CANDIDEMIA 2016 CASE REPORT FORM

Patient name: _____ Medical Record No.: _____
(Last, First, MI)

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

_____ _____ Acc No. (incident isolate): _____
(City, State) (Zip Code)

Acc No. (subseq isolate): _____

.....cut/tear here and retain portion above at EIP site.....

Check if not a case: ☐Out of catchment area ☐Duplicate entry ☐Not candidemia ☐Unable to verify address ☐Other reason:_____

1) State ID: ☐☐☐☐☐☐☐☐ **2) County:** _____ **3) Lab ID where positive culture was identified:** ☐☐☐☐☐

4) Age: _____ 1☐days 2☐mos 3☐yrs (check one) **5) Date of birth:** ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy)

6) Sex: 1☐Male 2☐Female 3☐Transgendered **7) Date first positive culture for *Candida* was drawn:** ☐☐/☐☐/☐☐☐☐

8) Source of first positive culture: 1☐Blood, from central venous catheter 2☐Blood, from peripheral stick 3☐Blood, not specified
4☐Other (specify) _____ 5☐Blood, from arterial line 6☐Unknown

9) *Candida* species (check all that apply):

1 ☐ *Candida albicans* (CA)
2 ☐ *Candida glabrata* (CG)
3 ☐ *Candida krusei* (CK)
4 ☐ *Candida lusitaniae* (CL)
5 ☐ *Candida parapsilosis* (CP)
6 ☐ *Candida tropicalis* (CT)
7 ☐ *Candida*, other (CO) _____
8 ☐ *Candida*, gram tube negative/ non albicans (CGN)
9 ☐ *Candida* species (CS)
10☐ Pending

9A) Antifungal susceptibility testing (check here ☐ if no testing done/no test reports available):

Date of culture	Species	Drug	MIC	Interpretation
		Amphotericin B	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Anidulafungin (Eraxis)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Caspofungin (Cancidas)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Fluconazole (Diflucan)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Flucytosine (5FC)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Itraconazole (Sporanox)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Micafungin (Mycamine)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Posaconazole (Noxafil)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Voriconazole (Vfend)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Amphotericin B	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Anidulafungin (Eraxis)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Caspofungin (Cancidas)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Fluconazole (Diflucan)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Flucytosine (5FC)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Itraconazole (Sporanox)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Micafungin (Mycamine)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Posaconazole (Noxafil)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk
		Voriconazole (Vfend)	☐Unk	☐S ☐SDD ☐I ☐R ☐NS ☐ND/Unk

9B) Additional *Candida* species or another C. *glabrata* isolated within 30d of incident culture (If yes, attach additional CRF: Q1, Q8, Q9, Q9A, and Q10): 1☐Yes **Date drawn:** ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy) 2☐ No 9 ☐Unknown

10) Additional organisms isolated from this blood culture: 1 ☐Yes 2 ☐No 9☐Unknown

If yes, specify additional organisms:_____

--SURVEILLANCE OFFICE USE ONLY--

a) Date reported to EIP site: ☐☐/☐☐/☐☐☐☐ b) Date review completed: ☐☐/☐☐/☐☐☐☐	c) Was case first identified through audit? 1 ☐Yes 2 ☐No d) Isolate available? 1 ☐Yes 2 ☐No	e) Previous candidemia episode? 1 ☐Yes **If yes, enter 1st state ID:** ☐☐☐☐☐☐☐☐ 2 ☐No 9 ☐Unknown	f) CRF status: 1 ☐Complete 2 ☐Pending 4 ☐Chart unavailable	g) SO's initials: _____

State ID: ☐☐☐☐☐☐☐☐ **Surveillance Officer Initials:** _____

DEMOGRAPHICS

11. Race:

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

12. Ethnic origin:

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

13. Date of last recorded patient encounter:

☐☐/☐☐/☐☐☐☐ **OR** 9☐Unk
(mm/dd/yyyy)

14. Outcome at last patient encounter:

1☐Alive
2☐Dead **Date of death:** ☐☐/☐☐/☐☐☐☐ **OR** 9☐Unk
9☐Unknown (mm/dd/yyyy)

15. Where was the patient located on the 4th calendar day prior to the date of initial culture?

1☐Private residence
2☐Hospital Inpatient (If transferred, complete Q16)
3☐LTCF
4☐LTACH
5☐Homeless
6☐Incarcerated
7☐Other (specify): _____
8☐Unknown

MEDICAL ENCOUNTERS

16. Did the patient require a prior hospitalization in the 90 days before the first positive blood culture for *Candida* was drawn?

