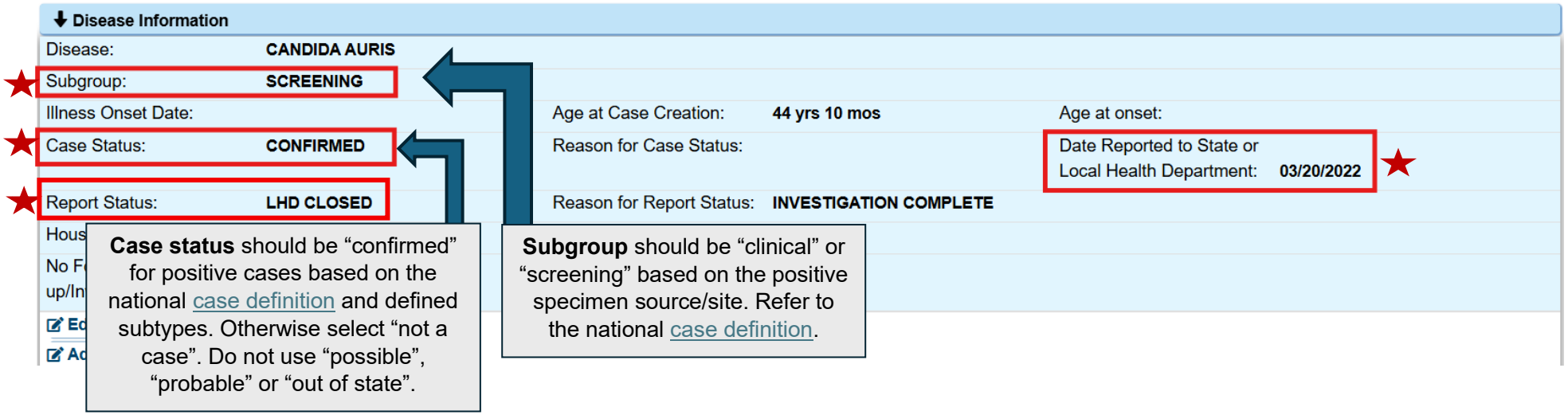
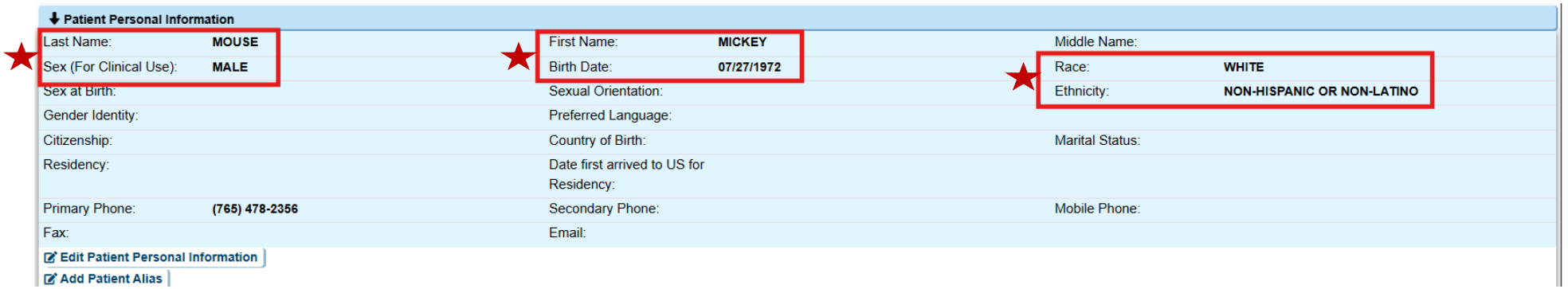
CDRSS Data Field Completion Guide for *Candida* (*Candidozyma*) *auris*

Local health departments (LHDs) should verify that all obtained data is entered into CDRSS prior to changing the report status to 'LHD closed'. Below is an example of a completed case investigation entered into CDRSS. The fields highlighted by **red boxes** are mandatory. The fields highlighted by **red stars** are to be completed by the LHD with jurisdiction over the patient's primary address, or the LHD with jurisdiction over the identifying healthcare facility if the patient is not a resident of NJ.

