

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



Form Approved  
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## 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
<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>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>8. FACILITY ID WHERE PATIENT TREATED:</b> _____		<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)

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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>
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<b>22a. Weight</b> _____ lbs _____ oz OR _____ kg Unknown	<b>22b. Height</b> _____ ft _____ in OR _____ cm Unknown	<b>22c. BMI</b> _____ Unknown
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<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
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**23c. Other substances:** (Check all that apply) None Unknown

Substance	Documented Use Disorder (DUD)/Abuse?	Mode of delivery: (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>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> <i>(Check all that apply)</i>		Metronidazole Vancomycin Fidaxomicin	Other, <i>(specify)</i> : _____ 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 <i>(specify)</i> : _____
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 <i>(specify)</i> : _____
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 <i>(specify)</i> : _____
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 <i>(specify)</i> : _____
Vancomycin taper (any route)		Fidaxomicin		
<b>35b. Probiotics <i>(specify)</i>:</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>		<b>36a.2 Most recent positive test:</b>
		_____		_____
		Date Unknown		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 <i>C. diff</i>+ episodes following this incident <i>C. diff</i>+ 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>				