/> Complete <input type="checkbox"/> Pending, last updated: ____-____-____ (mm-dd-yyyy)

A. Case Surveillance Information
Reporting state/jurisdiction: _____ Reporting county: _____  Why is case of epidemiologic interest? (check all that apply) <input type="checkbox"/> Travel-related (traveled to or received healthcare in another country OR part of the United States) <input type="checkbox"/> Pediatric case <input type="checkbox"/> No history of recent inpatient healthcare <input type="checkbox"/> Echinocandin resistance <input type="checkbox"/> Other, specify _____  Case classification status* (based on incident specimen of interest, either first specimen or first echinocandin-resistant specimen): <input type="checkbox"/> Screening Reason for screening: <input type="checkbox"/> Admission screening because the patient received healthcare in a different state or country from where C. auris was first identified <input type="checkbox"/> Admission screening based on local healthcare history because the patient was at risk for C auris because of recent healthcare at a high-risk facility (e.g., Long-term care facility (LTCF) or outbreak facility) <input type="checkbox"/> Response screening or point prevalence survey (PPS) (e.g., in response to known cases) <input type="checkbox"/> Proactive PPS <input type="checkbox"/> Discharge screening <input type="checkbox"/> Clinical <input type="checkbox"/> Not a case  Date of incident specimen collection (DISC)**: ____-____-____ (mm-dd-yyyy) *Based on <a href="#">Council of State and Territorial Epidemiologists position statement</a> **This is the earliest date that a patient had a positive C. auris specimen collected or, if the epidemiologic interest is 'echinocandin-resistance', the echinocandin-resistant specimen collected

B. Patient demographics
1. Age at DISC:

CDC estimates the average public reporting burden for this collection of information as 45 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).

(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 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
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"/> Other (specify): _____ <input type="checkbox"/> Unknown  Please specify any additional details noted in the chart about race (e.g., nationality, ethnic group): _____
5. Patient's county of residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"):	_____ <input type="checkbox"/> Unknown
6. Patient's city of primary residence	_____ <input type="checkbox"/> Unknown
7. Patient's state, jurisdiction, or territory of primary residence	_____ <input type="checkbox"/> Unknown
8. Patient's country of residence (e.g., USA)	_____ <input type="checkbox"/> Unknown
9. Patient's ZIP code of primary residence	_____ <input type="checkbox"/> Unknown
10. 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 1 year 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: _____	2. Immunocompromised: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Transplant in the last 2 years <input type="checkbox"/> Hematologic <input type="checkbox"/> Solid organ <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Chronic use of steroids <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 <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Diabetes <input type="checkbox"/> History of stroke, hemiplegia, paraplegia, paralysis <input type="checkbox"/> Chronic kidney disease <input type="checkbox"/> Chronic respiratory failure <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Requires care for chronic wounds <input type="checkbox"/> Other, specify: _____
3. 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. Other potentially relevant clinical information? <input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No <input type="checkbox"/> Unknown ----- ----- -----	5. Was mother screened for <i>C. auris</i> ? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Did mother have a positive <i>C. auris</i> specimen? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

D. Specimen information for incident specimen of interest and all specimens within 30 days of DISC				
Specimen	Specimen type	ARLN specimen ID	Drug	MIC

<b>collection date (mm/dd/yyyy)</b>				
	<input type="checkbox"/> Screening <input type="checkbox"/> Axilla/Groin <input type="checkbox"/> Axilla/Groin/Nares <input type="checkbox"/> Axilla <input type="checkbox"/> Groin <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown  <input type="checkbox"/> Clinical; Clinical specimen ID: _____ <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory <input type="checkbox"/> Wound <input type="checkbox"/> Other, specify: _____ <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)	

Did the patient have a prior *C. auris* specimen?  Yes  No  Unknown

If yes, what was the date of the first *C. auris* positive specimen (i.e., when the patient was first known to be positive)?  
 \_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_ (mm-dd-yyyy)

If yes, list the most recent *C. auris* specimen with AFST results prior to the ech-R isolate:

<b>Specimen collection date (mm/dd/yyyy)</b>	<b>Specimen type</b>	<b>ARLN specimen ID</b>	<b>Drug</b>	<b>MIC</b>
	<input type="checkbox"/> Screening <input type="checkbox"/> Axilla/Groin <input type="checkbox"/> Axilla/Groin/Nares <input type="checkbox"/> Axilla <input type="checkbox"/> Groin <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown  <input type="checkbox"/> Clinical; Clinical specimen ID: _____ <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory <input type="checkbox"/> Wound <input type="checkbox"/> Other, specify: _____ <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)	

Complete questions 1 – 3 for the incident specimen of interest (first specimen or first echinocandin-resistant specimen). If patient had multiple positive specimens on the same day meeting the same criteria (first positive specimens or first echinocandin resistant specimens), please complete for each of those specimens.