1☐Yes
2☐No
9☐Unknown

17. Was patient transferred from another hospital to the first treatment hospital?

1☐Yes (**If yes, transferred hospital ID:** ☐☐☐☐☐)
2☐No
9☐Unknown

18. Was patient hospitalized?

1☐Yes (**If yes, treatment hospital ID:** ☐☐☐☐☐)
2☐No
9☐Unknown

18A. If patient was hospitalized:

Date of admit: ☐☐/☐☐/☐☐☐☐ 9☐Unk
Date of discharge: ☐☐/☐☐/☐☐☐☐ 9☐Unk
(mm/dd/yyyy)

19A. Was the patient ever in an ICU in the 14 days before the date of first positive culture?

1 ☐Yes
2 ☐No
3 ☐Not applicable
9 ☐Unknown

19B. Was the patient ever in an ICU on the day of culture or in the 14 days after the date of first positive culture?

1 ☐Yes
2 ☐No
3 ☐Not applicable
9 ☐Unknown

20. If the patient was alive at discharge, where was the patient discharged to? 0☐Not applicable (i.e., patient died, or not hospitalized)

1☐Home
2☐Hospice care at home or in facility
3☐Skilled nursing facility/nursing home
4☐Rehabilitation facility
5☐Long term acute care hospital
6☐Another acute care hospital
7☐Other, specify: _____
9☐Unknown

PREVIOUS CONDITIONS

21. Underlying conditions prior to positive *Candida* culture (check all that apply): 1 ☐Yes 2 ☐No 9☐Unknown

Cancer-related diagnoses:
- 1 ☐Leukemia/Lymphoma/Multiple myeloma
- 1 ☐Solid organ malignancy
- 1 ☐Other cancer (specify): _____

Inflammatory Bowel Disease 1 ☐

Connective Tissue Disease 1 ☐

Diabetes 1☐

Pancreatitis 1 ☐

Liver diagnoses:
- 1 ☐Alcohol-related liver disease
- 1 ☐Cirrhosis
- 1 ☐Hepatitis B
- 1 ☐Hepatitis C
- 1 ☐Non-alcoholic fatty liver disease
- 1 ☐Other liver disease (specify): _____

Surgeries IN THE 90 DAYS PRIOR:
- 1 ☐Abdominal surgery
- 1 ☐Non-abdominal surgery (specify) _____

Renal diagnoses:
- 1 ☐CVVH/CVVHD IN THE 90 DAYS PRIOR
- 1 ☐Hemodialysis – type vascular access:
  - 1 ☐AV fistula/graft
  - 2 ☐Hemodialysis CVC
  - 3 ☐Hemodialysis tunneled catheter
  - 9 ☐Unknown
- 1 ☐Peritoneal dialysis

Organ transplant recipient:
- 1 ☐Stem cell transplant
- 1 ☐Solid organ transplant

Other diagnoses 1☐ _____

OTHER CONDITIONS

22. HIV related diagnoses: 1 ☐HIV infection without AIDS 2 ☐AIDS/CD4 count < 200 9 ☐No HIV-related diagnosis

23. IV drug user: 1 ☐Yes 2 ☐No 3 ☐Drug user - access type unknown 9 ☐Unknown

24. Premature Birth (only for ≤1 year of age) 1 ☐Yes 2 ☐No 3 ☐Not applicable 9 ☐Unknown

If yes, Gestational age at birth: ☐☐ wks AND Birth weight: ☐☐☐☐ gms or 9☐Unk

25. Infection with *Clostridium difficile* **90 days before to 30 days after** initial culture date: 1 ☐Yes 2 ☐No 9☐Unknown

If yes, date of C. Diff diagnosis: ☐☐/☐☐/☐☐☐☐ (mm/dd/yyyy) or 9☐Unk

26. Did the patient have a central venous catheter 2 days before, the day before, or on the day the first positive culture was drawn?

