Digitally Completing Case Report Forms

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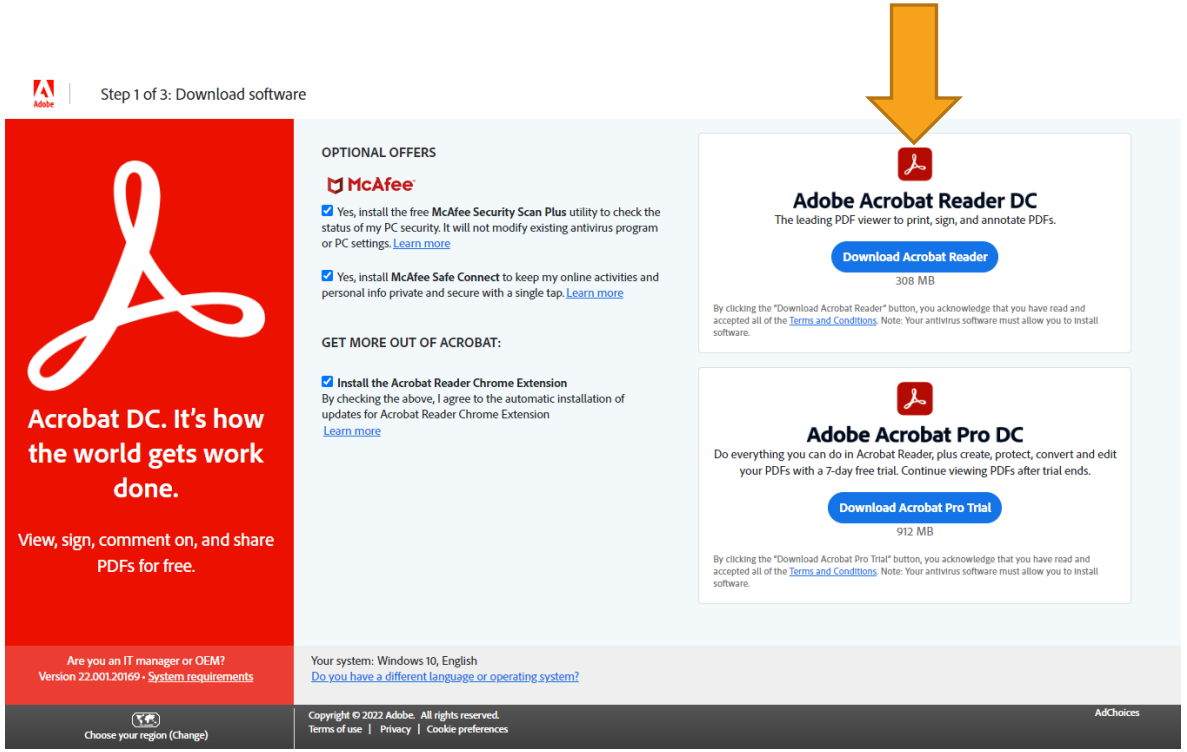
5 Quick Steps to Digitally Complete and Upload Case Report Forms (CRFs)

- **Download a PDF reader (Adobe Acrobat Reader DC recommended)**
- **Open the Case Report Form in the PDF reader (enabled for digital completion with fields highlighted in blue)**
- **If fillable fields do not appear in blue, select 'Fill and Sign'**
- **Complete CRF and save**
- **Upload completed PDF to http://healthsurveys.nj.gov/NoviSurvey/n/zz2g8.aspx**

