

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

Form Approved
OMB No. 092-0978

CANDIDEMIA 2021 CASE REPORT FORM

Patient name: _____ (Last, First, MI) Medical Record No.: _____
Address: _____ Hospital: _____
(Number, Street, Apt. No.)
Acc No. (incident isolate): _____
(City, State) (Zip Code) Acc No. (subseq isolate): _____
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 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No | 5. Previous candidemia episode? 1 <input type="checkbox"/> Yes 0 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown 5a. If yes, enter state IDs: <table border="1"><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr></table> | <input type="checkbox"/> | 6. CRF status: 1 <input type="checkbox"/> Complete 2 <input type="checkbox"/> Pending 3 <input type="checkbox"/> Chart unavailable | 7. SO's initials: _____ |
| <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"/> | | | | | | | | | | | | | | | | | | | | | |

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 <input type="checkbox"/> days 2 <input type="checkbox"/> mos 3 <input type="checkbox"/> yrs | 15. Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Check if transgender |
| 16. Weight: _____ lbs. _____ oz. OR _____ kg <input type="checkbox"/> Unknown | 17. Height: _____ ft. _____ in. OR _____ cm <input type="checkbox"/> Unknown | 18. BMI: (record only if ht. and/or wt. is not available) _____ <input type="checkbox"/> Unknown |
| 19. Race (check all that apply): <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Unknown | | 20. Ethnic origin: 1 <input type="checkbox"/> Hispanic/Latino 2 <input type="checkbox"/> Not Hispanic/Latino 9 <input type="checkbox"/> Unknown |

LABORATORY DATA

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

22. Location of Specimen Collection:

| | | |
|--|---|--|
| <input type="checkbox"/> Hospital Inpatient Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> Surgery/OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient | <input type="checkbox"/> Outpatient Facility ID: _____ <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Dialysis center <input type="checkbox"/> Surgery <input type="checkbox"/> Observational/clinical decision unit <input type="checkbox"/> Other outpatient | <input type="checkbox"/> LTCF Facility ID: _____ <input type="checkbox"/> LTACH Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown |
|--|---|--|

| | |
|--|--|
| 23. Incident Specimen Collection Site (check all that apply): <input type="checkbox"/> Blood, Central Line <input type="checkbox"/> Blood, Peripheral stick <input type="checkbox"/> Blood, not specified <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown | 24. Candida species from initial positive blood culture (check all that apply): <input type="checkbox"/> <i>Candida albicans</i> (CA) <input type="checkbox"/> <i>Candida krusei</i> (CK) <input type="checkbox"/> <i>Candida glabrata</i> (CG) <input type="checkbox"/> <i>Candida guilliermondii</i> (CGM) <input type="checkbox"/> <i>Candida parapsilosis</i> (CP) <input type="checkbox"/> <i>Candida</i> , other (CO) specify: _____ <input type="checkbox"/> <i>Candida tropicalis</i> (CT) <input type="checkbox"/> <i>Candida</i> , germ tube negative/non albicans (CGN) <input type="checkbox"/> <i>Candida dubliniensis</i> (CD) <input type="checkbox"/> <i>Candida</i> species (CS) <input type="checkbox"/> <i>Candida lusitanae</i> (CL) <input type="checkbox"/> Pending |
|--|--|

Public reporting burden of this collection of information is estimated to average 40 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30329; ATTN: PRA (0920-0978).

25. 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 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 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 | |

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"/> 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"/> 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"/> 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"/> 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. Infection with *Clostridioides difficile* on the day of or in the 89 days before or 29 days after the DISC:

1 Yes 0 No 9 Unknown

30a. If yes, date of first *C. diff* diagnosis: ____-____-____ Unknown

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

None Unknown

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Abdominal | <input type="checkbox"/> Candiduria | <input type="checkbox"/> Pulmonary | <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"/> GI tract | <input type="checkbox"/> Oral/thrush | <input type="checkbox"/> Respiratory specimen with <i>Candida</i> | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Abscess (specify): _____ | <input type="checkbox"/> Osteomyelitis | <input type="checkbox"/> CNS involvement (meningitis, brain abscess) | |
| <input type="checkbox"/> Peritonitis/peritoneal fluid | <input type="checkbox"/> Skin lesions/wounds | | |
| <input type="checkbox"/> Splenic | <input type="checkbox"/> Eyes (endophthalmitis or chorioretinitis) | | |

MEDICAL ENCOUNTERS

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

32a. If yes,
Date of first admission: ____-____-____ Unknown

Hospital ID: _____ Unknown

32b. 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

32c. Where was the patient located prior to admission or, if not 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: _____ | | |

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

1 Yes 0 No 9 Unknown

34. 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

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 <input type="checkbox"/> Not applicable (i.e. patient died, or not hospitalized) | 5 <input type="checkbox"/> Other (specify): _____ |
| 1 <input type="checkbox"/> Private residence | 6 <input type="checkbox"/> Homeless |
| 2 <input type="checkbox"/> LTCF Facility ID: _____ | 7 <input type="checkbox"/> Incarcerated |
| 3 <input type="checkbox"/> LTACH Facility ID: _____ | 9 <input type="checkbox"/> 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