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

27. Were all CVCs removed or changed within 7 days after the date of first positive culture?

1 ☐Yes
2 ☐No
3 ☐CVC removed, but can't find dates
4 ☐Not applicable (no CVC)
9 ☐Unknown

28. Was the patient neutropenic* 2 days before, the day before, or on the day the first positive culture was drawn?

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

***Neutropenia: ANC ≤ 500 OR calculated as: WBC count * (% polys + % bands) ≤500**

Laboratory-calculated ANC:_____

_____ * (%_____ + %_____) = _____

MEDICATIONS

29. Did the patient receive any of these medications in the 14 days before initial positive *Candida* culture date:

Antibacterial, systemic: 1 ☐Yes 2 ☐No 9☐Unknown

Total parenteral nutrition (TPN): 1 ☐Yes 2 ☐No 9☐Unknown

30. Did the patient receive systemic antifungal medication in the 14 days before initial positive *Candida* culture date?

1 ☐Yes *(fill out the table Antifungal medication prior to culture table)*
2 ☐No
9 ☐Unknown

31. Did the patient receive systemic antifungal medication to treat candidemia on or after positive culture date?

1 ☐Yes *(fill out the Antifungal medication table)*
2 ☐No
9 ☐Unknown

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

1 ☐Patient died before culture result available to clinicians
2 ☐Comfort care only measures were instituted
3 ☐Patient discharged before culture result available to clinician
4 ☐Medical records indicated culture result not clinically significant
5 ☐Other reason documented in medical records, specify:

_____

6 ☐Unknown

33. If antifungal medication was given to treat current candidemia, what was the reason for stopping?

1 ☐Completion of treatment
2 ☐Hospital discharge
3 ☐Withdrawal of care/transition to comfort care only
4 ☐Death
5 ☐Other, specify:

_____

6 ☐No additional records/lost to follow-up
7 ☐Not applicable, no therapy given
8 ☐Unknown

----------IF ANY ANTIFUNGAL MEDICATION WAS GIVEN, COMPLETE NEXT PAGE. OTHERWISE END OF CHART REVIEW FORM----------

State ID: ☐☐☐☐☐☐☐☐

Surveillance Officer Initials: ________________

Date of initial culture: ______/______/__________

ANTIFUNGAL MEDICATION TABLES

Drug abbreviations:
Amphotericin – any IV formulation (Amphotec, Amphocil, Fungizone, Abelcet, AmBiosome, etc.)=AMBIV
Amphotericin – any inhaled formulation ()=AMBINH
Anidulafungin (Eraxis)=ANF
Caspofungin (Cancidas)=CAS
Fluconazole (Diflucan)=FLC
Flucytosine (5FC)=5FC
Isuvaconazole (cresemba)=ISU
Itraconazole (Sporanox)=ITC
Micafungin (Mycamine)=MFG
Other=OTH
Posaconazole (Noxafil)=PSC
UNKNOWN DRUG=UNK
Voriconazole (Vfend)=VRC

ANTIFUNGAL MEDICATION PRIOR TO CULTURE, DAY -14 to DAY -1

Drug Abbrev	Indication	Date Start (mm/dd/yyyy)	Date start unknown	Date Stop (mm/dd/yyyy)	Date stop unknown
	☐ Prophylaxis ☐ Therapy for another fungal infection ☐ Empiric therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	
	☐ Prophylaxis ☐ Therapy for another fungal infection ☐ Empiric therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	
	☐ Prophylaxis ☐ Therapy for another fungal infection ☐ Empiric therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	

ANTIFUNGAL MEDICATION TABLE, DAY 0 TO DAY 30

Drug Abbrev	Indication	Date Start (mm/dd/yyyy)	Date start unknown	Date Stop (mm/dd/yyyy)	Date stop unknown
	☐ Prophylaxis ☐ Therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	
	☐ Prophylaxis ☐ Therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	
	☐ Prophylaxis ☐ Therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	
	☐ Prophylaxis ☐ Therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	
	☐ Prophylaxis ☐ Therapy ☐ Unknown	☐☐/☐☐/☐☐☐☐		☐☐/☐☐/☐☐☐☐	

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