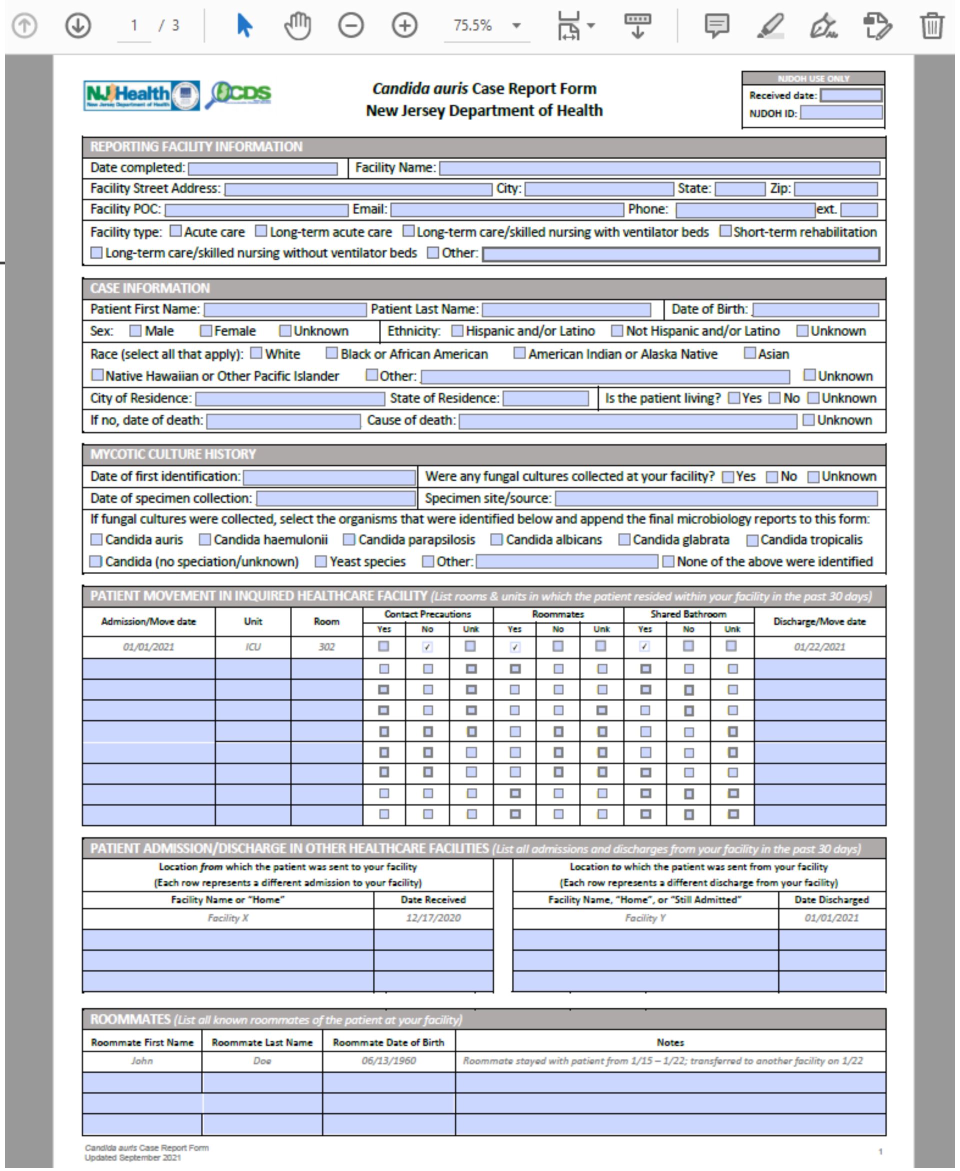
Downloading a PDF Reader to Use to Digitally Complete CRFs

- Adobe Acrobat Reader DC is the recommended program to use for completing CRFs
  - It's FREE!
  - Visit: get.adobe.com/reader/
- Other PDF readers enabled for digital completion (with fields highlighted in blue) are also acceptable



Opening and Viewing the Blank CRF in a PDF Reader

- Open the Case Report Form in the PDF reader (enabled for digital completion with fields highlighted in blue)
- If fillable fields do not appear in blue, select 'Fill and Sign'



Candida auris Case Report Form
New Jersey Department of Health

NJDOH USE ONLY
Received date:
NJDOH ID:

REPORTING FACILITY INFORMATION

Date completed: 07/25/2022 | Facility Name: Hospital A
Facility Street Address: 135 E State Street | City: Trenton | State: NJ | Zip: 00000
Facility POC: Infection Preventionist | Email: IP@HospitalA.org | Phone: 555-555-5555 ext. 123
Facility type: ☑ Acute care ☐ Long-term acute care ☐ Long-term care/skilled nursing with ventilator beds ☐ Short-term rehabilitation
☐ Long-term care/skilled nursing without ventilator beds ☐ Other:

CASE INFORMATION

Patient First Name: John | Patient Last Name: Doe | Date of Birth: 01/01/1990
Sex: ☑ Male ☐ Female ☐ Unknown | Ethnicity: ☐ Hispanic and/or Latino ☑ Not Hispanic and/or Latino ☐ Unknown
Race (select all that apply): ☑ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Other: ☐ Unknown
City of Residence: Trenton | State of Residence: NJ | Is the patient living? ☑ Yes ☐ No ☐ Unknown
If no, date of death: | Cause of death: ☐ Unknown

