

1. PATIENT ID: \_\_\_\_\_ 2. STATE ID: \_\_\_\_\_  
 3. SPECIMEN ID: \_\_\_\_\_ 4. Date of incident *C. diff*+ stool collection (DISC): \_\_\_\_\_



Form Approved  
 OMB No. 092-0978  
 Expiration Date: 2/28/26

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

Patient's Name: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Address: \_\_\_\_\_

Address type: \_\_\_\_\_ Hospital: \_\_\_\_\_ Chart Number: \_\_\_\_\_

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

<b>10. DATE OF BIRTH:</b>	<b>12. SEX AT BIRTH:</b>	<b>14. RACE:</b> (Check all that apply)
_____	Male    Female    Unknown    Transgender	
Unknown		American Indian or Alaska Native    Native Hawaiian or Other Pacific Islander
<b>11. AGE:</b> (years)	<b>13. ETHNIC ORIGIN:</b>	Asian    White
_____	Hispanic or Latino    Not Hispanic or Latino    Unknown	Black or African American    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 3<sup>rd</sup> calendar day before the DISC?**

Private Residence    LTACH    Facility ID: \_\_\_\_\_

LTCF    Facility ID: \_\_\_\_\_    Homeless

Hospital Inpatient    Facility ID: \_\_\_\_\_    Incarcerated

**16a. Was the patient transferred from this hospital?**    Other (specify): \_\_\_\_\_

Yes    No    Unknown    Unknown

**17. Location of incident *C. diff*+ stool collection**

<b>Outpatient</b>	<b>Hospital Inpatient</b>	<b>LTCF</b>	<b>Autopsy</b>
Facility ID: _____	Facility ID: _____	Facility ID: _____	<b>Other (specify):</b> _____
Emergency room	ICU	<b>LTACH</b>	
Clinic/doctor's office	OR	Facility ID: _____	<b>Unknown</b>
Dialysis center	Radiology		
Surgery	Other inpatient		
Observation/Clinical decision unit			
Other outpatient			

**18. HCFO classification questions:**

**18a. Was incident *C. diff*+ stool collected at least 3 calendar days after the date of hospital admission?**  
 Yes (HCFO - go to 18d)    No

**18b. Was incident *C. diff*+ stool collected in an outpatient setting for a LTCF resident, or in a LTCF or LTACH?**  
 Yes (HCFO - go to 18d)    No

**18c. Was the patient admitted from a LTCF or a LTACH?**  
 Yes—Facility ID: \_\_\_\_\_ (HCFO - go to 18d)    No (CO - complete CRF)

**18d. If HCFO, was this case sampled for full CRF?**

Yes (Complete CRF)    No (STOP data abstraction here)

1      2      3      4      5      6      7      8      9      10

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).

**19. Patient Outcome:** **Unknown**  
**Survived** **Died**  
**19a. Date of discharge:** \_\_\_\_\_ Unknown **19c. Date of Death:** \_\_\_\_\_ Unknown  
 Left against medical advice (AMA)  
**19b. If survived, discharged to:**  
 Private residence LTCF Facility ID: \_\_\_\_\_ LTACH Facility ID: \_\_\_\_\_ Other (specify): \_\_\_\_\_  
 Unknown

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

<b>20a. Previous hospitalization</b>	Yes	No	Unknown	Facility ID: _____	<b>20a.1 If yes, date of discharge closest to DISC:</b> _____
<b>20b. Overnight stay in LTACH</b>	Yes	No	Unknown	Facility ID: _____	Unknown
<b>20c. Overnight stay in LTCF</b>	Yes	No	Unknown	Facility ID: _____	
<b>20d. Chronic dialysis</b>	Yes	No	Unknown	<b>20d.1 Type:</b>	Hemodialysis Peritoneal Unknown
<b>20e. Surgery</b>	Yes	No	Unknown		
<b>20f. ER visit</b>	Yes	No	Unknown		
<b>20g. Observation/CDU stay</b>	Yes	No	Unknown		

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

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

<b>22a. Weight</b> _____ lbs _____ oz OR _____ kg Unknown	<b>22b. Height</b> _____ ft _____ in OR _____ cm Unknown	<b>22c. BMI</b> _____ Unknown
--------------------------------------------------------------	-------------------------------------------------------------	----------------------------------

<b>23. Substance Use</b>	<b>23a. Smoking:</b> None Tobacco Unknown	<b>23b. Alcohol abuse:</b> E-Nicotine Delivery System Marijuana Yes No Unknown
--------------------------	-------------------------------------------	--------------------------------------------------------------------------------

