Facility_____
Contact Person: _____

Candida auris Line List

Date: ____/____/_____

	Patient Name	Room #	Facility Admit Date	LOS (days) in Current Room	DOB	Infection or Coloniza-tion?	Laboratory			Hospitalization			Invasive Devices (List)	Invasive Procedures (List and Date)	Incontinent (bowel, bladder, both, no)	Outcome (Recovered, Transferred, Deceased)
							Specimen	Specimen Collection Date	Genus Species	Hospital Name	Admit Date	Discharge Date				
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3																
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