- | | | |
|--|---|---|
| <input type="checkbox"/> B37 (candidiasis) Specify sub-code: _____ Specify sub-code: _____ | <input type="checkbox"/> B48 (other mycoses, not classified elsewhere) <input type="checkbox"/> B49 (unspecified mycoses) <input type="checkbox"/> T80.211 (BSI due to central venous catheter) | <input type="checkbox"/> A41.9 (sepsis, unspecified organism) <input type="checkbox"/> R65.2 (severe sepsis) <input type="checkbox"/> Other <i>Candida</i> -related code Specify code: _____ |
| <input type="checkbox"/> 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

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

SOCIAL HISTORY

41. Smoking (Check all that apply):

- | | |
|----------------------------------|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Tobacco |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> E-nicotine delivery system |
| | <input type="checkbox"/> 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"/> Skin popping | <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"/> Skin popping | <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"/> Skin popping | <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"/> Skin popping | <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"/> Skin popping | <input type="checkbox"/> Non-IDU | <input type="checkbox"/> Unknown |

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- Methamphetamine DUD or abuse IDU Skin popping Non-IDU Unknown
Other (specify): _____ DUD or abuse IDU Skin popping Non-IDU Unknown
Unknown substance DUD or abuse IDU Skin popping Non-IDU 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. Chronic Urinary Tract Problems/Abnormalities:

1 Yes 0 No 9 Unknown

49a. 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

50. 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)

51. 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, check here if central line in place for > 2 calendar days:

51a. If yes, CVC type: (Check all that apply)

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

51b. Were all CVCs removed or changed on the day of 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

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

1 Yes 0 No 9 Unknown

53. 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

Urinary Catheter/Device Respiratory Gastrointestinal
Indwelling urethral ET/NT Abdominal drain (specify): _____
Suprapubic Tracheostomy Gastrostomy
Invasive mechanical ventilation

MEDICATIONS

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

1 Yes 0 No 9 Unknown

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

1 Yes 0 No 9 Unknown

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

1 Yes 0 No 9 Unknown

57. 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 60) 0 No 9 Unknown

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

1 Yes (if Yes, fill out question 60) 0 No 9 Unknown

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

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

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

OTHER

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

- 1 Yes 0 No 9 Unknown

62. 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

COVID-19 QUESTIONS

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

- 1 Yes 0 No 9 Unknown

1a. If yes, date of specimen collection for initial positive SARS-CoV-2 test:

Date: _____ 9 Date Unknown

1b. If yes, EIP COVID-NET Case ID: _____ 9 Unknown Out of EIP COVID-NET catchment area

2. Did the patient receive invasive mechanical ventilation in the 30 days before the DISC, not including the DISC?

- 1 Yes 0 No 9 Unknown

3. 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

4. If patient received any systemic steroids in the 30 days before the DISC (question 55), not including the DISC, are any of the following scenarios true? (check all that apply)

- Steroid(s) given as an outpatient medication
 Steroid(s) given during hospitalization associated with candidemia episode prior to Candida DISC
 Steroid(s) given as part of treatment/management for COVID-19

5. Did the patient receive any of the following immunomodulatory drugs in the 30 days before the DISC, not including the DISC?

- None Tocilizumab Sarilumab Baricitinib Unknown

5a. If yes (and patient had a positive SARS-CoV-2 test), were any of the immunomodulatory drugs given as part of treatment/management for COVID-19?

- 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

60. 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 | 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 |
| | 2 <input type="checkbox"/> CG | 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 |
| | 3 <input type="checkbox"/> CP | 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 |
| | 4 <input type="checkbox"/> CT | 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 |
| | 5 <input type="checkbox"/> CD | 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 |
| | 6 <input type="checkbox"/> CL | 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 |
| | 7 <input type="checkbox"/> CK | 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 |
| | 8 <input type="checkbox"/> CGM | 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 |
| | 9 <input type="checkbox"/> CO | 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 |
| | 10 <input type="checkbox"/> CGN | 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 |
| | 11 <input type="checkbox"/> CS | 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 |
| | 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 |
| | 1 <input type="checkbox"/> CA | 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 |
| | 2 <input type="checkbox"/> CG | 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 |
| | 3 <input type="checkbox"/> CP | 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 |
| | 4 <input type="checkbox"/> CT | 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 |
| | 5 <input type="checkbox"/> CD | 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 |
| | 6 <input type="checkbox"/> CL | 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 |
| | 7 <input type="checkbox"/> CK | 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 |
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| | 11 <input type="checkbox"/> CS | 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 |
| | 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 |

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 | 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 |
| | 2 <input type="checkbox"/> CG | 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 |
| | 3 <input type="checkbox"/> CP | 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 |
| | 4 <input type="checkbox"/> CT | 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 |
| | 5 <input type="checkbox"/> CD | 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 |
| | 6 <input type="checkbox"/> CL | 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 |
| | 7 <input type="checkbox"/> CK | 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 |
| | 8 <input type="checkbox"/> CGM | 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 |
| | 9 <input type="checkbox"/> CO | 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 |
| | 10 <input type="checkbox"/> CGN | 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 |
| | 11 <input type="checkbox"/> CS | 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 |
| | 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 |
| | 1 <input type="checkbox"/> CA | 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 |
| | 2 <input type="checkbox"/> CG | 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 |
| | 3 <input type="checkbox"/> CP | 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 |
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| | 6 <input type="checkbox"/> CL | 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 |
| | 7 <input type="checkbox"/> CK | 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 |
| | 8 <input type="checkbox"/> CGM | 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 |
| | 9 <input type="checkbox"/> CO | 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 |
| | 10 <input type="checkbox"/> CGN | 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 |
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| | 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 |