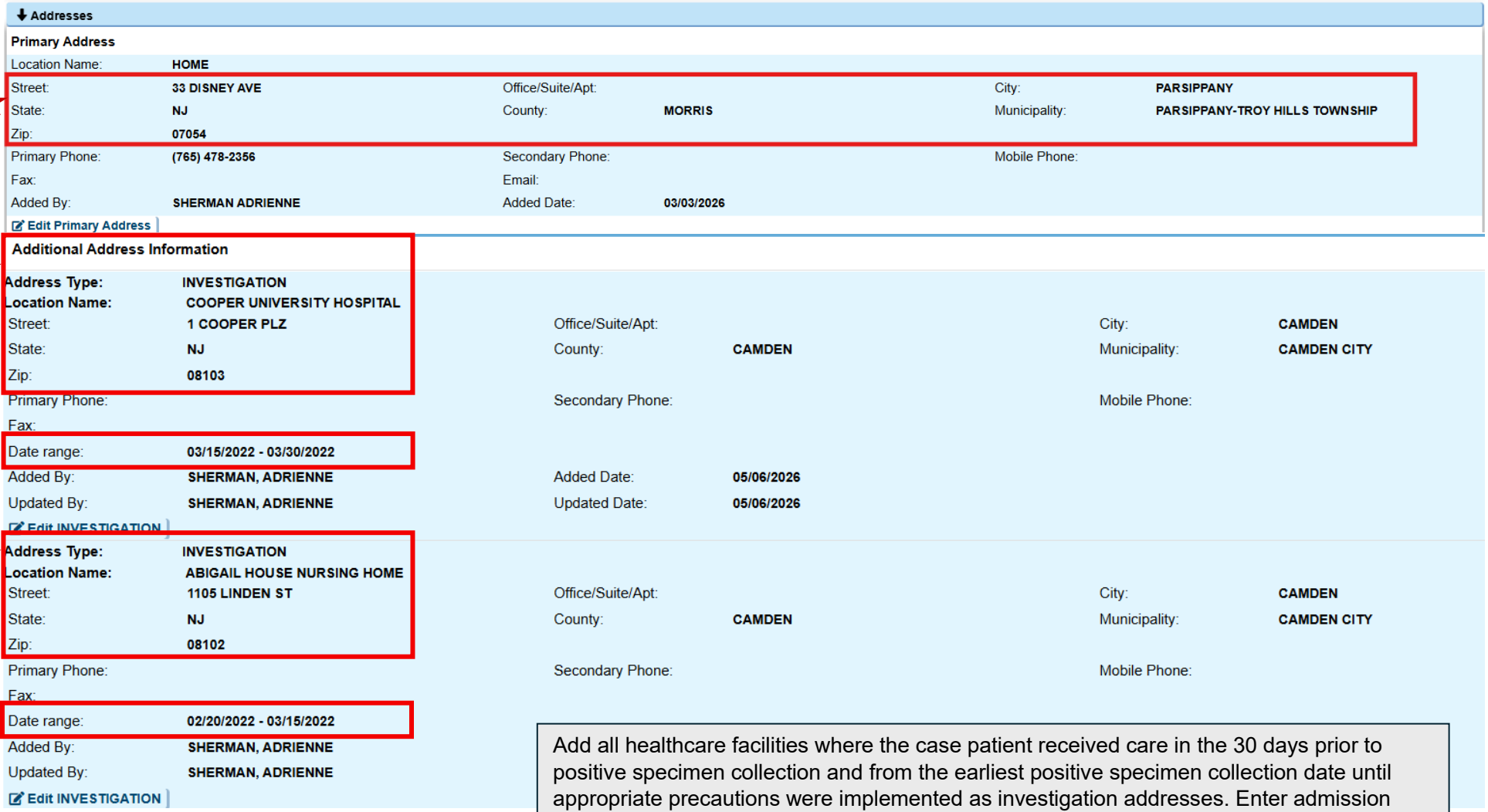
Disease Information



Patient Personal Information



Addresses



Add all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection and from the earliest positive specimen collection date until appropriate precautions were implemented as investigation addresses. Enter admission dates for each facility in the date range fields.

Address Type:	**INVESTIGATION**				
Location Name:	**JEFFERSON CHERRY HILL**				
Street:	**2201 CHAPEL AVE W**	Office/Suite/Apt:		City:	**CHERRY HILL**
State:	**NJ**	County:	**CAMDEN**	Municipality:	**CHERRY HILL TOWNSHIP**
Zip:	**08002**				
Primary Phone:		Secondary Phone:		Mobile Phone:	
Fax:					
Date range:	**02/19/2022 - 02/20/2022**				
Added By:	**SHERMAN, ADRIENNE**	Added Date:	**05/06/2026**		
Updated By:	**SHERMAN, ADRIENNE**	Updated Date:	**05/07/2026**		

Edit INVESTIGATION

Address Type:	**INVESTIGATION**				
Location Name:	**CEDAR GROVE RESPIRATORY AND NURSING**				
Street:	**1420 S BLACK HORSE PIKE**	Office/Suite/Apt:		City:	**WILLIAMSTOWN**
State:	**NJ**	County:	**GLOUCESTER**	Municipality:	**MONROE TOWNSHIP**
Zip:	**08094**				
Primary Phone:		Secondary Phone:		Mobile Phone:	
Fax:					
Date range:	**01/01/2022 - 02/19/2022**				
Added By:	**SHERMAN, ADRIENNE**	Added Date:	**05/07/2026**		
Updated By:	**SHERMAN, ADRIENNE**	Updated Date:	**05/07/2026**		

