

Form Approved
OMB No. 0920-0978

CANDIDEMIA 2024 CASE REPORT FORM

Patient name: _____
(Last, First, MI)

Medical Record No.: _____

Address: _____
(Number, Street, Apt. No.)

Hospital: _____

(City, State) (Zip Code)

Acc No. (incident isolate): _____

Acc No. (subseq isolate): _____

Address type:

- 1 Residential 2 Post office 3 Long-term care facility 4 Corrections 5 Military 6 Homeless 7 Other 8 Insufficient 9 Missing

Phone no.: () _____ - _____

Check if not a case:

Reason not a case: Out of catchment area Duplicate entry Not candidemia Unable to verify address Other (specify): _____

SURVEILLANCE OFFICER INFORMATION

1. Date reported to EIP site:

____ - ____ - ____

3. Was case first identified through audit?

1 Yes 0 No

2. Date review completed:

____ - ____ - ____

4. Isolate available?

1 Yes 0 No

5. Previous candidemia episode?

1 Yes 0 No 9 Unknown

5a. If yes, enter state

IDs:

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. CRF status:

- 1 Complete
2 Pending
3 Chart unavailable

7. SO's initials:

DEMOGRAPHICS

8. State ID:

10. State: _____

11. County: _____

9. Patient ID: _____

12. Lab ID where positive culture was identified: _____

13. Date of birth (mm-dd-yyyy):

____ - ____ - ____

14. Age:

____ 1 days 2 mos 3 yrs

15. Sex:

Male Female Check if transgender

16. Weight:

____ lbs. ____ oz. OR
____ kg Unknown

17. Height:

____ ft. ____ in. OR
____ cm Unknown

18. BMI: (record only if ht. and/or wt. is not available) _____ Unknown

19. Race (check all that apply):

- American Indian/Alaska Native Native Hawaiian/Pacific Islander
 Asian White
 Black/African American Unknown

20. Ethnic origin:

- 1 Hispanic/Latino
2 Not Hispanic/Latino
9 Unknown

LABORATORY DATA

21. Date of Incident Specimen Collection (DISC) (mm-dd-yyyy): ____ - ____ - ____

22. Location of Specimen Collection:

Hospital Inpatient

Facility ID: _____

- ICU
 Surgery/OR
 Radiology
 Other inpatient

Outpatient

Facility ID: _____

- Emergency Room
 Clinic/Doctor's office
 Dialysis center
 Surgery
 Observational/clinical decision unit
 Other outpatient

LTCF

Facility ID: _____

LTACH

Facility ID: _____

- Autopsy
 Other (specify): _____
 Unknown

23. Candida species from initial positive blood culture (check all that apply):

- Candida albicans (CA) Candida dubliniensis (CD) Candida, other (CO) specify: _____
 Candida auris (CAU) Candida lusitanae (CL) Candida, germ tube negative/non albicans (CGN)
 Candida glabrata (CG) Candida krusei (CK) Candida species (CS)
 Candida parapsilosis (CP) Candida guilliermondii (CGM) Pending
 Candida tropicalis (CT)

24. Antifungal susceptibility testing (check here if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation
1 <input type="checkbox"/> CA 13 <input type="checkbox"/> CAU 2 <input type="checkbox"/> CG 3 <input type="checkbox"/> CP 4 <input type="checkbox"/> CT 5 <input type="checkbox"/> CD 6 <input type="checkbox"/> CL 7 <input type="checkbox"/> CK 8 <input type="checkbox"/> CGM 9 <input type="checkbox"/> CO 10 <input type="checkbox"/> CGN 11 <input type="checkbox"/> CS 12 <input type="checkbox"/> Pending		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
1 <input type="checkbox"/> CA 13 <input type="checkbox"/> CAU 2 <input type="checkbox"/> CG 3 <input type="checkbox"/> CP 4 <input type="checkbox"/> CT 5 <input type="checkbox"/> CD 6 <input type="checkbox"/> CL 7 <input type="checkbox"/> CK 8 <input type="checkbox"/> CGM 9 <input type="checkbox"/> CO 10 <input type="checkbox"/> CGN 11 <input type="checkbox"/> CS 12 <input type="checkbox"/> Pending		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND