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

<u>Substance</u>	<u>Documented Use Disorder (DUD)/Abuse?</u>	<u>Mode of delivery:</u> (Check all that apply)
Marijuana/cannabinoid (other than smoking)	DUD or Abuse	IDU skin popping non-IDU Unknown
Opioid, DEA schedule I (e.g., heroin)	DUD or Abuse	IDU skin popping non-IDU Unknown
Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)	DUD or Abuse	IDU skin popping non-IDU Unknown
Opioid, NOS	DUD or Abuse	IDU skin popping non-IDU Unknown
Cocaine	DUD or Abuse	IDU skin popping non-IDU Unknown
Methamphetamine	DUD or Abuse	IDU skin popping non-IDU Unknown
Other (specify): _____	DUD or Abuse	IDU skin popping non-IDU Unknown
Unknown substance	DUD or Abuse	IDU skin popping non-IDU 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)

<b>24. Was CDI a primary or contributing reason for patient's admission?</b> Yes No Not admitted Unknown	<b>25. Was ICD-9 008.45 or ICD-10 A04.7 listed on the discharge form?</b> Yes                      Not admitted No                         Unknown  <b>25a. If YES, what was the POA code assigned to it?</b> Y, Yes                      W, Clinically Undetermined N, No                        Missing U, Unknown                Not Applicable	<b>26. Was the patient in an ICU on the day of or in the 6 days after the DISC?</b> Yes              No              Unknown  <b>26a. If YES, date of ICU admission:</b> _____ Unknown	
<b>27. Symptoms</b> (in the 6 calendar days before, the day of, or 1 calendar day after the DISC) <i>(Check all that apply)</i>  "Asymptomatic" documented in medical record                      Nausea Diarrhea by definition (unformed or watery stool,                      Vomiting ≥ 3/day for ≥ 1 day)                                                              No diarrhea, nausea, or Diarrhea documented, but unable to determine                      vomiting documented if it is by definition                                                                Information not available		<b>28. Fever</b> (in the 2 calendar days before or calendar day of the DISC)  Fever ≥38°C or ≥100.4°F documented <b>Highest fever documented:</b> _____ °C or _____ °F Self-reported fever No fever documented Information not available	
<b>29. Toxic megacolon and ileus</b> (in the 6 calendar days before, the day of, or the 6 calendar days after the DISC)			
<b>29a. Radiographic findings</b> Toxic megacolon                      Neither toxic megacolon Ileus                                        nor ileus Both toxic megacolon and ileus      Radiology not performed Information not available		<b>29b. Clinical findings</b> Toxic megacolon                      Neither toxic megacolon Ileus                                        nor ileus Both toxic megacolon and ileus      Information not available	
<b>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?</b> Yes              Not Done No                Information not available	<b>31. Colectomy</b> (related to CDI): Yes No Unknown	<b>31a. If YES, Date of Procedure:</b> _____ Unknown	
<b>32. Were other enteric pathogens isolated from stool collected on the DISC?</b> Astrovirus Campylobacter Enteroaggregative <i>E. coli</i> (EAEC) Enteropathogenic <i>E. coli</i> (EPEC) Enterotoxigenic <i>E. coli</i> (ETEC) Norovirus Rotavirus Salmonella Sapovirus Shiga Toxin-Producing <i>E.coli</i>	Shigella Yersinia enterocolitica Other (specify): <div style="border: 1px solid black; height: 40px; width: 100%;"></div> None No other pathogens tested Unknown	<b>33. LABORATORY FINDINGS</b> (in the 6 calendar days before, the day of, or the 6 calendar days after the DISC)	
<b>33a. Albumin ≤ 2.5g/dl:</b> Yes No Not Done Information not available		<b>33c. White blood cell count ≥ 15,000/μl:</b> Yes No Not Done Information not available	
<b>33b. White blood cell count ≤ 1,000/μl:</b> Yes No Not Done Information not available		<b>33d. Serum creatinine &gt; 1.5 mg/dl:</b> Yes No Not Done Information not available	
<b>34. MEDICATIONS taken in the 12 weeks before the DISC:</b>			
<b>34a. Proton pump inhibitor</b> (e.g. Omeprazole, Lansoprazole, Pantoprazole, Rabeprazole) Yes No Unknown	<b>34b. H2 Blockers</b> (e.g. Famotidine, Ranitidine, Cimetidine) Yes No Unknown	<b>34c. Immunosuppressive therapy</b> <i>(Check all that apply)</i> Steroids                                      None Chemotherapy                              Unknown Other agents (specify): _____	
<b>34d. Antimicrobial therapy</b> <i>(Check all that apply)</i>			
Yes, name unknown Amikacin Amoxicillin Amoxicillin/clavulanic acid Ampicillin Ampicillin/sulbactam Azithromycin Aztreonam Cefadroxil Cefazolin Cefdinir Cefepime Cefiderocol Cefixime Cefotaxime Cefoxitin	Yes, name unknown Cefpodoxime Ceftaroline Ceftazidime Ceftazidime/avibactam Ceftizoxime Ceftolozane/tazobactam Ceftriaxone Cefuroxime Cephalexin Ciprofloxacin Clarithromycin Clindamycin Dalbavancin Daptomycin Delafloxacin	None Doripenem Doxycycline Eravacycline Ertapenem Fosfomycin Gentamicin Imipenem/cilastatin Levofloxacin Linezolid Meropenem Meropenem/vaborbactam Metronidazole Moxifloxacin Nitrofurantoin Omadacycline	Unknown Oritavancin Penicillin Piperacillin/tazobactam Polymyxin B Polymyxin E (colistin) Rifaximin Tedizolid Telavancin Tigecycline Tobramycin Trimethoprim Trimethoprim/sulfamethoxazole Vancomycin (IV) Vancomycin (PO for prophylaxis) Other (specify): _____

