Form Approved
OMB No. 0920-1385
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***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: □ Complete □ 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)
□ Travel-related (traveled to or received healthcare in another country OR part of the United States)
□ Pediatric case
□ No history of recent inpatient healthcare □ Echinocandin resistance
□ Other, specify _____

Case classification status* (based on incident specimen of interest, either first specimen or first echinocandin-resistant specimen):
□ Screening
Reason for screening:
□ Admission screening because the patient received healthcare in a different state or country from where C. auris was first identified
□ 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)
□ Response screening or point prevalence survey (PPS) (e.g., in response to known cases)
□ Proactive PPS
□ Discharge screening
□ Clinical
□ Not a case

Date of incident specimen collection (DISC)**: _____-_____-_____ (mm-dd-yyyy)
*Based on Council of State and Territorial Epidemiologists position statement
**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: (use months or days if patient was aged <2 years)	_____ ◻ Years ◻ Months ◻ Days ◻ Unknown
2. Sex at birth	◻ Male ◻ Female ◻ Unknown
3. Gender identity	◻ Male ◻ Female ◻ Transgender, non-binary, or another gender ◻ Prefer not to answer/Decline ◻ Unknown
4. What is your race and/or ethnicity? (select all that apply and enter additional details in the spaces provided)	◻ American Indian or Alaska Native *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.* _____ ◻ Asian – provide details below ◻ Chinese ◻ Asian Indian ◻ Filipino ◻ Vietnamese ◻ Korean ◻ Japanese *Enter, for example, Pakistani, Hmong, Afghan, etc.* _____ ◻ Black or African American – provide details below ◻ African American ◻ Jamaican ◻ Haitian ◻ Nigerian ◻ Ethiopian ◻ Somali *Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.* _____ ◻ Hispanic or Latino – provide details below ◻ Mexican ◻ Puerto Rican ◻ Salvadoran ◻ Cuban ◻ Dominican ◻ Guatemalan *Enter, for example, Colombian, Honduran, Spaniard, etc.* _____ ◻ Middle Eastern or North African – provide details below ◻ Lebanese ◻ Iranian ◻ Egyptian ◻ Syrian ◻ Iraqi ◻ Israeli *Enter, for example, Moroccan, Yemeni, Kurdish, etc.* _____ ◻ Native Hawaiian or Pacific Islander – provide details below ◻ Native Hawaiian ◻ Samoan ◻ Chamorro ◻ Tongan ◻ Fijian ◻ Marshallese *Enter, for example, Chuukese, Palauan, Tahitian, etc.* _____ ◻ White – provide details below ◻ English ◻ German ◻ Irish ◻ Italian ◻ Polish ◻ Scottish *Enter, for example, French, Swedish, Norwegian, etc.* _____
5. Patient's county of residence (Please do not write the word "County"; for example, write "Cook" instead of "Cook County"):	_____ ◻ Unknown
6. Patient's city of primary residence	_____ ◻ Unknown
7. Patient's state, jurisdiction, or territory of primary residence	_____ ◻ Unknown
8. Patient's country of residence (e.g., USA)	_____ ◻ Unknown
9. Patient's ZIP code of primary residence	_____ ◻ Unknown
10. Patient's type of health insurance at DISC	◻ Private ◻ Medicare ◻ Medicaid/state assistance program ◻ Military ◻ Indian Health Service ◻ Incarcerated ◻ Uninsured ◻ Other (specify): _____ ◻ Unknown

C. Patient underlying risk factors & medical conditions present during the 1 year before DISC (unless other timeframe specified)

1. Cancer □ Yes □ No □ Unknown
□ Hematologic malignancy
specify type: _____
□ Solid organ malignancy
specify type:_____

3. HIV infection □ Yes □ No □ Unknown
If yes, choose one of the below
Ever had CD4 < 200 cells/mm^3 within past 6 months
□ Yes □ No □ Unknown

2. Immunocompromised: □ Yes □ No □ Unknown
□ Transplant in the last 2 years
□ Hematologic
□ Solid organ
□ Chemotherapy
□ Chronic use of steroids
□ Medications/therapies that weaken the immune system
□ TNF-alpha inhibitors (e.g., infliximab, adalimumab, etanercept)
□ Other (specify):
_____
□ Cirrhosis
□ Liver disease
□ Cirrhosis
□ Diabetes
□ History of stroke, hemiplegia, paraplegia, paralysis
□ Chronic kidney disease
□ Chronic respiratory failure
□ Cardiac disease
□ Requires care for chronic wounds
□ Other, specify: _____

4. Other potentially relevant clinical information?
□ Yes (specify below) □ No □ Unknown
_____
_____
_____

5. Was mother screened for *C. auris*? □ Yes □ No □ Unknown
Did mother have a positive *C. auris* specimen?
□ Yes □ No □ Unknown

D. Specimen information for incident specimen of interest and all specimens within 30 days of DISC

Specimen collection date (mm/dd/yyyy))	Specimen type	ARLN specimen ID	Drug	MIC
	□ Screening □ Axilla/Groin □ Axilla/Groin/Nares □ Axilla □ Groin □ Other, specify: _____ □ Unknown □ Clinical; Clinical specimen ID: _____ □ Blood □ Urine □ Respiratory □ Wound □ Other, specify: _____ □ 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:

Specimen collection date (mm/dd/yyyy))	Specimen type	ARLN specimen ID	Drug	MIC

	□ Screening □ Axilla/Groin □ Axilla/Groin/Nares □ Axilla □ Groin □ Other, specify: _____ □ Unknown □ Clinical; Clinical specimen ID: _____ □ Blood □ Urine □ Respiratory □ Wound □ Other, specify: _____ □ 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:	□ Clade I □ Clade II □ Clade III □ Clade IV □ Clade V □ Other, specify: _____ Interpretation of relatedness: _____
2. Location of patient at time of specimen collection:	□ Hospital inpatient □ Was the patient in the ICU Y/N □ Was the patient in a unit providing specialized care to a specific population □ Pediatric □ Oncology □ Burn □ Other, specify_____ □ Outpatient, specify: _____ _____ □ Long-term acute care hospital (LTACH) □ Was the patient in an ICU Y/N □ Ventilator-capable skilled nursing facility (vSNF) □ Was the patient in a dedicated vent unit □ Skilled nursing facility (SNF) □ Autopsy □ Unknown □ Other (specify) _____
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:	□ Private Residence □ Hospital inpatient □ Was the patient in the ICU Y/N □ Was the patient in a unit providing specialized care to a specific population □ Pediatric □ Oncology □ Burn □ Other, specify_____ □ Outpatient, specify: _____ □ Long-term acute care hospital (LTACH)

	□ Was the patient in the ICU Y/N □ Ventilator-capable skilled nursing facility (vSNF) □ Was the patient in a dedicated vent unit □ Skilled nursing facilities facility (SNF) □ Unknown □ Other (specify)
2. Does the patient have a history of additional prior healthcare encounters in the 90 days before DISC	□ No □ Yes If yes, please indicate the type of healthcare encounters in the past 90 days (check all that apply) □ Hospital inpatient □ Intensive care unit □ Outpatient (specify): _____ □ Long-term acute care hospital (LTACH) □ Ventilator-capable skilled nursing facility (vSNF) □ Skilled nursing facility (SNF) □ Unknown □ Other (specify)
3. Any history of travel or healthcare outside of the current jurisdiction within one year prior to DISC?	□ Yes If yes, □ Jurisdiction/Country: _____ Healthcare: □ Yes □ No □ Unknown Notes about care provided: _____ □ Jurisdiction/Country: _____ Healthcare: □ Yes □ No □ Unknown Notes about care provided: _____ □ Jurisdiction/Country: _____ Healthcare: □ Yes □ No □ Unknown Notes about care provided: _____ □ No
4. Has patient ever had multidrug-resistant organisms (MDROs) or *C. difficile*? (check all that apply)	□ None □ CRAB □ CRE □ CRPA □ *C. difficile* □ MRSA □ VRE □ Other, specify _____ □ Unknown
5. Did patient have any of the following invasive device or procedure in the 7 days prior to DISC? (check all that apply)	□ Endotracheal tube □ Tracheostomy □ Ventilator □ Central line □ Urinary catheter (not condom catheter) □ Feeding tube □ Require hemodialysis □ Wound care □ None
6. Did patient receive chlorohexidine gluconate (CHG) bathing during admission where incident specimen of interest was collected?	□ y=Yes □ No □ N/A (i.e., outpatient) □ Unknown
7. Ambulatory status (choose most appropriate status at DISC)	□ Ambulatory □ Wheelchair-dependent □ Bedbound □ Unknown

8. Signs of *C. auris* clinical infection (based on clinician diagnosis with signs/symptoms of clinical infection)?	☐ No ☐ 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 ☐ Acute care hospital ☐ Private residence ☐ Long-term acute care hospital (LTACH) ☐ Ventilator-capable skilled nursing facility (vSNF) ☐ Skilled nursing facility (SNF) ☐ Death ☐ Unknown ☐ Other (specify) ☐ Still admitted ☐ N/A (i.e., outpatient) ☐ Unknown
10. ICD-10 Discharge Code:	
11. Died within 30 days after DISC?	☐ No ☐ Yes, date of death ________ - ________- _______________ (mm-dd-yyyy) Cause(s) of death ___________________ ☐ Unknown

G. Antifungal treatment: Please use the table below to indicate antifungal drugs that the patient received during the <u>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.</u>

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)

Drug Abbrev	b. First date given (*mm-dd-yyyy*)	c. Last date given (*mm-dd-yyyy*)	d. Indication
	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Start date unknown	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Still on treatment at time CRF completed ☐ Stop date unknown	☐ Prophylaxis ☐ Treatment ☐ Unknown
	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Start date unknown	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Still on treatment at time CRF completed ☐ Stop date unknown	☐ Prophylaxis ☐ Treatment ☐ Unknown
	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Start date unknown	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Still on treatment at time CRF completed ☐ Stop date unknown	☐ Prophylaxis ☐ Treatment ☐ Unknown
	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Start date unknown	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Still on treatment at time CRF completed ☐ Stop date unknown	☐ Prophylaxis ☐ Treatment ☐ Unknown
	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Start date unknown	___ ___ - ___ ___ - ___ ___ ___ ___ ☐ Still on treatment at time CRF completed ☐ Stop date unknown	☐ Prophylaxis ☐ Treatment ☐ Unknown
	___ ___ - ___ ___ - ___ ___ ___ ___	___ ___ - ___ ___ - ___ ___ ___ ___	☐ Prophylaxis ☐ Treatment

	□ Start date unknown	□ Still on treatment at time CRF completed □ Stop date unknown	□ Unknown

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