NEVADA DIVISION of PUBLIC and BEHAVIORAL HEALTH

Submit this form for newly identified *C. auris* positive patients. Send secure email to outbreak@health.nv.gov or fax to 702-486-0490.

Attach patient's face sheet, test results, H&P, and antifungal medication list.

CASE REPORT FORM: *Candida auris*

Patient Name: **Date of Birth:** (mm/dd/yy) ____/____/____ **Patient Sex:** [ ] Male [ ] Female [ ] Other **Deceased at time of report:** [ ] Yes [ ] No

Race: [ ] American Indian/Alaskan Native [ ] Asian [ ] Black/African American [ ] Native Hawaiian/Other Pacific Islander [ ] White [ ] Other Race [ ] Unknown

Ethnicity: [ ] Hispanic or Latino [ ] Not Hispanic or Latino [ ] Other [ ] Unknown

Reporting Facility Name:

Type of Facility:
[ ] Inpatient [ ] Outpatient [ ] Long Term Acute Care
[ ] SNF [ ] Other (list): _____

Name of person completing this form:

Direct phone number for person completing this form: _____-_____-_____

Date Form Completed: (mm/dd/yy) ____/____/____

Admitted From:

Admission Date: (mm/dd/yy) ____/____/____
Was the patient transferred from another state?
[ ] No [ ] Yes – State: _____

Discharged To:

Discharge Date: (mm/dd/yy) ____/____/____
Was the patient transferred to another state?
[ ] No [ ] Yes – State: _____

Reason for hospitalization:

Specimen Collection Date: (mm/dd/yy) ____/____/____
Specimen Source:
[ ] Axilla/groin swab [ ] Other skin swab: _____
[ ] Blood [ ] Urine
[ ] Central line/PICC [ ] Urinary catheter
[ ] Respiratory [ ] Suprapubic catheter
[ ] Surgical wound* [ ] Rectal swab
[ ] Non-surgical wound* [ ] Other:_____
*Wound location: _____
Room/Unit at time of specimen collection:

Isolation Precautions and start date:
[ ] Contact ..... ____/____/____
[ ] Enhanced Barrier (SNF only) ____/____/____
[ ] Droplet..... ____/____/____
[ ] Airborne..... ____/____/____
[ ] Other (list):_____ ... ____/____/____
[ ] Other (list):_____ ... ____/____/____

Did the patient have roommates prior to being isolated?
[ ] No [ ] Yes – if yes:

Roommate Name:	**Shared Rm/Unit:**	**Date of Birth:**	**Was roommate screened for C. auris?**	**Does roommate have C. auris?**
_____	_____	____/____/____	[ ] No [ ] Yes [ ] Pending	[ ] No [ ] Yes
_____	_____	____/____/____	[ ] No [ ] Yes [ ] Pending	[ ] No [ ] Yes
_____	_____	____/____/____	[ ] No [ ] Yes [ ] Pending	[ ] No [ ] Yes

Invasive Devices and approx. insertion date: (mm/dd/yy)
Central line/PICC ..... ____/____/____
Hemodialysis catheter ..... ____/____/____
Urinary catheter ..... ____/____/____
Suprapubic urinary catheter ..... ____/____/____
Percutaneous gastrostomy (PEG) tube .... ____/____/____
Tracheostomy ..... ____/____/____
Other (list): _____ ... ____/____/____

Is the patient on dialysis? [ ] No [ ] Yes – If yes:
What is the patient's dialysis schedule?
Su M Tu W Th F Sa [ ] PRN
[ ] [ ] [ ] [ ] [ ] [ ] [ ]
Where does the patient have dialysis?
[ ] Bedside [ ] In house but not at bedside
[ ] At an outside facility – if yes:
Facility name: _____

Did the patient receive antifungal medications at the reporting facility? [ ] No [ ] Yes – Attach medication list with antifungal name(s), dose, start date, end date

THE OFFICE OF STATE Epidemiology