

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 <i>A. fumigatus</i>

A. 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. What is your race and/or ethnicity? (select all that apply and enter additional details in the spaces provided)	<input type="checkbox"/> American Indian or Alaska Native <i>Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.</i> _____ <input type="checkbox"/> Asian - provide details below <input type="checkbox"/> Chinese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Filipino <input type="checkbox"/> Vietnamese <input type="checkbox"/> Korean <input type="checkbox"/> Japanese <i>Enter, for example, Pakistani, Hmong, Afghan, etc.</i> _____ <input type="checkbox"/> Black or African American - provide details below <input type="checkbox"/> African American <input type="checkbox"/> Jamaican <input type="checkbox"/> Haitian <input type="checkbox"/> Nigerian <input type="checkbox"/> Ethiopian <input type="checkbox"/> Somali <i>Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.</i> _____ <input type="checkbox"/> Hispanic or Latino - provide details below <input type="checkbox"/> Mexican <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Salvadoran <input type="checkbox"/> Cuban <input type="checkbox"/> Dominican <input type="checkbox"/> Guatemalan <i>Enter, for example, Colombian, Honduran, Spaniard, etc.</i> _____ <input type="checkbox"/> Middle Eastern or North African - provide details below <input type="checkbox"/> Lebanese <input type="checkbox"/> Iranian <input type="checkbox"/> Egyptian <input type="checkbox"/> Syrian <input type="checkbox"/> Iraqi <input type="checkbox"/> Israeli <i>Enter, for example, Moroccan, Yemeni, Kurdish, etc.</i> _____

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).

	<input type="checkbox"/> Native Hawaiian or Pacific Islander – provide details below <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Chamorro <input type="checkbox"/> Tongan <input type="checkbox"/> Fijian <input type="checkbox"/> Marshallese <i>Enter, for example, Chuukese, Palauan, Tahitian, etc.</i> <hr/> <input type="checkbox"/> White – provide details below <input type="checkbox"/> English <input type="checkbox"/> German <input type="checkbox"/> Irish <input type="checkbox"/> Italian <input type="checkbox"/> Polish <input type="checkbox"/> Scottish <i>Enter, for example, French, Swedish, Norwegian, etc.</i> <hr/>
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 state, jurisdiction, or territory of residence	_____ <input type="checkbox"/> Unknown
7. Patient's country of residence (e.g., USA)	_____ <input type="checkbox"/> Unknown
8. Healthcare facility name (Note: 'healthcare facility' refers to the facility where the patient's incident specimen was collected)	_____ <input type="checkbox"/> Unknown
9. Healthcare facility CMS ID #	_____ <input type="checkbox"/> Unknown

A. Patient Demographics (continued)	
10. Healthcare facility ZIP code	_____ <input type="checkbox"/> Unknown
11. Healthcare facility state, jurisdiction, or territory	_____ <input type="checkbox"/> Unknown
12. Healthcare facility type	<input type="checkbox"/> Acute care hospital (ACH) <input type="checkbox"/> Long-term acute care hospital (LTACH) <input type="checkbox"/> Skilled nursing facility <i>with</i> ventilated residents (vSNF) <input type="checkbox"/> Skilled nursing facility <i>without</i> ventilated residents (SNF) <input type="checkbox"/> Outpatient <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____

B. Patient underlying risk factors & medical conditions present during the 2 years before DISC (unless other timeframe specified)
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<p>1. Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Hematologic malignancy specify type: _____</p> <p><input type="checkbox"/> Solid organ malignancy specify type: _____</p> <p><input type="checkbox"/> Chemotherapy If yes, specify: _____</p>	<p>3. Chronic pulmonary diagnosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Chronic obstructive pulmonary disease (COPD) or emphysema</p> <p><input type="checkbox"/> Bronchiectasis</p> <p><input type="checkbox"/> Cystic fibrosis</p> <p><input type="checkbox"/> Allergic bronchopulmonary aspergillosis (ABPA)</p> <p><input type="checkbox"/> Pulmonary fibrosis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Interstitial Lung Disease</p> <p><input type="checkbox"/> Other chronic pulmonary diagnosis (specify): _____</p>
<p>2. HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, choose one of the below</p> <p>Ever had CD4 < 200 cells/mm³ within past 6 months</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>	<p>4. Positive respiratory viral test in 120 days before or after DISC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, (select all that apply):</p> <p><input type="checkbox"/> SARS-CoV-2 (PCR or antigen test)</p> <p><input type="checkbox"/> antigen <input type="checkbox"/> PCR <input type="checkbox"/> unknown test type</p> <p><input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> Other respiratory virus (specify) _____</p>
<p>6. Other selected conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Cardiovascular disease (specify): _____</p> <p><input type="checkbox"/> Diabetes mellitus</p> <p><input type="checkbox"/> End stage renal disease/dialysis</p> <p><input type="checkbox"/> Autoimmune disease(s) or inherited immunodeficiency(-ies) (specify): _____</p> <p><input type="checkbox"/> Medications/therapies that weaken the immune system</p> <p><input type="checkbox"/> TNF-alpha inhibitors (e.g., infliximab, adalimumab, etanercept)</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Liver disease without cirrhosis</p> <p><input type="checkbox"/> Systemic lupus erythematosus</p> <p><input type="checkbox"/> Active tuberculosis</p> <p><input type="checkbox"/> Pregnant</p> <p><input type="checkbox"/> Pregnant on DISC Gestational age (weeks): _____ Unknown</p> <p><input type="checkbox"/> Post-partum (gave birth within 6 weeks before DISC)</p>	<p>5. Transplant received within 2 years before DISC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><input type="checkbox"/> Solid organ transplant:</p> <p><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: _____</p> <p><input type="checkbox"/> Hematopoietic stem cell transplant (HSCT)</p> <p>7. Other potentially relevant clinical information?</p> <p><input type="checkbox"/> Yes (specify below) <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>-----</p> <p>-----</p> <p>-----</p> <p>-----</p>