Edit INVESTIGATION

Laboratory and Diagnostic Test Information

Laboratory and Diagnostic Test Information

Laboratory Information

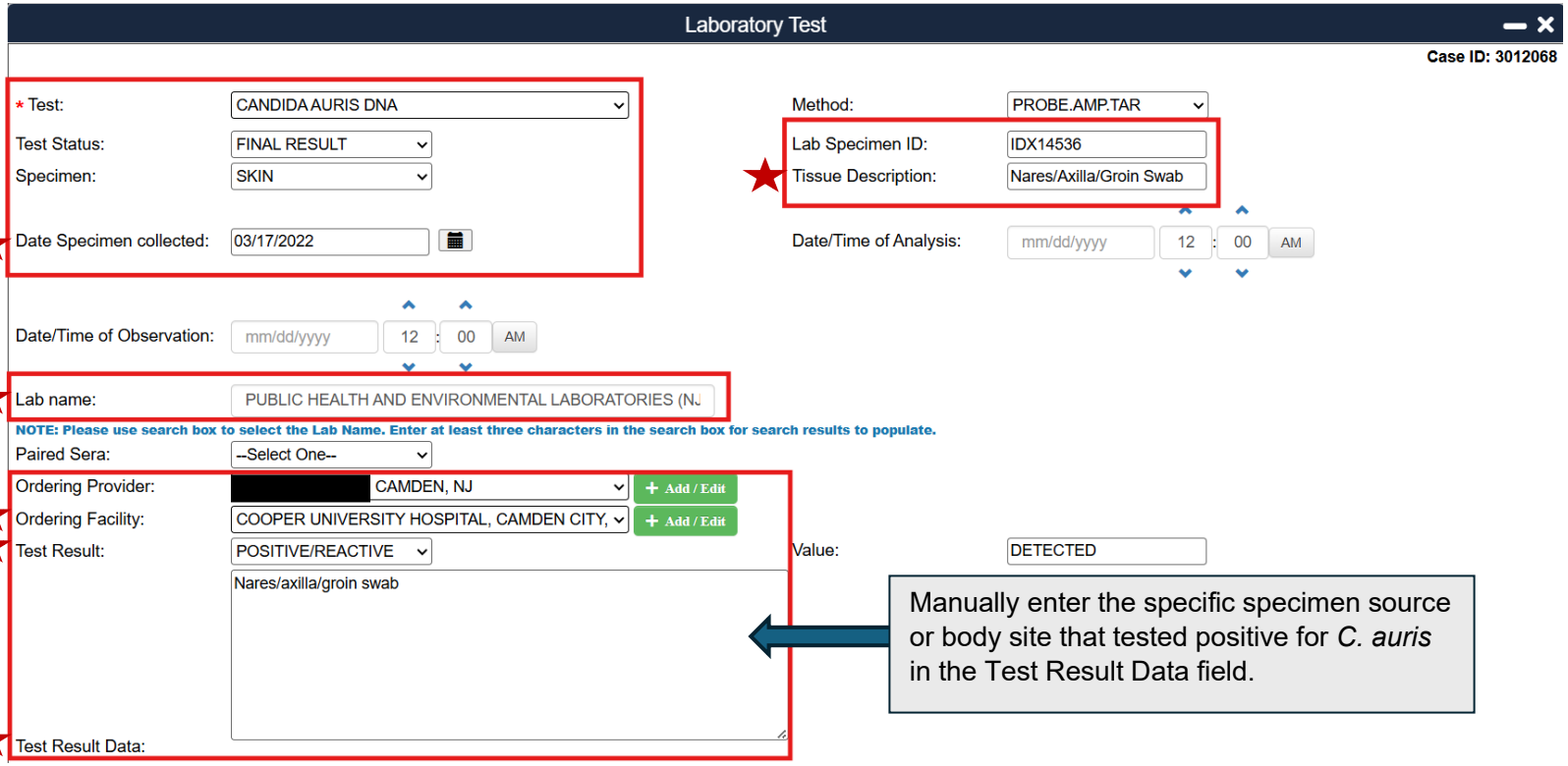
Test	Specimen	Lab Name	Lab Specimen ID	Date Specimen Collected	Value	Report Units	Result	Delete
CANDIDA AURIS DNA	SKIN	PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES (NJPHEL)	IDX14536	03/17/2022	DETECTED			