25. Did the patient have a PCR molecular test for *Candida* (e.g., T2), in the 6 days before or two days after the DISC?

1 Yes 0 No 9 Unknown

25a. If yes, test type: _____

25b. Result: _____

26. Any subsequent positive *Candida* blood cultures in the 29 days after, not including the DISC? 1 Yes 0 No 9 Unknown

26a. If yes, provide dates of all subsequent positive *Candida* blood cultures and select the species:

Date Drawn (mm-dd-yyyy)	Species identified*
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CAU <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CAU <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CAU <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending
____-____-____	<input type="checkbox"/> CA <input type="checkbox"/> CAU <input type="checkbox"/> CG <input type="checkbox"/> CP <input type="checkbox"/> CT <input type="checkbox"/> CD <input type="checkbox"/> CL <input type="checkbox"/> CK <input type="checkbox"/> CGM <input type="checkbox"/> CO:_____ <input type="checkbox"/> CGN <input type="checkbox"/> CS <input type="checkbox"/> Pending

*Attach additional MIC page if additional *Candida* species (different from original), if another *C. glabrata* (even if original was *C. glabrata*), or if same *Candida* species (if no AFST results available for original)

27. Documented negative *Candida* blood culture on the day of or in the 29 days after the DISC (in which no blood cultures after this negative culture were positive in the 29 days after the DISC)? 1 Yes 0 No 9 Unknown

27a. If yes, date of negative blood culture: ____ - ____ - _____

28. On the day of or in the 6 days before the DISC, was the patient known to be colonized with or being managed as if they were colonized with a multi-drug resistant organism (MDRO) (e.g., on contact precautions)? MDROs include CRE, CRPA, CRAB, MRSA, and VRE.

1 Yes 0 No 9 Unknown

28a. If yes, specify organisms (Enter up to 3 pathogens): _____, _____, _____

29. Additional non-*Candida* organisms isolated from blood cultures on the day of or in the 6 days before the DISC:

1 Yes 0 No 9 Unknown

29a. If yes, additional organisms (Enter up to 3 pathogens): _____, _____, _____

30. Did the patient have any of the following types of infection related to their *Candida* infection? (check all that apply):

None Unknown

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abdominal infection | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Pulmonary infection | <input type="checkbox"/> Endocarditis |
| <input type="checkbox"/> Hepatobiliary or pancreatic | <input type="checkbox"/> Esophagitis | <input type="checkbox"/> Abscess | <input type="checkbox"/> Septic emboli (specify location): _____ |
| <input type="checkbox"/> Abscess (specify): _____ | <input type="checkbox"/> Oral/thrush | <input type="checkbox"/> CNS infection (meningitis, brain abscess) | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Peritonitis/peritoneal fluid | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> Eyes | |
| <input type="checkbox"/> Splenic | <input type="checkbox"/> Skin /wound infection | <input type="checkbox"/> Endophthalmitis | |
| | | <input type="checkbox"/> Chorioretinitis | |

MEDICAL ENCOUNTERS

31. Was the patient hospitalized on the day of or in the 6 days after the DISC? 1 Yes 0 No 9 Unknown

31a. If yes,
Date of first admission: ____ - ____ - _____ Unknown
Hospital ID: _____ Unknown

31b. Was the patient transferred during this hospitalization?

1 Yes 0 No 9 Unknown

If yes, enter up to two transfers:

Date of transfer: ____ - ____ - _____ Unknown Date of second transfer: ____ - ____ - _____ Unknown
Hospital ID: _____ Unknown Hospital ID: _____ Unknown

31c. Where was the patient located prior to admission or, if not currently hospitalized, where was the patient located on the 3rd calendar day before the DISC? (Check one)

- | | | |
|---|-------------------------------------|---|
| 1 <input type="checkbox"/> Private residence | 4 <input type="checkbox"/> LTACH | 6 <input type="checkbox"/> Incarcerated |
| 2 <input type="checkbox"/> Hospital inpatient | Facility ID: _____ | 7 <input type="checkbox"/> Other (specify): _____ |
| Facility ID: _____ | 5 <input type="checkbox"/> Homeless | 9 <input type="checkbox"/> Unknown |
| 3 <input type="checkbox"/> LTCF | | |
| Facility ID: _____ | | |

32. Was the patient in an ICU in the 14 days before, not including the DISC?

1 Yes 0 No 9 Unknown

33. Was the patient in an ICU on the day of incident specimen collection or in the 13 days after the DISC?

1 Yes 0 No 9 Unknown

34. Did the patient receive dialysis or renal replacement therapy (RRT) in the 30 days before the DISC, not including the DISC?