1. Specimen Clade:	<input type="checkbox"/> Clade I <input type="checkbox"/> Clade II <input type="checkbox"/> Clade III <input type="checkbox"/> Clade IV <input type="checkbox"/> Clade V <input type="checkbox"/> Other, specify: _____ Interpretation of relatedness: _____
2. Location of patient at time of specimen	<input type="checkbox"/> Hospital inpatient <input type="checkbox"/> Was the patient in the ICU Y/N

collection:	<input type="checkbox"/> Was the patient in a unit providing specialized care to a specific population <ul style="list-style-type: none"> <li><input type="checkbox"/> Pediatric</li> <li><input type="checkbox"/> Oncology</li> <li><input type="checkbox"/> Burn</li> <li><input type="checkbox"/> Other, specify _____</li> </ul> <input type="checkbox"/> Outpatient, specify: _____ <input type="checkbox"/> Long-term acute care hospital (LTACH) <ul style="list-style-type: none"> <li><input type="checkbox"/> Was the patient in an ICU Y/N</li> </ul> <input type="checkbox"/> Ventilator-capable skilled nursing facility (vSNF) <ul style="list-style-type: none"> <li><input type="checkbox"/> Was the patient in a dedicated vent unit</li> </ul> <input type="checkbox"/> Skilled nursing facility (SNF) <ul style="list-style-type: none"> <li><input type="checkbox"/> Autopsy</li> <li><input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Other (specify) _____</li> </ul>
3. Name and location of facility at time of specimen collection	Facility name: Facility CMS ID: Facility state, jurisdiction, or territory: Facility zip code:

F. Patient medical history, symptoms, diagnosis, and outcomes	
1. Specify from where the patient was directly admitted:	<input type="checkbox"/> Private Residence <input type="checkbox"/> Hospital inpatient <ul style="list-style-type: none"> <li><input type="checkbox"/> Was the patient in the ICU Y/N</li> <li><input type="checkbox"/> Was the patient in a unit providing specialized care to a specific population <ul style="list-style-type: none"> <li><input type="checkbox"/> Pediatric</li> <li><input type="checkbox"/> Oncology</li> <li><input type="checkbox"/> Burn</li> <li><input type="checkbox"/> Other, specify _____</li> </ul> </li> </ul> <input type="checkbox"/> Outpatient, specify: _____ <input type="checkbox"/> Long-term acute care hospital (LTACH) <ul style="list-style-type: none"> <li><input type="checkbox"/> Was the patient in the ICU Y/N</li> </ul> <input type="checkbox"/> Ventilator-capable skilled nursing facility (vSNF) <ul style="list-style-type: none"> <li><input type="checkbox"/> Was the patient in a dedicated vent unit</li> </ul> <input type="checkbox"/> Skilled nursing facilities facility (SNF) <ul style="list-style-type: none"> <li><input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Other (specify)</li> </ul>
2. Does the patient have a history of additional prior healthcare encounters in the 90 days before DISC	<input type="checkbox"/> No <input type="checkbox"/> Yes If yes, please indicate the type of healthcare encounters in the past 90 days (check all that apply) <ul style="list-style-type: none"> <li><input type="checkbox"/> Hospital inpatient <ul style="list-style-type: none"> <li><input type="checkbox"/> Intensive care unit</li> </ul> </li> <li><input type="checkbox"/> Outpatient (specify): _____</li> <li><input type="checkbox"/> Long-term acute care hospital (LTACH)</li> <li><input type="checkbox"/> Ventilator-capable skilled nursing facility (vSNF)</li> <li><input type="checkbox"/> Skilled nursing facility (SNF)</li> <li><input type="checkbox"/> Unknown</li> <li><input type="checkbox"/> Other (specify)</li> </ul>
3. Any history of travel or healthcare outside of the current jurisdiction within one year prior to DISC?	<input type="checkbox"/> Yes If yes, <ul style="list-style-type: none"> <li><input type="checkbox"/> Jurisdiction/Country: _____ Healthcare: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Notes about care provided: _____</li> <li><input type="checkbox"/> Jurisdiction/Country: _____ Healthcare: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Notes about care provided: _____</li> <li><input type="checkbox"/> Jurisdiction/Country: _____ Healthcare: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</li> </ul>

