CANDIDA AURIS CASE REPORT FORM

Completed By: _____ Date of completion:__/__/____

PATIENT INFORMATION

Name:_____ Date of Birth: __/__/____

MR#:_____ Sex: □ Female □ Male

Facility Name:_____ Date of admission: __/__/____

Admission source: □ Home □ Facility, specify: _____ □ Unknown

Reason for admission:_____

Date of discharge: __/__/____

Reason for discharge: □ expired □ hospice □ home □ transferred (facility name): _____

Past Travel History:

Has the patient recently travelled to another country? □ No □ Yes, specify: _____ □ Unknown

If yes, did the patient receive healthcare there? □ No □ Yes, when? __/__/____ □ Unknown

CLINICAL INFORMATION

List all hospitalization dates at your facility and any other known facilities (including long-term care facilities or nursing homes) **in the 6 months prior to *C. auris* specimen collection**:

Facility name:_____ Admission date: __/___/____ Discharge date: __/__/____

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List the unit and room the patient stayed in **during each admission to your facility within the 6 months** prior to *C. auris* specimen collection (if more than 3, please list on a separate page):

Unit & Room:_____ From: __/__/____ To:__/__/____

Approximate number of patients located on this floor: _____

Was the patient on Contact Precautions during this timeframe? Yes / No

Did the patient have any roommates during this time? Yes / No

If yes, Roommate 1's Name: _____ Current location: _____

If yes, Roommate 2's Name: _____ Current location: _____

Unit & Room:_____ From: __/__/____ To:__/__/____

Approximate number of patients located on this floor: _____

Was the patient on Contact Precautions during this timeframe? Yes / No

Did the patient have any roommates during this time? Yes / No

If yes, Roommate 1's Name: _____ Current location: _____

If yes, Roommate 2's Name: _____ Current location: _____

Unit & Room:_____ From: __/__/____ To:__/__/____

Approximate number of patients located on this floor: _____

Was the patient on Contact Precautions during this timeframe? Yes / No

Did the patient have any roommates during this time? Yes / No

If yes, Roommate 1's Name: _____ Current location: _____

If yes, Roommate 2's Name: _____ Current location: _____

CULTURE INFORMATION

List all cultures performed during hospitalization:

SPECIMEN SOURCE	CULTURE DATE	ORGANISM	COMMENT

RISK FACTORS

Past Medical History:_____

_____

_____

Ambulatory status: □ Ambulatory □ Bedbound □ Wheelchair-dependent

In the 2 weeks prior to *C. auris* specimen collection, did the patient have or experience any of the following:

Cholorhexidine bath: □ Yes □ No □ Unknown

If yes, how often (e.g. daily, PRN): _____

If yes, which CHG product is used: _____

Endotracheal tube: □ Yes □ No □ Unknown If yes, Date placed: __/__/____

Tracheostomy: □ Yes □ No □ Unknown If yes, Date placed: __/__/____

Ventilator: □ Yes □ No □ Unknown

If yes, Start Date: __/__/____ End Date: __/__/____

IV Device: □ Yes □ No □ Unknown

If yes, type (e.g. PICC) and site:_____ Date placed: __/__/____

Was the IV device removed/replaced? □ Yes □ No If yes, when: __/__/____

Urinary Catheter: □ Yes □ No □ Unknown

If yes, type (e.g. Foley): _____ Date placed:__/__/____

Was urinary catheter removed/replaced? □ Yes □ No If yes, when: __/__/____

Wounds: □ Yes □ No □ Unknown

If yes, describe site and grade:_____

Feeding tube: □ Yes □ No □ Unknown If yes, type (e.g. g-tube): _____

TPN: □ Yes □ No □ Unknown

Invasive procedures: □ Yes □ No □ Unknown

If yes, type and date: _____

Hemodialysis (HD): □ Yes □ No □ Unknown

Location of HD: □ HD Suite □ Bedside □ Other

Consult services:

Physical therapy: □ Yes □ No □ Unknown

Occupational therapy: □ Yes □ No □ Unknown

Wound care: □ Yes □ No □ Unknown

Other:_____

MEDICATION INFORMATION

Medications received during hospitalization:

Chemotherapy: □ Yes □ No

Corticosteroids: □ Yes □ No If yes, medication name:_____

List all systemic antibiotics or antifungal treatments received during hospitalization:

Medication	Start Date	End Date	Indication