

Candida auris Case Detail Form New Jersey Department of Health

Completing facility name: _____ Your initials: _____

Case information

Patient's name: _____ Date of birth: _____ MRN: _____

Sex: _____ Race: _____ Ethnicity: _____

City/state of residence: _____

Has the patient died? Yes, Date of death: _____ Cause of death: _____
 No Unknown

Medical conditions

Check all diagnoses at the date of first C. auris culture or last discharge before the date of first culture

- Diabetes
- Respiratory disease
- Ventilator dependent
- Liver disease
- Chronic kidney disease
- Hemodialysis
- Neurologic disease
- Cardiovascular disease
- Solid tumor
- Solid organ transplant
- Bone marrow transplant
- Hematologic malignancy
- HIV/AIDS
- Chronic wounds
- History of MDROs (e.g. MRSA, VRE)
- Other diagnoses not mentioned, specify: _____

Culture history

Were any fungal cultures collected at your facility? Yes* No Unknown

If yes, select the fungal organisms that were identified:

- Candida auris*
- Candida haemulonii*
- Candida duobushaemulonii*
- Candida* spp. unknown
- Candida* spp., no speciation
- Other, specify: _____
- None of the above organisms were identified

*Please attach the final microbiology reports to this case report form, including no growth results

Medical devices

Check all devices the patient had within the two weeks before the date of first C. auris culture, or last day the patient was in the facility

- Urinary catheter
- Central venous catheter
- Mechanical ventilator
- Surgical drain
- Tracheostomy
- Intraabdominal drain or catheter
- Abdominal feeding tube (e.g. G, GJ, J tube)
- Other device(s) not listed, specify: _____

Please complete and fax this form to the Communicable Disease Service at 609-292-5811. You can contact the Communicable Disease Service at 609-826-5964 to ask questions or report additional cases of *Candida auris*.

Date completed: _____

NJDOH ID: _____

NJDOH Notes: _____

Medical procedures

Did the patient undergo surgical or bedside procedures in the 90 days before the date of first C. auris culture, or last day the patient was in the facility? (e.g. line placement, IR intervention, surgical procedure)

- Yes, procedures listed below
- No
- Unknown

If yes, list and date the procedures in the table below:

Procedure name/location	Date

Procedure name/location	Date

Medication exposures

Check all medications the patient received in the 90 days before the date of first culture or last discharge before the date of first culture

- Cytotoxic chemotherapy Start date: _____ Stop date: _____
- Total parenteral nutrition (TPN)..... Start date: _____ Stop date: _____
- Systemic antibiotics (IV or oral)..... Start date: _____ Stop date: _____
- Corticosteroids Start date: _____ Stop date: _____

Name/type: _____ Dose/frequency: _____

List all antifungal medications the patient received in the 90 days before and after the date of first C. auris culture, or last day the patient was in the facility

Antifungal	Start date	Stop date	Dose	Route

Travel history

Did the patient indicate any travel in the last year? Yes, details listed below No Unknown

Travel location(s): _____ Date(s): _____

Did the patient receive healthcare during travel? Yes No Unknown

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