Add Laboratory Test

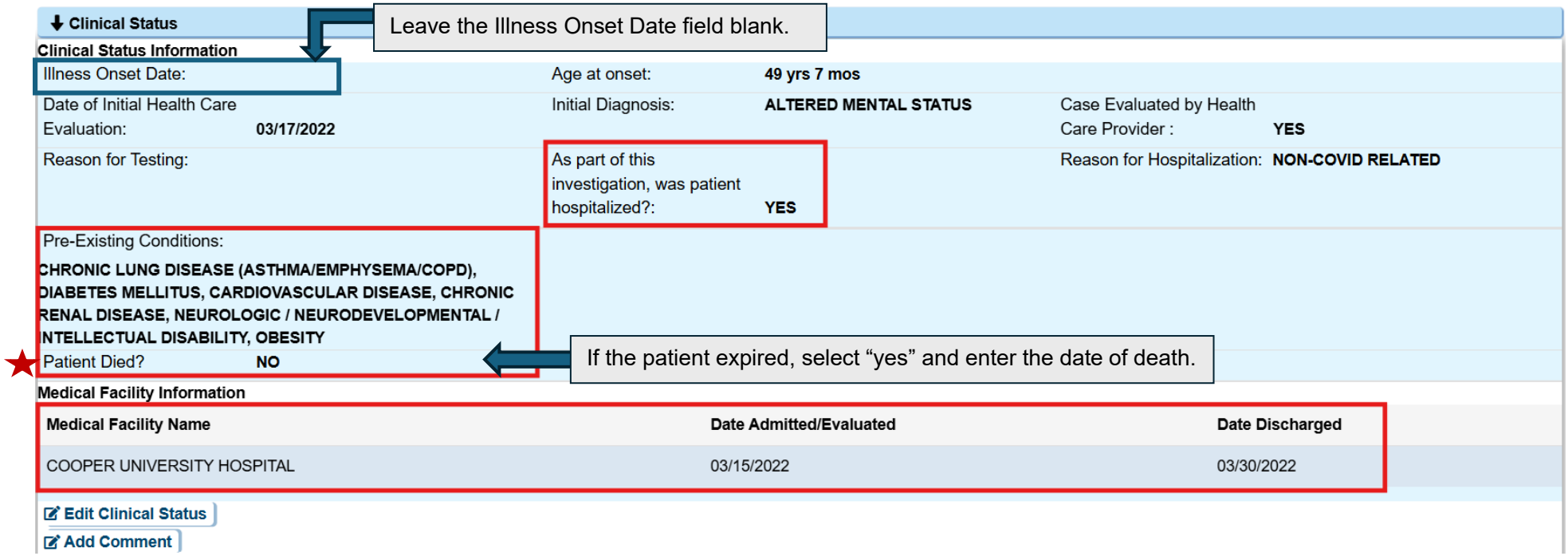
Lab Test History

If positive laboratory results are not already in CDRSS, add a laboratory test for each positive specimen corresponding to the case patient.

Click on the test name shown in blue to open the laboratory test information section.