1 Yes 0 No 9 Unknown

35. Patient outcome: 1 Survived 9 Unknown 2 Died

Date of discharge: ____ - ____ - _____ Unknown Date of death: ____ - ____ - _____ Unknown

Left against medical advice (AMA)

35a. Discharged to:

- 0 Not applicable (i.e. patient died, or not hospitalized) 5 Other (specify): _____
 1 Private residence 6 Homeless
 2 LTCF Facility ID: _____ 7 Incarcerated
 3 LTACH Facility ID: _____ 9 Unknown

36. Did the patient have any of the following classes or specific ICD-10 codes, including any sub-codes for this hospitalization?

(Check all that apply): None Unknown Not applicable (i.e., patient not hospitalized)

- B37 (candidiasis) B48 (other mycoses, not classified elsewhere) A41.9 (sepsis, unspecified organism)
 Specify sub-code: _____ B49 (unspecified mycoses) R65.2 (severe sepsis)
 Specify sub-code: _____ T80.211 (BSI due to central venous catheter) Other *Candida*-related code
 Specify code: _____
 P37.5 (neonatal candidiasis)

37. Previous Hospitalization in the 90 days before, not including the DISC: 1 Yes 0 No 9 Unknown

37a. If yes, date of discharge: ____-____-____ Unknown

Facility ID: _____

38. Overnight stay in LTACH in the 90 days before, not including the DISC: 1 Yes 0 No 9 Unknown

Facility ID: _____

39. Overnight stay in LTCF in the 90 days before, not including the DISC: 1 Yes 0 No 9 Unknown

Facility ID: _____

UNDERLYING CONDITIONS

40. Underlying conditions (Check all that apply): None Unknown

- | | | |
|--|---|---|
| <p><input type="checkbox"/> Chronic Lung Disease</p> <p><input type="checkbox"/> Cystic Fibrosis</p> <p><input type="checkbox"/> Chronic Pulmonary disease</p> <p><input type="checkbox"/> Chronic Metabolic Disease</p> <p><input type="checkbox"/> Diabetes Mellitus</p> <p><input type="checkbox"/> With Chronic Complications</p> <p><input type="checkbox"/> Cardiovascular Disease</p> <p><input type="checkbox"/> CVA/Stroke/TIA</p> <p><input type="checkbox"/> Congenital Heart disease</p> <p><input type="checkbox"/> Congestive Heart Failure</p> <p><input type="checkbox"/> Myocardial infarction</p> <p><input type="checkbox"/> Peripheral Vascular Disease (PVD)</p> <p><input type="checkbox"/> Gastrointestinal Disease</p> <p><input type="checkbox"/> Diverticular disease</p> <p><input type="checkbox"/> Inflammatory Bowel Disease</p> <p><input type="checkbox"/> Peptic Ulcer Disease</p> <p><input type="checkbox"/> Short gut syndrome</p> <p><input type="checkbox"/> Immunocompromised Condition</p> <p><input type="checkbox"/> HIV infection</p> <p><input type="checkbox"/> AIDS/CD4 count <200</p> <p><input type="checkbox"/> Primary Immunodeficiency</p> <p><input type="checkbox"/> Transplant, Hematopoietic Stem Cell</p> <p><input type="checkbox"/> Transplant, Solid Organ (specify): _____</p> | <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Chronic Liver Disease</p> <p><input type="checkbox"/> Ascites</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Hepatic Encephalopathy</p> <p><input type="checkbox"/> Variceal Bleeding</p> <p><input type="checkbox"/> Hepatitis B, chronic</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> Treated, in SVR</p> <p><input type="checkbox"/> Current, chronic</p> <p><input type="checkbox"/> Hepatitis B, acute</p> <p><input type="checkbox"/> Malignancy</p> <p><input type="checkbox"/> Malignancy, Hematologic</p> <p><input type="checkbox"/> Malignancy, Solid Organ (non-metastatic)</p> <p><input type="checkbox"/> Malignancy, Solid Organ (metastatic)</p> <p><input type="checkbox"/> Neurologic Condition</p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Chronic Cognitive Deficit</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Epilepsy/seizure/seizure disorder</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Other (specify): _____</p> | <p><input type="checkbox"/> Plegias/Paralysis</p> <p><input type="checkbox"/> Hemiplegia</p> <p><input type="checkbox"/> Paraplegia</p> <p><input type="checkbox"/> Quadriplegia</p> <p><input type="checkbox"/> Renal Disease</p> <p><input type="checkbox"/> Chronic Kidney Disease</p> <p>Lowest serum creatinine: _____mg/DL</p> <p><input type="checkbox"/> Unknown or not done</p> <p><input type="checkbox"/> Skin Condition</p> <p><input type="checkbox"/> Burn</p> <p><input type="checkbox"/> Decubitus/Pressure Ulcer</p> <p><input type="checkbox"/> Surgical Wound</p> <p><input type="checkbox"/> Other chronic ulcer or chronic wound</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Connective tissue disease</p> <p><input type="checkbox"/> Obesity or morbid obesity</p> <p><input type="checkbox"/> Pregnant</p> |
|--|---|---|

