

Candida auris Report Form



Department of
Public Health
CITY OF PHILADELPHIA
LIFE • LIBERTY • AND YOU™

Philadelphia Department of Public Health

Division of Disease Control

1101 Market St., 12th Floor

Philadelphia, PA 19107

Telephone: (215) 685-6748

Fax: (215) 238-6947

Form available at hip.phila.gov

PATIENT DEMOGRAPHIC INFORMATION

PATIENT'S NAME (LAST, FIRST)		D.O.B. ____/____/____	AGE (years) _____	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other
RACE <input type="checkbox"/> African-American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Native-American <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				HISPANIC <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK
CURRENT ADDRESS <input type="checkbox"/> Private Residence <input type="checkbox"/> Healthcare/Assisted Living Facility		ZIP CODE	PATIENT TELEPHONE <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Home	
FACILITY NAME, if residing in a healthcare/assisted living facility		WAS FACILITY NOTIFIED <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		PART OF OUTBREAK/CLUSTER <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

CLINICAL DATA

HOSPITALIZED <input type="checkbox"/> Yes <input type="checkbox"/> No	HOSPITAL NAME	ADMIT DATE ____/____/____	DISCHARGE DATE ____/____/____	Admitted to Intensive Care Unit <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UNK Fatal <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Date of Death: ____/____/____
REASON FOR TESTING <input type="checkbox"/> Screening/Surveillance <input type="checkbox"/> Signs/Symptoms of Infection		SIGNS/SYMPTOMS ONSET DATE, if infection: ____/____/____		History of <i>C. auris</i> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> 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: ____/____/____ - ____/____/____
 Facility: _____ Admission/Discharge Dates: ____/____/____ - ____/____/____
 Facility: _____ Admission/Discharge Dates: ____/____/____ - ____/____/____

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: ____/____/____

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) <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Wound <input type="checkbox"/> Respiratory Secretions <input type="checkbox"/> Skin <input type="checkbox"/> Ear <input type="checkbox"/> Groin <input type="checkbox"/> Axilla <input type="checkbox"/> Other, specify: _____	DIAGNOSTIC METHOD <input type="checkbox"/> MALDI-TOF <input type="checkbox"/> VITEK 2 YST <input type="checkbox"/> MALDI Biotyper <input type="checkbox"/> API 20c AUX <input type="checkbox"/> BD Phoenix <input type="checkbox"/> MicroScan <input type="checkbox"/> Whole Genome Sequencing (WGS) <input type="checkbox"/> Other: _____	RESISTANT/INTERMEDIATE TO AT LEAST ONE DRUG IN THE CLASS: (Check all that apply) <input type="checkbox"/> Azoles (e.g. Fluconazole) <input type="checkbox"/> 5-fluorocytosine <input type="checkbox"/> Polyenes (e.g. Amphotericin B) <input type="checkbox"/> Pandrug-Resistant <input type="checkbox"/> Echinocandins (e.g. anidula-, caspo-, mica-fungin) <input type="checkbox"/> None <input type="checkbox"/> Allylamines (e.g. terbinafine, amorolfina, naftifina) <input type="checkbox"/> Unknown
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REPORTER INFORMATION

REPORT DATE ____/____/____	REPORTER NAME Role: <input type="checkbox"/> DO/MD <input type="checkbox"/> CP <input type="checkbox"/> PA/NP <input type="checkbox"/> RN <input type="checkbox"/> Other: _____	FACILITY NAME	REPORTER PHONE # & EMAIL
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PLEASE FAX REPORT TO (215) 238-6947 UPON COMPLETION. RETAIN ISOLATE FOR ONE MONTH

Reporting Guidelines for *Candida auris*

Report **all** positive cultures of *Candida auris* and *Candida haemulonii* (*Candida auris* is frequently misidentified as *Candida haemulonii*).

Report cultures from all body sites (including but not limited to blood, wound, skin, ear, urine, rectum, and respiratory secretions) that were collected for diagnostic purposes as well as surveillance/screening purposes.

All positive test results should be reported to PDPH **within 24 hours**. Please call PDPH at (215) 685-6748 [after-hours (215) 686-4514] to report a case of *Candida auris*. A *Candida auris* case report form should also be filled out and faxed to PDPH at (215) 238-6947 after reporting the case via phone.

Isolates should be retained for one month. PDPH will follow up to coordinate further testing as needed.