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, culture results, H&P, and antifungal medication list.

CASE REPORT FORM: *Candida auris*

Patient Name: **Date of Birth:** (mm/dd/yyyy) **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: *Please include location*

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/yyyy)

Admitted From:

Admission Date: (mm/dd/yyyy) _____
Was the patient transferred *from* another state?
☐ No ☐ Yes – State: _____

Discharged To:

Discharge Date: (mm/dd/yyyy)
Was the Patient transferred *to* another state?
☐ No ☐ Yes – State: _____

Reason for hospitalization:

Specimen Collection Date: (mm/dd/yyyy) _____
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 and location: _____
Location(E.g. ICU/Rm2/Bed1) 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/yyyy)
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