	Notes about care provided: _____ <input type="checkbox"/> No
4. Has patient ever had multidrug-resistant organisms (MDROs) or <i>C. difficile</i> ? (check all that apply)	<input type="checkbox"/> None <input type="checkbox"/> CRAB <input type="checkbox"/> CRE <input type="checkbox"/> CRPA <input type="checkbox"/> <i>C. difficile</i> <input type="checkbox"/> MRSA <input type="checkbox"/> VRE <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Unknown
5. Did patient have any of the following invasive device or procedure in the 7 days prior to DISC? (check all that apply)	<input type="checkbox"/> Endotracheal tube <input type="checkbox"/> Tracheostomy <input type="checkbox"/> Ventilator <input type="checkbox"/> Central line <input type="checkbox"/> Urinary catheter (not condom catheter) <input type="checkbox"/> Feeding tube <input type="checkbox"/> Require hemodialysis <input type="checkbox"/> Wound care <input type="checkbox"/> None
6. Did patient receive chlorohexidine gluconate (CHG) bathing during admission where incident specimen of interest was collected?	<input type="checkbox"/> y=Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (i.e., outpatient) <input type="checkbox"/> Unknown
7. Ambulatory status (choose most appropriate status at DISC)	<input type="checkbox"/> Ambulatory <input type="checkbox"/> Wheelchair-dependent <input type="checkbox"/> Bedbound <input type="checkbox"/> Unknown
8. Signs of <i>C. auris</i> clinical infection (based on clinician diagnosis with signs/symptoms of clinical infection)?	<input type="checkbox"/> No <input type="checkbox"/> Yes  If yes, please provide details about type or severity of clinical infections: _____
9. Date and location of discharge from facility of initial positive specimen of interest collection:	_____ - _____ - _____ (mm-dd-yyyy) Location <input type="checkbox"/> Acute care hospital <input type="checkbox"/> Private residence <input type="checkbox"/> Long-term acute care hospital (LTACH) <input type="checkbox"/> Ventilator-capable skilled nursing facility (vSNF) <input type="checkbox"/> Skilled nursing facility (SNF) <input type="checkbox"/> Death <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify) <input type="checkbox"/> Still admitted <input type="checkbox"/> N/A (i.e., outpatient) <input type="checkbox"/> Unknown
10. ICD-10 Discharge Code:	
11. Died within 30 days after DISC?	<input type="checkbox"/> No  <input type="checkbox"/> Yes, date of death _____ - _____ - _____ (mm-dd-yyyy) Cause(s) of death _____  <input type="checkbox"/> Unknown

**G. Antifungal treatment:** Please use the table below to indicate antifungal drugs that the patient received during the 90 days before to 60 days after the DISC for the specimen of interest, the first specimen or first echinocandin resistant specimen. For all other cases (not echinocandin resistant), please use the table to indicate antifungal drugs that the patient received during the 60 days after DISC.

Select one of the following to complete each row of the table

Amphotericin B lipid complex (ABLC)	Caspofungin (CAS)	Isavuconazole (ISA)	Voriconazole (VRC)
Liposomal Amphotericin B (L-AmB)	Fluconazole (FLC)	Itraconazole (ITC)	Other drug (specify):
Amphotericin B colloidal dispersion (ABCD)	Flucytosine (5FC)	Micafungin (MFG)	_____

Anidulafungin (ANF)	Ibrexafungerp (IBR)	Posaconazole (PSC)	Unknown drug (UNK)
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Drug Abbrev	b. First date given (mm-dd-yyyy)	c. Last date given (mm-dd-yyyy)	d. Indication
	____ - ____ - ____ <input type="checkbox"/> Start date unknown	____ - ____ - ____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment <input type="checkbox"/> Unknown
	____ - ____ - ____ <input type="checkbox"/> Start date unknown	____ - ____ - ____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment <input type="checkbox"/> Unknown
	____ - ____ - ____ <input type="checkbox"/> Start date unknown	____ - ____ - ____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment <input type="checkbox"/> Unknown
	____ - ____ - ____ <input type="checkbox"/> Start date unknown	____ - ____ - ____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment <input type="checkbox"/> Unknown
	____ - ____ - ____ <input type="checkbox"/> Start date unknown	____ - ____ - ____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment <input type="checkbox"/> Unknown
	____ - ____ - ____ <input type="checkbox"/> Start date unknown	____ - ____ - ____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment <input type="checkbox"/> Unknown

H. Regional response information:	
1. The region with this facility is considered which epidemiological tier?	<input type="checkbox"/> Tier 2 <input type="checkbox"/> Tier 3 <input type="checkbox"/> Tier 4
2. What is the burden of <i>C. auris</i> in the facility where this case was identified in the last year?	<input type="checkbox"/> No prior cases in this facility (i.e., this was the first case) <input type="checkbox"/> No prior cases in this facility but associated or affiliated facilities (e.g., facilities on the same campus or part of the same medical complex, facilities with frequent transfers) have had cases <input type="checkbox"/> Very few cases previously identified (<5 cases) <input type="checkbox"/> 5-20 cases previously identified <input type="checkbox"/> >20 cases or a previous outbreak have occurred at this facility  Please provide more details: _____
3. Was transmission suspected?	<input type="checkbox"/> Yes, this case resulted in transmission to other patients; provide details: _____ <input type="checkbox"/> Yes, this case was part of a larger identified facility outbreak; provide details: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown
4. Please provide more details about the investigation and response (e.g., screening? transmission? environmental sampling? Lesson learned or success story?):	