MYCOTIC CULTURE HISTORY

Date of first identification: 07/25/2022 | Were any fungal cultures collected at your facility? ☑ Yes ☐ No ☐ Unknown
Date of specimen collection: 07/18/2022 | Specimen site/source: Nares/Axilla/Groin swab
If fungal cultures were collected, select the organisms that were identified below and append the final microbiology reports to this form:
☑ Candida auris ☐ Candida haemulonii ☐ Candida parapsilosis ☐ Candida albicans ☐ Candida glabrata ☐ Candida tropicalis
☐ Candida (no speciation/unknown) ☐ Yeast species ☐ Other: ☐ None of the above were identified

PATIENT MOVEMENT IN INQUIRED HEALTHCARE FACILITY *(List rooms & units in which the patient resided within your facility in the past 30 days)*

Admission/Move date	Unit	Room	Contact Precautions			Roommates			Shared Bathroom			Discharge/Move date
			Yes	No	Unk	Yes	No	Unk	Yes	No	Unk	
01/01/2021	*ICU*	*302*	☐	☑	☐	☑	☐	☐	☑	☐	☐	*01/22/2021*
06/05/2022	ICU	300	☐	☑	☐	☐	☑	☐	☐	☑	☐	06/20/2022
06/20/2022	CCU	401	☐	☑	☐	☐	☑	☐	☐	☑	☐	07/13/2022
07/13/2022	Telemetry	222	☐	☑	☐	☑	☐	☐	☑	☐	☐	07/24/2022
			☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	

PATIENT ADMISSION/DISCHARGE IN OTHER HEALTHCARE FACILITIES *(List all admissions and discharges from your facility in the past 30 days)*

Location *from* which the patient was sent to your facility (Each row represents a different admission to your facility)		Location *to* which the patient was sent from your facility (Each row represents a different discharge from your facility)	
Facility Name or "Home"	Date Received	Facility Name, "Home", or "Still Admitted"	Date Discharged
Facility X	*12/17/2020*	*Facility Y*	*01/01/2021*
Home	06/05/2022	LTCF A	07/24/2022

ROOMMATES *(List all known roommates of the patient at your facility)*

Roommate First Name	Roommate Last Name	Roommate Date of Birth	Notes
John	*Doe*	*06/13/1960*	*Roommate stayed with patient from 1/15 – 1/22; transferred to another facility on 1/22*
Jack	Smith	05/05/1955	Roommate from 7/13-7/20; transferred to LTCF B on 7/20

HEALTHCARE SERVICES *(Select all healthcare services provided to the patient within the past 30 days)*

☐ Chemotherapy ☐ ECMO ☑ Imaging ☐ Inpatient dialysis ☐ IVIG ☐ Outpatient dialysis ☐ Rehabilitation
☑ Respiratory therapy ☑ Wound care ☑ Ultrasound ☐ Other:

MEDICAL CONDITIONS *(Select all of the patient's present medical conditions and those existing 14 days prior to the day of report)*

☐ Autoimmune disorder ☑ Bacteremia ☐ Bone marrow transplant ☐ Cancer (hematogenous) ☐ Cancer (solid)
☐ Cardiovascular disease ☐ Chronic kidney disease ☑ Chronic wounds ☑ COVID-19 (or history of COVID-19) ☐ Diabetes
☑ History of MDR infection ☐ HIV/AIDS ☐ Kidney failure ☐ Liver disease ☐ Neurologic disease ☐ Obesity
☑ Respiratory disease (Non-COVID) ☐ Sepsis ☐ Solid organ transplant ☐ Tuberculosis ☑ Ventilator dependent
☐ Other:

MEDICAL DEVICES *(Select all of the patient's present medical devices)*

☑ Abdominal feeding tube ☑ Central venous catheter ☐ Colostomy ☐ Hemodialysis catheter ☐ Intraabdominal drain/catheter
☑ Mechanical ventilator ☐ Nephrostomy ☐ Port(s) ☐ Surgical drain ☐ Tracheostomy/tracheostomy collar ☑ Urinary catheter
☐ Other:

MEDICAL PROCEDURES

Did the patient undergo medical procedures in the past 30 days (If yes, list the procedures below)? ☑ Yes ☐ No ☐ Unknown