SOCIAL HISTORY

41. Smoking (Check all that apply):

- None Tobacco
 Unknown E-nicotine delivery system
 Marijuana

42. Alcohol Abuse:

- 1 Yes
 0 No
 9 Unknown

43. Other Substances (Check all that apply):

- None Unknown

Documented Use Disorder (DUD/Abuse): Mode of Delivery (Check all that apply):

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Marijuana (other than smoking) | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Opioid, DEA schedule I (e.g., Heroin) | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Opioid, DEA schedule II-IV (e.g., methadone, oxycodone) | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Opioid, NOS | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Cocaine | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Methamphetamine | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Other (specify): _____ | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Unknown substance | <input type="checkbox"/> DUD or abuse | <input type="checkbox"/> IDU <input type="checkbox"/> Non-IDU <input type="checkbox"/> Unknown |

44. During the current hospitalization, did the patient receive medication-assisted treatment (MAT) for opioid use disorder?

- 1 Yes 0 No 8 N/A (patient not hospitalized or did not have DUD) 9 Unknown

OTHER CONDITIONS

45. For cases ≤ 1 year of age: Gestational age at birth: _____ wks 9 Unknown AND Birth weight: _____ gms 9 Unknown

46. Chronic Dialysis: Not on chronic dialysis Unknown 46a. If Hemodialysis, type of vascular access:
 Type: Hemodialysis Peritoneal AV fistula/graft Hemodialysis central line Unknown

47. Surgeries in the 90 days before, not including the DISC:

- Abdominal surgery (specify): _____
 If yes: 1 Open abdomen 0 Laparoscopic 9 Unknown
 Non-abdominal surgery (specify): _____
 No surgery

48. Pancreatitis in the 90 days before, not including the DISC:

- 1 Yes
 0 No
 9 Unknown

49. Did the patient have any ostomies of the gastrointestinal tract including ileostomy, colostomy, etc. in the 30 calendar days before, not including the DISC?

- 1 Yes 0 No 9 Unknown

50. Chronic Urinary Tract Problems/Abnormalities:

- 1 Yes 0 No 9 Unknown

50a. If yes, did the patient have any urinary tract procedures in the 90 days before, not including the DISC?

- 1 Yes 0 No 9 Unknown

51. Was the patient neutropenic in the 2 calendar days before, not including the DISC?

- 1 Yes 0 No 9 Unknown (no WBC days -2 or 0, or no differential)

52. Did the patient have a CVC in the 2 calendar days before, not including the DISC?

- 1 Yes 2 No 3 Had CVC but can't find dates 9 Unknown

If yes, was the central line in place for > 2 calendar days: 1 Yes 0 No 9 Unknown

52a. If yes, CVC type: (Check all that apply)

- Non-tunneled CVCs Implantable ports Other (specify): _____
 Tunneled CVCs Peripherally inserted central catheter (PICC) Unknown

52b. Were all CVCs removed or changed in the 2 days before or in the 6 days after the DISC?