<b>34e. Was patient treated for suspected or confirmed CDI in the 12 weeks before the DISC?</b>		Yes	No	Unknown
<b>34f.1 If YES, which treatment was taken?</b> (Check all that apply)		Metronidazole Vancomycin Fidaxomicin	Other, (specify): _____ Unknown	
<b>35. Treatment for incident CDI</b>	No treatment	Unknown treatment		
<b>35a.1 Course 1</b>				
<b>Start Date:</b> _____	Unknown	<b>Stop Date:</b> _____	Unknown	<b>OR Duration (days):</b> _____
Vancomycin (PO)		Metronidazole (PO)		Rifaximin
Vancomycin (Rectal)		Metronidazole (IV)		Nitazoxanide
Vancomycin (Unknown route)		Metronidazole (Unknown route)		Other (specify): _____
Vancomycin taper (any route)		Fidaxomicin		
<b>35a.2 Course 2</b>				
<b>Start Date:</b> _____	Unknown	<b>Stop Date:</b> _____	Unknown	<b>OR Duration (days):</b> _____
Vancomycin (PO)		Metronidazole (PO)		Rifaximin
Vancomycin (Rectal)		Metronidazole (IV)		Nitazoxanide
Vancomycin (Unknown route)		Metronidazole (Unknown route)		Other (specify): _____
Vancomycin taper (any route)		Fidaxomicin		
<b>35a.3 Course 3</b>				
<b>Start Date:</b> _____	Unknown	<b>Stop Date:</b> _____	Unknown	<b>OR Duration (days):</b> _____
Vancomycin (PO)		Metronidazole (PO)		Rifaximin
Vancomycin (Rectal)		Metronidazole (IV)		Nitazoxanide
Vancomycin (Unknown route)		Metronidazole (Unknown route)		Other (specify): _____
Vancomycin taper (any route)		Fidaxomicin		
<b>35a.4 Course 4</b>				
<b>Start Date:</b> _____	Unknown	<b>Stop Date:</b> _____	Unknown	<b>OR Duration (days):</b> _____
Vancomycin (PO)		Metronidazole (PO)		Rifaximin
Vancomycin (Rectal)		Metronidazole (IV)		Nitazoxanide
Vancomycin (Unknown route)		Metronidazole (Unknown route)		Other (specify): _____
Vancomycin taper (any route)		Fidaxomicin		
<b>35b. Probiotics (specify):</b> _____				
<b>35c. Stool transplant</b> <b>Date:</b> _____      Unknown				
<b>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?</b>		<b>36a. Specimen collection dates for positive tests in the 90 days before or day of DISC</b>		
Yes	No	Unknown		
		<b>36a.1. First positive test:</b> _____		
		Date Unknown		
		<b>36a.2 Most recent positive test:</b> _____		
		Date Unknown		
<b>37. COVID-NET Case IDs in the year before or day of DISC:</b> _____ <span style="float: right;">None or N/A</span>				
<b>38. Previous unique CDI episode (&gt;8 weeks before the DISC):</b>	<b>39. Any recurrent C. diff+ episodes following this incident C. diff+ episode?</b>	<b>40. CRF status:</b>	<b>41. Initials of S.O.:</b> _____	<b>42. Date of abstraction:</b> _____
Yes	Yes	Complete		
No	No	Incomplete		
		Chart unavailable after 3 requests		
<b>38a. If YES, previous STATEID:</b> _____	<b>39a. If YES, Date of first recurrent specimen:</b> _____			
<b>Comments:</b>				