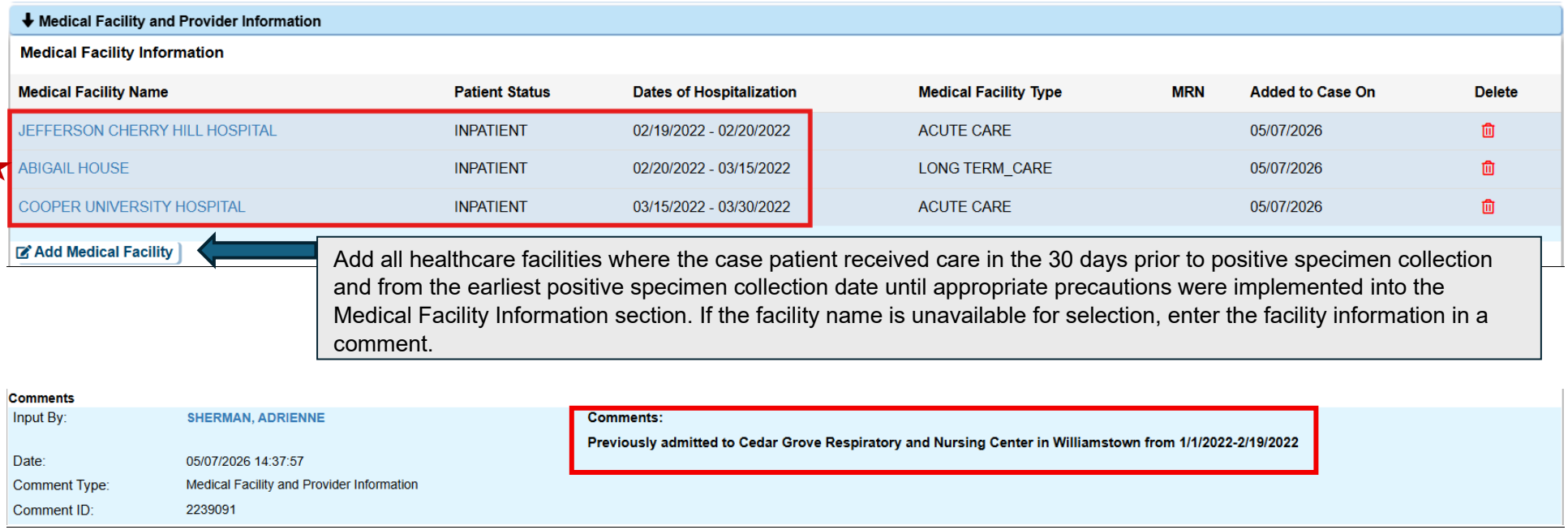

Laboratory Test
Case ID: 3012068
* Test: CANDIDA AURIS DNA
Test Status: FINAL RESULT
Specimen: SKIN
Date Specimen collected: 03/17/2022
Method: PROBE.AMP.TAR
Lab Specimen ID: IDX14536
Tissue Description: Nares/Axilla/Groin Swab
Date/Time of Analysis: mm/dd/yyyy 12 : 00 AM
Date/Time of Observation: mm/dd/yyyy 12 : 00 AM
Lab name: PUBLIC HEALTH AND ENVIRONMENTAL LABORATORIES (NJ
NOTE: Please use search box to select the Lab Name. Enter at least three characters in the search box for search results to populate.
Paired Sera: --Select One--
Ordering Provider: [redacted] CAMDEN, NJ
Add / Edit
Ordering Facility: COOPER UNIVERSITY HOSPITAL, CAMDEN CITY,
Add / Edit
Test Result: POSITIVE/REACTIVE
Value: DETECTED
Nares/axilla/groin swab
Test Result Data:
Manually enter the specific specimen source or body site that tested positive for C. auris in the Test Result Data field.

Clinical Status



The “Pre-Existing Conditions” field within the Clinical Status section is intended to combine and document all information on a patient’s pre-existing conditions provided by all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection. Some healthcare facilities may have more detailed information on a patient’s history of pre-existing conditions, while other healthcare facilities may have incomplete or conflicting information on pre-existing conditions. For this reason, once a pre-existing condition is indicated to be present, that pre-existing condition should not be changed based on information gathered from additional healthcare facilities. Only pre-existing conditions not already selected from the drop-down menu should be changed (i.e., added) based on information obtained from additional healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

Medical Facility



Risk Factors

The risk factor section is intended to combine and document all information on a patient's risk factors provided by all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection. Some healthcare facilities may have more detailed information on a patient's history of indwelling medical devices and other risk factors, while other healthcare facilities may have incomplete or conflicting information on risk factors. For this reason, once a risk factor is indicated to be present (i.e., answered with "Yes"), that answer should not be changed based on information gathered from additional healthcare facilities. **Only risk factors answered with "No" or "Not Asked" should be changed** based on information obtained from additional healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection.

Risk Factor	Response	Attribute
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A TRACHEOSTOMY?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A SURGICAL DRAIN?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A CENTRAL VENOUS CATHETER?	YES	Central line
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE MECHANICAL VENTILATION?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, WAS THE PATIENT NON-AMBULATORY?	YES	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE CHRONIC WOUNDS?	YES	
DOES THE PATIENT HAVE A HISTORY OF COLONIZATION OR INFECTION WITH A CARBAPENEMASE-PRODUCING ORGANISM(S) OR OTHER MDRO(S)?	YES	Acinetobacter baumannii
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN INDWELLING URINARY CATHETER?	YES	
IN THE 6 MONTHS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT STAY OVERNIGHT IN A HEALTHCARE FACILITY LOCATED IN A DIFFERENT STATE?	YES	Prior stay at Thomas Jefferson Center City
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A HEMODIALYSIS CATHETER?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE A NEPHROSTOMY?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN ABDOMINAL FEEDING TUBE?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN IMMUNOCOMPROMISING CONDITION?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE AN INTRAABDOMINAL DRAIN/CATHETER?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE ANOTHER INDWELLING MEDICAL DEVICE?	NO	
IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT HAVE ANOTHER INTRAVENOUS LINE (E.G., MIDLINE)?	NO	
IN THE 6 MONTHS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT RECEIVE AN ORGAN OR TISSUE TRANSPLANT?	NO	
IN THE 6 MONTHS PRIOR TO POSITIVE SPECIMEN COLLECTION, DID THE PATIENT STAY OVERNIGHT IN A HEALTHCARE FACILITY LOCATED IN A DIFFERENT COUNTRY?	NO	
IS THE PATIENT DIABETIC?	NO	

Add/Edit Risk Factors

Add Comment

All risk factor fields are required to be completed.

Additional Requirements: *Candida auris* – Disease Specific Questionnaire (DSQ)

The Disease Specific Questionnaire section is intended to combine and document a case patient's healthcare facility admission and visit information provided by all healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection. This section will be completed and updated by the local health department with jurisdiction over the case patient's primary address (questions marked with **red stars**) and each local health department with a healthcare facility in their jurisdiction that rendered healthcare services to the case patient in the 30 days prior to their positive specimen collection (all remaining questions).

