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

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 |
|-----------------|--------------|----------|---------|
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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:

Chlorhexidine 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 |
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