Date	Procedure	Location	Facility
01/01/2021	*Line placement (PICC)*	*Interventional Radiology*	*Example Facility*
06/05/2022	CT Imaging	Interventional Radiology Ste 6	Hospital A
06/06/2022	Intubation	Bedside, ICU Rm 300	Hospital A

ANTIBIOTIC EXPOSURES *(Select all of the patient's present antibiotics and those administered 14 days prior to the day of report)*

Which (if any) of the following classes of antibiotics was the patient exposed to? ☐ Unknown ☐ None

☐ **Aminoglycosides:** | ☐ **Oxazolidinones:**
☑ **Carbapenems:** Doripenem | ☐ **Penicillins:**
☐ **Cephalosporins:** | ☐ **Polypeptides:**
☐ **Fluoroquinolones:** | ☐ **Rifamycins:**
☐ **Glycopeptides:** | ☐ **Sulfonamides:**
☐ **Macrolides:** | ☐ **Tetracyclines:**
☐ **Monobactams:** | ☐ Other:

ANTIFUNGAL EXPOSURES *(Select all of the patient's present antifungals and those administered 14 days prior to the day of report)*

Which (if any) of the following classes of antifungals was the patient exposed to? ☐ Unknown ☐ None

☐ **Allylamines:** | ☑ **Echinocandins:** Micafungin
☐ **Azoles:** | ☐ **Polyenes:**

TRAVEL HISTORY

Did the patient receive any international healthcare during travel in the past year? ☐ Yes ☑ No ☐ Unknown