Please note: All fields in the DSQ are required to be completed. Due to the length of the DSQ, it is highly recommended that CDRSS users frequently save progress while entering DSQ data to prevent the loss of data if CDRSS times out during data entry.

This section asks about the facility/facilities that identified and reported the *C. auris* case.

↓ ADDITIONAL REQUIREMENTS: CANDIDA AURIS	
NJDOH ASSIGNED CANDIDA AURIS CASE ID (FOR NJDOH USE ONLY)	
★ NAME OF REPORTING FACILITY	**Cooper University Hospital**
★ SELECT THE LOCATION TYPE OF THE REPORTING FACILITY	**Acute Care Hospital**
★ NAME OF FACILITY WHERE IDENTIFYING SPECIMEN WAS COLLECTED (IF DIFFERENT FROM REPORTING FACILITY)	**N/A**
★ SELECT THE LOCATION TYPE WHERE THE SPECIMEN WAS COLLECTED (IF DIFFERENT FROM REPORTING FACILITY)	**Not Applicable**

This section asks about the reason for *C. auris* testing and the patient's prior history of *C. auris*.

★ INDICATE THE REASON FOR SPECIMEN COLLECTION	**Point Prevalence Screening (PPS)**
WAS THE PATIENT PREVIOUSLY IDENTIFIED AS A COLONIZATION/SCREENING CASE FOR THIS ORGANISM?	**No**
WAS THE PATIENT PREVIOUSLY IDENTIFIED AS A CLINICAL CASE FOR THIS ORGANISM?	**No**

This section asks about the patient's dates of admission at the identifying/reporting facility, their location prior to admission and their discharge disposition.

WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Skilled Nursing Facility (Non-Vent)**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Abigail House, Camden**
IS THE PATIENT STILL CURRENTLY ADMITTED TO THIS FACILITY?	**No**
DATE OF DISCHARGE OR EXPIRATION	**03/30/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Long-Term Acute Care**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Select Specialty Hospital Willingboro**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at the identifying/reporting facility.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION?	**Droplet Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**03/15/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**03/20/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION?	**Contact Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**03/18/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**03/30/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at the identifying/reporting facility and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**Yes**
ARE ANY OF THE FOLLOWING EPIDEMIOLOGIC LINKS PRESENT FOR ANY KNOWN C. AURIS CASE PATIENT(S) AND THE NEW C. AURIS CASE PATIENT?	**Admission to a common unit**
IF "OTHER" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY OTHER EPIDEMIOLOGIC LINK(S)	**N/A**
IF "ADMISSION TO A COMMON UNIT" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY THE UNIT(S) OF COMMON ADMISSION	**Neuro ICU**

This section asks about the healthcare services the patient received at the identifying/reporting facility in the 30 days prior to positive specimen collection.

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT THE IDENTIFYING FACILITY?	**Imaging,Wound Care,Other**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**Interventional Radiology**

This section asks about the patient's admission to another inpatient facility in the 30 days prior to positive specimen collection (i.e., Prior Facility #1), the dates of admission at that facility, their location prior to admission and their discharge disposition.

★ WAS THIS PATIENT ADMITTED TO ANOTHER INPATIENT HEALTHCARE FACILITY IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ WHAT IS THE NAME OF THE INPATIENT HEALTHCARE FACILITY WHERE THE PATIENT WAS ADMITTED IMMEDIATELY PRIOR TO THE IDENTIFYING HEALTHCARE FACILITY (I.E., "PRIOR FACILITY #1")?	**Abigail House**
WHAT TYPE OF INPATIENT SETTING IS "PRIOR FACILITY #1"?	**Skilled Nursing Facility (Non-Vent)**
WHEN WAS THE PATIENT FIRST ADMITTED TO "PRIOR FACILITY #1"?	**02/20/2022**
WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Acute Care Hospital**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Jefferson Cherry Hill**
IS THE PATIENT CURRENTLY ADMITTED TO "PRIOR FACILITY #1"?	**No**
WHEN DID THIS PATIENT LEAVE "PRIOR FACILITY #1"?	**03/15/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Acute Care Hospital**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Cooper University Hospital, Camden**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at Prior Facility #1.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION TO "PRIOR FACILITY #1"?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #1"?	**Enhanced Barrier Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**02/20/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**03/15/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at Prior Facility #1 and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED TO "PRIOR FACILITY #1" DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**No**

This section asks about the healthcare services the patient received at Prior Facility #1 in the 30 days prior to positive specimen collection.

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT "PRIOR FACILITY #1"?	**Rehabilitation or Physical Therapy**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**N/A**

This section asks about the patient's admission to another inpatient facility in the 30 days prior to positive specimen collection (i.e., Prior Facility #2), the dates of admission at that facility, their location prior to admission and their discharge disposition.

