Candida auris Report Form

Pennsylvania Department of Health
Division of Healthcare Associated Infection Prevention
625 Forster Street
9th Floor, Room 912
Harrisburg, PA 17120
Telephone: (717) 787-3350 Fax: (717) 772-6975

Pennsylvania Department of Health

PATIENT DEMOGRAPHIC INFORMATION

PATIENT'S NAME (LAST, FIRST)	D.O.B.	AGE (years)	SEX
		0	☑ Male ☐ Female ☐ Other

RACE ☐ African-American ☐ White ☐ Asian ☐ Pacific Islander ☐ Native-American ☐ Unknown ☑ Other | HISPANIC ☐ Yes ☐ No ☑ UNK

CURRENT ADDRESS ☐ Private Residence ☑ Healthcare/Assisted Living Facility	ZIP CODE	PATIENT TELEPHONE ☐ Work ☑ Cell ☐ Home

FACILITY NAME, if residing in a healthcare/assisted living facility	WAS FACILITY NOTIFIED ☑ Yes ☐ No ☐ Unknown	PART OF OUTBREAK/CLUSTER ☐ Yes ☐ No ☑ Unknown

CLINICAL DATA

HOSPITALIZED ☐ Yes ☑ No	HOSPITAL NAME	ADMIT DATE	DISCHARGE DATE	Admitted to Intensive Care Unit ☐ Yes ☐ No ☐ UNK Fatal ☑ Yes ☐ No ☐ Unknown Date of Death:

REASON FOR TESTING ☐ Screening/Surveillance ☑ Signs/Symptoms of Infection	SIGNS/SYMPTOMS ONSET DATE, if infection:	History of *C. auris* ☐ Y ☐ N ☑ UNK Date of first positive:

INFECTION(S) ASSOCIATED WITH CULTURE(S) (Check all that apply) ☐ None ☐ Candidemia (blood) ☐ Respiratory Tract Infection ☐ Urinary Tract Infection (UTI) ☐ Organ Space/Abscess ☐ Skin/Soft Tissue Infection or Wound ☐ Other:

UNDERLYING MEDICAL CONDITIONS (Check all that apply or **attach problems list or pertinent sections of medical records**)

☐ Chronic Heart/Cardiovascular Disease ☐ Kidney Disease; ☐ Dialysis in Past Year ☐ Wound(s), specify:
☐ Diabetes ☐ Neurological, specify: ☐ Other, specify:
☐ COPD ☐ Immunosuppression, specify: ☐ None ☐ Unknown

RISK FACTORS

IF AVAILABLE, HISTORY OF HEALTHCARE STAYS IN THE UNITED STATES IN THE PREVIOUS YEAR **(List where the patient was transferred from first)**

Facility: Admission/Discharge Dates: -

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HISTORY OF INTERNATIONAL TRAVEL and/or MEDICAL CARE ABROAD IN PREVIOUS YEAR (Check all that apply)

☐ International Travel ☐ Medical Care Abroad ☐ No ☐ Unknown Dates of travel: -

If yes, location(s):

SURGERY/PROCEDURE INVOLVING A SCOPING DEVICE IN THE PAST YEAR? ☐ Yes ☐ No ☑ Unknown If yes, date:

CURRENT INDWELLING / INVASIVE DEVICE(S)? ☐ Yes ☐ No ☑ Unknown If yes, specify:

LABORATORY (Please attach culture and sensitivity results and any other applicable test results available)

SPECIMEN COLLECTION DATE: RESULT DATE:

GENUS and SPECIES: ☐ *Candida auris* ☐ *Candida haemulonii* ☑ Other:

SPECIMEN TYPE (Check all that apply)

☐ Blood ☐ Urine
☐ Wound ☐ Respiratory Secretions
☐ Skin ☐ Ear
☐ Groin ☐ Axilla
☐ Other, specify:

DIAGNOSTIC METHOD

☐ MALDI-TOF ☐ VITEK 2 YST
☐ MALDI Biotyper ☐ API 20c AUX
☐ BD Phoenix ☐ MicroScan
☐ Whole Genome Sequencing (WGS)
☐ Other:

RESISTANT/INTERMEDIATE TO AT LEAST ONE DRUG IN THE CLASS: (Check all that apply)

☐ Azoles (e.g. Fluconazole, voriconazole, posaconazole) ☐ 5-fluorocytosine
☐ Polyenes (e.g. Amphotericin B) ☐ Pandrug-Resistant
☐ Echinocandins (e.g. anidula-, caspo-, mica-fungin) ☐ None
☐ Allylamines (e.g. terbinafine, amorolfin, naftifine) ☐ Unknown

REPORTER INFORMATION

REPORT DATE	REPORTER NAME: Role: ☐ DO/MD ☐ ICP ☑ PA/NP ☐ RN ☐ Other:	FACILITY NAME	REPORTER PHONE # & EMAIL

PLEASE FAX REPORT TO (717) 772-6975 UPON COMPLETION. RETAIN ISOLATE FOR ONE MONTH