COMMENTS

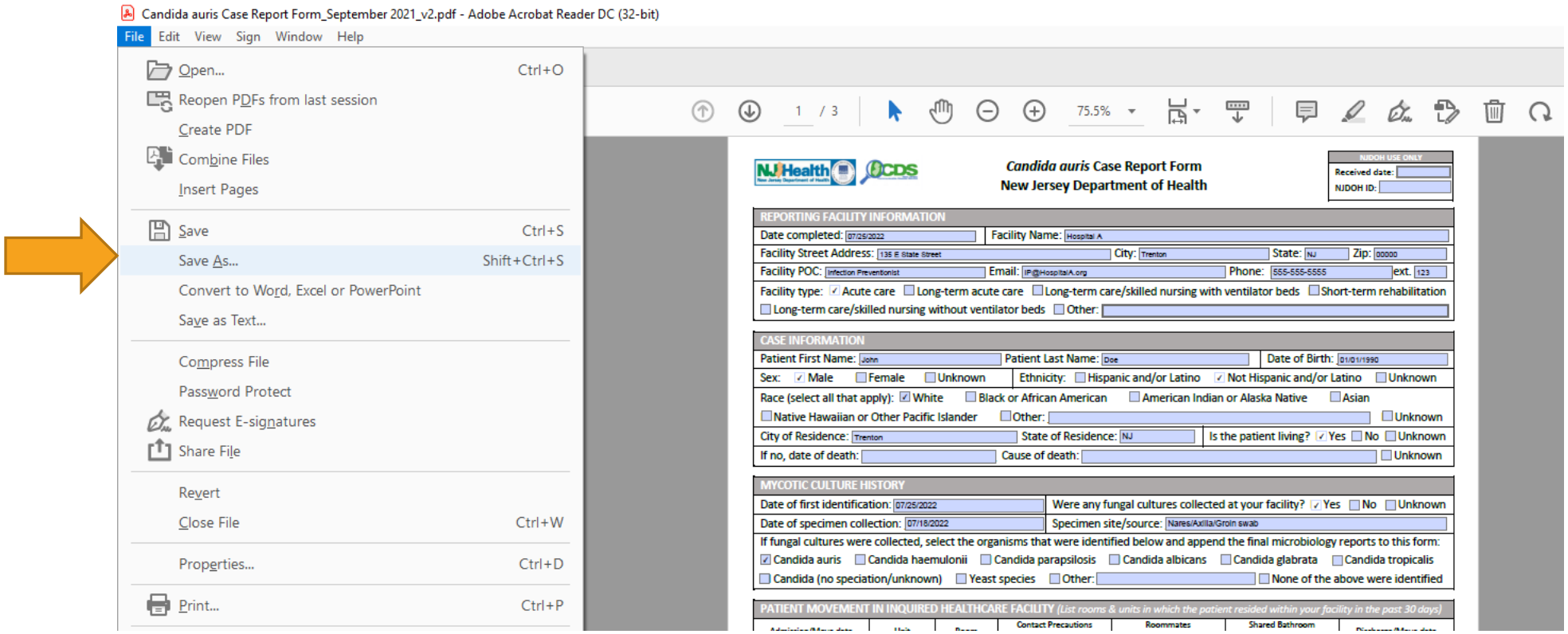
PLEASE REMEMBER TO APPEND FINAL MICROBIOLOGY REPORTS TO THIS FORM

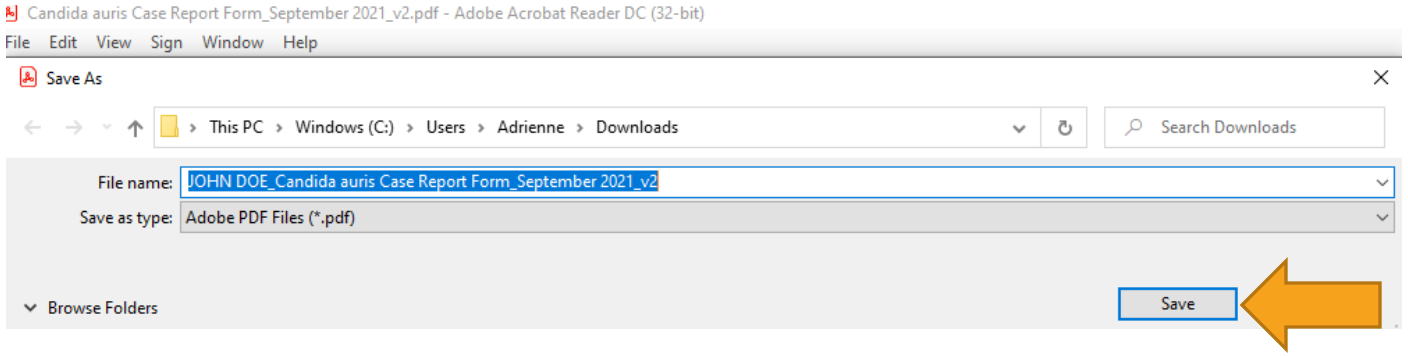
Correctly completed CRFs should resemble the images above

NJHealth New Jersey Department of Health Communicable Disease Service

Saving Digitally Completed CRFs

- Go to File > Save As
  - Select a location to save the completed form on your local device
  - Update file name and save completed CRF