- 1 Yes 3 CVC removed, but can't find dates 9 Unknown
 2 No 5 Died or discharged before indwelling catheter replaced

53. Did the patient have a midline catheter in the 2 calendar days before, not including the DISC?

- 1 Yes 0 No 9 Unknown

54. Did the patient have any of the following indwelling devices or other devices present in the 2 calendar days before, not including the DISC? None Unknown

- | | | |
|--|--|---|
| <input type="checkbox"/> Urinary Catheter/Device | <input type="checkbox"/> Respiratory | <input type="checkbox"/> Gastrointestinal |
| <input type="checkbox"/> Indwelling urethral | <input type="checkbox"/> ET/NT | <input type="checkbox"/> Abdominal drain (specify): _____ |
| <input type="checkbox"/> Suprapubic | <input type="checkbox"/> Tracheostomy | <input type="checkbox"/> Gastrostomy |
| | <input type="checkbox"/> Invasive mechanical ventilation | |

55. Did the patient have a positive SARS-CoV-2 test result (molecular assay, antigen, or other confirmatory test, excluding serology) from a specimen collected in the 90 days before the DISC or on the DISC?

1 Yes 0 No 9 Unknown

55a. If yes, date of specimen collection for initial positive SARS-CoV-2 test:

Date: _____ 9 Date Unknown

55b. If yes, EIP COVID-NET Case ID: _____ None or N/A

56. Did the patient receive systemic antibacterial medication in the 14 days before, not including the DISC?

1 Yes 0 No 9 Unknown

57. Did the patient receive any systemic steroids in the 30 days before, not including the DISC?

1 Yes 0 No 9 Unknown

57a. If yes, what was the reason steroids were administered? (check all that apply)

- Steroid(s) given as an outpatient medication
- Steroid(s) given, prior to *Candida* DISC, during hospitalization associated with candidemia episode
- Steroid(s) given as part of treatment/management for COVID-19
- None of the above

58. Did the patient receive total parenteral nutrition (TPN) in the 14 days before, not including the DISC?

1 Yes 0 No 9 Unknown

59. Did the patient receive systemic antifungal medication on the day of or in the 13 days before the DISC?

1 Yes (if Yes, fill out question 66) 0 No 9 Unknown

60. Was the patient administered systemic antifungal medication after, not including the DISC?

1 Yes (if Yes, fill out question 66) 0 No 9 Unknown

61. If antifungal medication was not given to treat current candidemia infection, what was the reason?

- | | |
|--|---|
| 1 <input type="checkbox"/> Patient died before culture result available to clinicians | 5 <input type="checkbox"/> Other reason documented in medical records, specify: _____ |
| 2 <input type="checkbox"/> Comfort care only measures were instituted | 6 <input type="checkbox"/> Patient refused treatment against medical advice |
| 3 <input type="checkbox"/> Patient discharged before culture result available to clinician | 9 <input type="checkbox"/> Unknown |
| 4 <input type="checkbox"/> Medical records indicated culture result not clinically significant or contaminated | |

-----IF ANY ANTIFUNGAL MEDICATION WAS GIVEN, COMPLETE NEXT PAGE. -----

OTHER

62. Does the chart indicate that the incident specimen was considered a contaminant or was considered to not be indicative of true infection?

1 Yes 0 No 9 Unknown

63. Was the patient under the care of an infectious disease physician on the day of the DISC or within the 6 days after the DISC?

1 Yes 0 No 9 Unknown

64. Did the patient have an echocardiogram (ECHO), including transthoracic (TTE) or transesophageal (TEE), on the day of or 13 days after the DISC?