C. Patient diagnosis and outcomes	
<p>1. According to treating clinicians, which clinical syndrome(s) related to <i>Aspergillus</i> did the patient have?</p>	<p><input type="checkbox"/> Invasive pulmonary aspergillosis (IPA)</p> <p><input type="checkbox"/> Other disease/syndrome(s) related to <i>A. fumigatus</i>: _____</p> <p><input type="checkbox"/> <i>Aspergillus</i> was not believed to be causing clinical illness or is not mentioned in medical records</p> <p><input type="checkbox"/> Unknown</p>
<p>2. Was the patient hospitalized at an acute care hospital in the 30 days before to 30 days after DISC?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If yes, dates of admission of hospitalization most proximal to DISC,</p> <p>Admission date: _____ - _____ - _____ (mm-dd-yyyy)</p>

	<p>Discharge date: _____ - _____ - _____ (mm-dd-yyyy) <input type="checkbox"/> Still hospitalized</p> <p><i>If yes,</i></p> <p>Received ICU-level care in the 14 days <i>before</i> DISC?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Received ICU-level care in the 14 days <i>after</i> DISC?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Discharge ICD-10 diagnosis code(s): _____</p>
3. Died within 30 days after DISC?	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes, date of death _____ - _____ - _____ (mm-dd-yyyy) Cause(s) of death _____</p> <p><input type="checkbox"/> Unknown</p>

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)	Caspofungin (CAS)	Isavuconazole (ISA)	Other drug (specify):
Liposomal Amphotericin B (L-AmB)	Fluconazole (Not mold-active) (FLC)	Itraconazole (ITC)	_____
Amphotericin B colloidal dispersion (ABCD)	Flucytosine (5FC)	Micafungin (MFG)	___
Anidulafungin (ANF)	Ibrexafungerp (IBR)	Posaconazole (PSC)	Unknown drug (UNK)
		Voriconazole (VRC)	

Drug Abbrev	b. First date given (mm-dd-yyyy)	c. Last date given (mm-dd-yyyy)	d. Indication	e. Therapeutic drug monitoring (TDM)
	_____ <input type="checkbox"/> Start date unknown <input type="checkbox"/> Start date was >60 days before DISC	_____ _____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Aspergillus</i> <input type="checkbox"/> Treatment for non- <i>Aspergillus</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"/> Start date unknown <input type="checkbox"/> Start date was >60 days before DISC	_____ _____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Aspergillus</i> <input type="checkbox"/> Treatment for non- <i>Aspergillus</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"/> Start date unknown <input type="checkbox"/> Start date was >60 days before DISC	_____ _____ <input type="checkbox"/> Still on treatment at time CRF completed <input type="checkbox"/> Stop date unknown	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment for <i>Aspergillus</i> <input type="checkbox"/> Treatment for non- <i>Aspergillus</i> infection	<input type="checkbox"/> Yes Date of earliest TDM: TDM level: Date of second TDM: TDM level: <input type="checkbox"/> No
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Supplemental patient interview form:
 Note that "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. What was your job or occupation before [DISC]?	_____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> N/A <input type="checkbox"/> Refused to answer <input type="checkbox"/> Unknown																				
3. What was your industry before [DISC]?	_____ <input type="checkbox"/> Unemployed <input type="checkbox"/> Student <input type="checkbox"/> Retired <input type="checkbox"/> N/A <input type="checkbox"/> Refused to answer <input type="checkbox"/> 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)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown _____ _____																				
4. Did you perform any of the following activities during the 90 days before [DISC]	<table border="0"> <tr> <td>Gardening</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Handling compost</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Handling a fungicide product (agriculture)</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Handling a fungicide product (home gardening)</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> <tr> <td>Spending time on a farm</td> <td><input type="checkbox"/> Yes</td> <td><input type="checkbox"/> No</td> <td><input type="checkbox"/> Unknown</td> </tr> </table> <p>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:</p> _____ ----- -----	Gardening	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Handling compost	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Handling a fungicide product (agriculture)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Handling a fungicide product (home gardening)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown	Spending time on a farm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
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Additional comments: _____