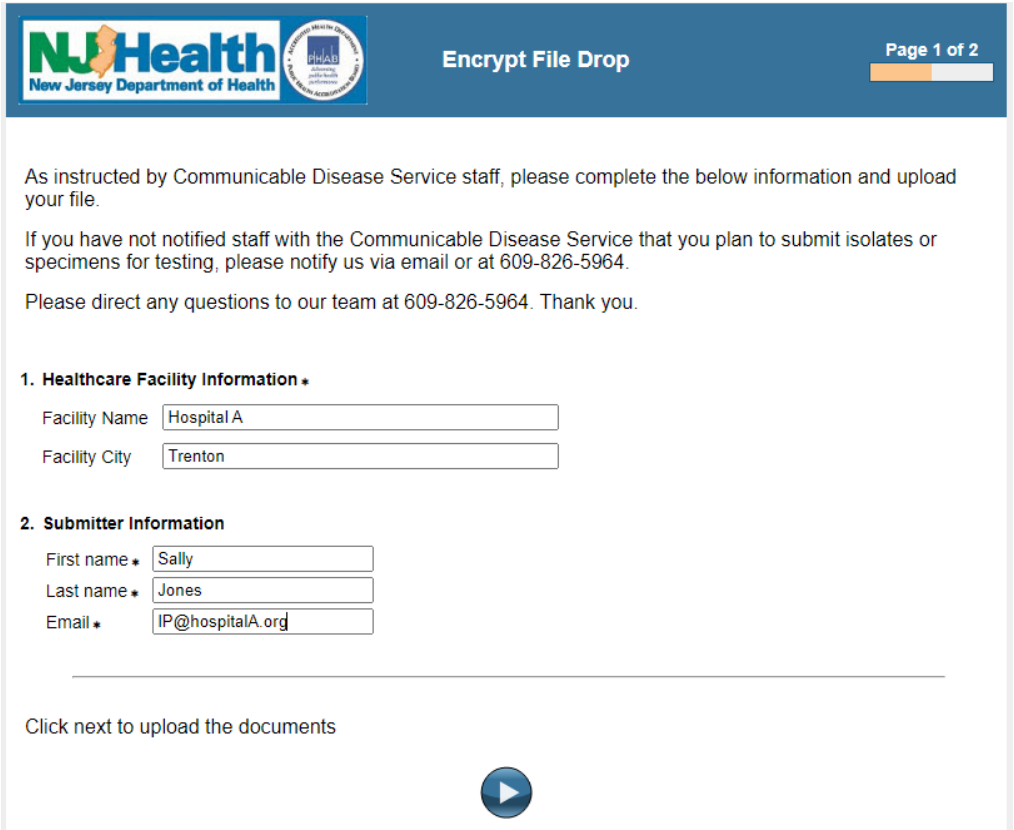




Save completed CRFs as shown above

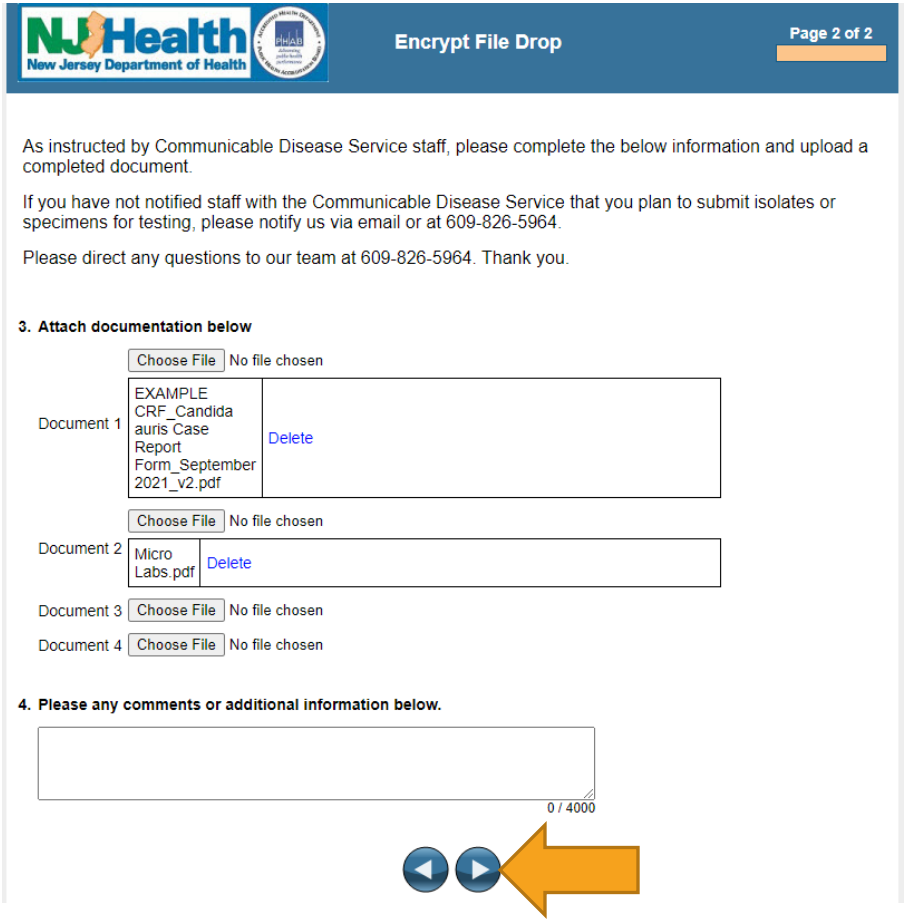
Uploading Digitally Completed CRFs

- Navigate to the encrypted file drop webpage: http://healthsurveys.nj.gov/NoviSurvey/n/zz2g8.aspx
- Provide submitter's contact information and facility name and location on page 1



Uploading Digitally Completed CRFs

- Proceed to page 2, where you will select the file(s) from your local device to upload and attach
  - Microbiology lab results are encouraged to be submitted as a separate, additional attachment
  - Please **do not** scan or combine completed CRFs and labs into one file
- Once files have been selected and uploaded, proceed to the next page to complete the submission



Uploading Digitally Completed CRFs

- The following message will appear indicating successful completion of file upload(s):