1 Yes 0 No 9 Unknown

65. Did the patient have a dilated fundoscopic eye exam on the day of or 13 days after the DISC?

1 Yes 0 No 9 Unknown

ANTIFUNGAL MEDICATION TABLES

Drug abbreviations (**NOTE: Please use abbreviation when entering data**):

Amphotericin – any IV formulation (Amphotec, Amphocil, Fungizone, Abelcet, Ambiosome, etc.)=AMBIV
 Anidulafungin (Eraxis)=ANF
 Caspofungin (Cancidas)=CAS

Fluconazole (Diflucan)=FLC
 Flucytosine (5FC)=5FC
 Isavuconazole (cresemba)=ISU
 Itraconazole (Sporanox)=ITC
 Micafungin (Mycamine)=MFG

Other=OTH
 Posaconazole (Noxafil)=PSC
 UNKNOWN DRUG=UNK
 Voriconazole (Vfend)=VRC

66. ANTIFUNGAL MEDICATION

a. Drug Abbrev	b. First date given (mm-dd-yyyy)	c. Date start unknown	d. Last date given (mm-dd-yyyy)	e. Date stop unknown	f. Indication	g. Reason for stopping (if applicable)*
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	
	____-____-____	<input type="checkbox"/>	____-____-____	<input type="checkbox"/>	<input type="checkbox"/> Prophylaxis <input type="checkbox"/> Treatment	

*Reasons for stopping antifungal treatment include: (1) completion of treatment; (2) started on different antifungal; (3) hospital discharge; (4) withdrawal of care/transition to comfort care only; (5) death; (6) other; (7) no additional records/lost to follow-up; (8) not applicable, no therapy given; and (9) unknown.

-----END OF CHART REVIEW FORM-----

AFST results for additional *Candida* isolates

Antifungal susceptibility testing (check here if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation	
1 <input type="checkbox"/> CA 13 <input type="checkbox"/> CAU 2 <input type="checkbox"/> CG 3 <input type="checkbox"/> CP 4 <input type="checkbox"/> CT 5 <input type="checkbox"/> CD 6 <input type="checkbox"/> CL 7 <input type="checkbox"/> CK 8 <input type="checkbox"/> CGM 9 <input type="checkbox"/> CO 10 <input type="checkbox"/> CGN 11 <input type="checkbox"/> CS 12 <input type="checkbox"/> Pending		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
	1 <input type="checkbox"/> CA 13 <input type="checkbox"/> CAU 2 <input type="checkbox"/> CG 3 <input type="checkbox"/> CP 4 <input type="checkbox"/> CT 5 <input type="checkbox"/> CD 6 <input type="checkbox"/> CL 7 <input type="checkbox"/> CK 8 <input type="checkbox"/> CGM 9 <input type="checkbox"/> CO 10 <input type="checkbox"/> CGN 11 <input type="checkbox"/> CS 12 <input type="checkbox"/> Pending		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
			Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
			Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	

Antifungal susceptibility testing (check here if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation	
1 <input type="checkbox"/> CA 13 <input type="checkbox"/> CAU 2 <input type="checkbox"/> CG 3 <input type="checkbox"/> CP 4 <input type="checkbox"/> CT 5 <input type="checkbox"/> CD 6 <input type="checkbox"/> CL 7 <input type="checkbox"/> CK 8 <input type="checkbox"/> CGM 9 <input type="checkbox"/> CO 10 <input type="checkbox"/> CGN 11 <input type="checkbox"/> CS 12 <input type="checkbox"/> Pending		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
	1 <input type="checkbox"/> CA 13 <input type="checkbox"/> CAU 2 <input type="checkbox"/> CG 3 <input type="checkbox"/> CP 4 <input type="checkbox"/> CT 5 <input type="checkbox"/> CD 6 <input type="checkbox"/> CL 7 <input type="checkbox"/> CK 8 <input type="checkbox"/> CGM 9 <input type="checkbox"/> CO		Amphotericin B		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
			Anidulafungin (Eraxis)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
			Caspofungin (Cancidas)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
		Fluconazole (Diflucan)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Flucytosine (5FC)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Itraconazole (Sporanox)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Micafungin (Mycamine)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	
		Posaconazole (Noxafil)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND	

State ID: _____ Date of Incident Specimen Collection (mm-dd-yyyy): ____ - ____ - _____ Surveillance Officer Initials _____

	10 <input type="checkbox"/> CGN 11 <input type="checkbox"/> CS 12 <input type="checkbox"/> Pending	Voriconazole (Vfend)		<input type="checkbox"/> S <input type="checkbox"/> SDD <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> NI <input type="checkbox"/> ND
--	--	----------------------	--	---