★ WAS THIS PATIENT ADMITTED TO ANOTHER INPATIENT HEALTHCARE FACILITY IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ WHAT IS THE NAME OF THE INPATIENT HEALTHCARE FACILITY WHERE THE PATIENT WAS PREVIOUSLY ADMITTED (I.E., "PRIOR FACILITY #2")?	**Jefferson Cherry Hill**
WHAT TYPE OF INPATIENT SETTING IS "PRIOR FACILITY #2"?	**Acute Care Hospital**
WHEN WAS THE PATIENT FIRST ADMITTED TO "PRIOR FACILITY #2"?	**02/19/2022**
WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Ventilator Skilled Nursing Facility**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Cedar Grove Respiratory, Williamstown**
IS THE PATIENT CURRENTLY ADMITTED TO "PRIOR FACILITY #2"?	**No**
WHEN DID THIS PATIENT LEAVE "PRIOR FACILITY #2"?	**02/20/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Skilled Nursing Facility (Non-Vent)**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Abigail House, Camden**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at Prior Facility #2.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION TO "PRIOR FACILITY #2"?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #2"?	**Contact Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**02/19/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**02/20/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at Prior Facility #2 and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED TO "PRIOR FACILITY #2" DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**No**

This section asks about the healthcare services the patient received at Prior Facility #2 in the 30 days prior to positive specimen

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT "PRIOR FACILITY #2"?	**Wound Care,Respiratory Therapy,Ultrasound**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**N/A**

This section asks about the patient's admission to another inpatient facility in the 30 days prior to positive specimen collection (i.e., Prior Facility #3), the dates of admission at that facility, their location prior to admission and their discharge disposition.

★ WAS THIS PATIENT ADMITTED TO ANOTHER INPATIENT HEALTHCARE FACILITY IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ WHAT IS THE NAME OF THE INPATIENT HEALTHCARE FACILITY WHERE THE PATIENT WAS PREVIOUSLY ADMITTED (I.E., "PRIOR FACILITY #3")?	**Cedar Grove Respiratory, Williamstown**
WHAT TYPE OF INPATIENT SETTING IS "PRIOR FACILITY #3"?	**Ventilator Skilled Nursing Facility**
WHEN WAS THE PATIENT FIRST ADMITTED TO "PRIOR FACILITY #3"?	**01/01/2022**
WHAT SETTING OR LOCATION TYPE DID THE PATIENT PRESENT FROM?	**Acute Care Hospital**
SPECIFY THE NAME AND LOCATION OF THE FACILITY WHERE THE PATIENT PRESENTED FROM	**Thomas Jefferson Center City**

IS THE PATIENT CURRENTLY ADMITTED TO "PRIOR FACILITY #3"?	**No**
WHEN DID THIS PATIENT LEAVE "PRIOR FACILITY #3"?	**02/19/2022**
DISCHARGE DISPOSITION	**Discharge to another facility**
WHAT SETTING OR LOCATION TYPE WAS THE PATIENT DISCHARGED TO?	**Acute Care Hospital**
PLEASE SPECIFY THE NAME AND LOCATION OF THE FACILITY THE PATIENT WAS DISCHARGED TO	**Jefferson Cherry Hill**

This section asks about the type(s) of transmission-based precautions used and the dates transmission-based precautions were implemented for the patient at Prior Facility #3.

WAS THE PATIENT ON ANY TRANSMISSION-BASED PRECAUTIONS DURING THEIR ADMISSION TO "PRIOR FACILITY #3"?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #3"?	**Contact Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**01/01/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**01/09/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**Yes**
WHAT TYPE OF TRANSMISSION-BASED PRECAUTIONS WAS THE PATIENT PLACED ON DURING THEIR ADMISSION TO "PRIOR FACILITY #3"?	**Enhanced Barrier Precautions**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS BEGIN?	**01/09/2022**
DURING THE PATIENT'S ADMISSION, WHEN DID TRANSMISSION-BASED PRECAUTIONS END?	**02/19/2022**
DO YOU WANT TO ADD ANOTHER DATE RANGE?	**No**

This section asks about the presence of other known *C. auris* case patients at Prior Facility #3 and any known epidemiologic links to the newly reported *C. auris* case patient.

WERE THERE ANY OTHER KNOWN C. AURIS CASE PATIENTS ADMITTED TO "PRIOR FACILITY #3" DURING THE SAME TIME AS THE NEW C. AURIS CASE PATIENT?	**Yes**
ARE ANY OF THE FOLLOWING EPIDEMIOLOGIC LINKS PRESENT FOR ANY KNOWN C. AURIS CASE PATIENT(S) AND THE NEW C. AURIS CASE PATIENT?	**Admission to a common unit,Shared staff,Other**

IF "OTHER" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY OTHER EPIDEMIOLOGIC LINK(S)	**Shared room**
IF "ADMISSION TO A COMMON UNIT" EPIDEMIOLOGIC LINK PRESENT, PLEASE SPECIFY THE UNIT(S) OF COMMON ADMISSION	**Vent unit**

This section asks about the healthcare services the patient received at Prior Facility #3 in the 30 days prior to positive specimen collection.

AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR, WAS THE PATIENT RECEIVING ANY OF THE FOLLOWING HEALTHCARE SERVICES AT "PRIOR FACILITY #3"?	**Respiratory Therapy,Wound Care,Other**
IF "OTHER" HEALTHCARE SERVICES, PLEASE SPECIFY THE OTHER HEALTHCARE SERVICES THE PATIENT RECEIVED AT THE TIME OF SPECIMEN COLLECTION AND/OR IN THE 30 DAYS PRIOR	**Podiatry**

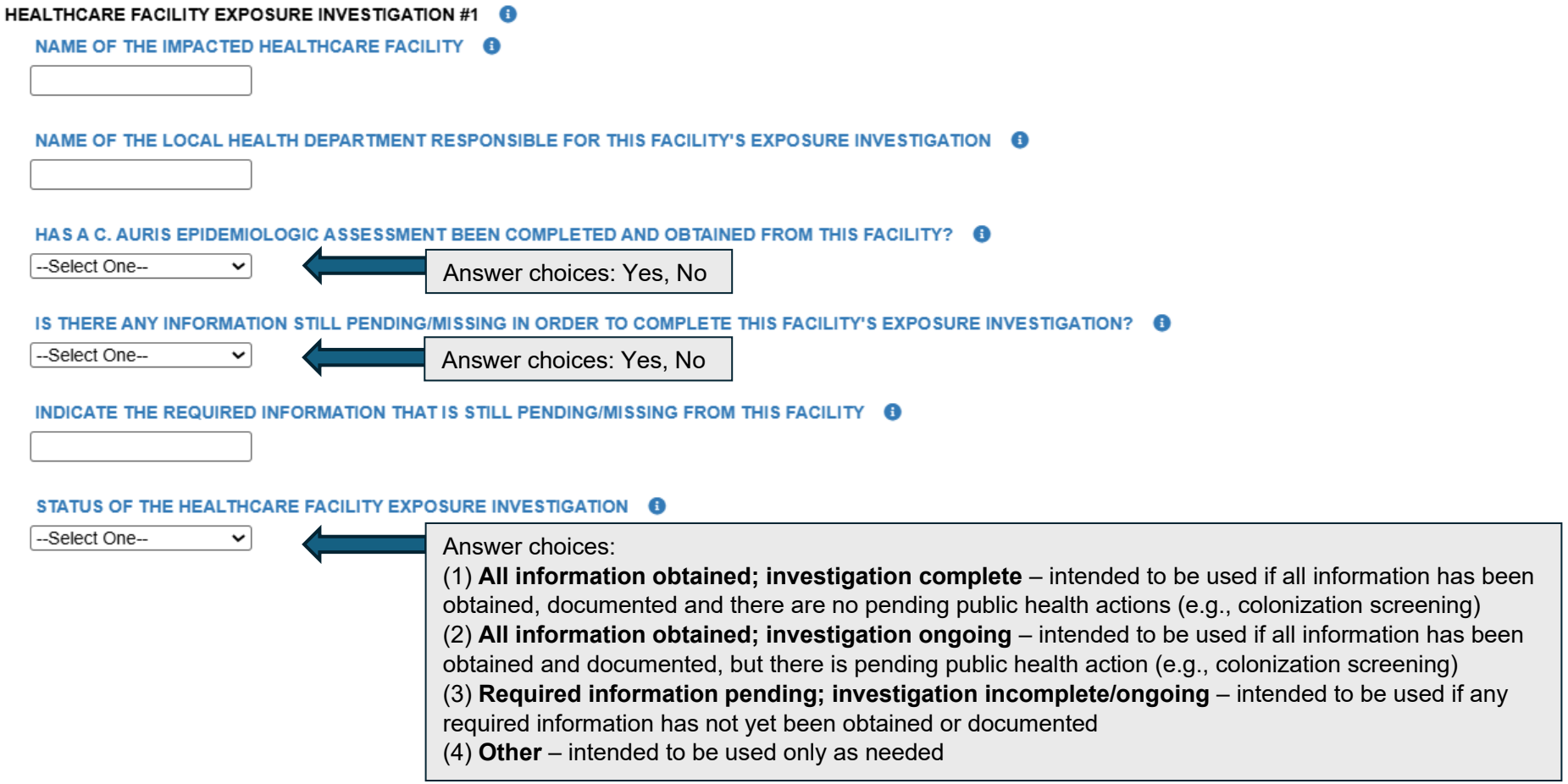
This section asks about visits to outpatient facilities and outpatient healthcare services the patient received in the 30 days prior to positive specimen collection.

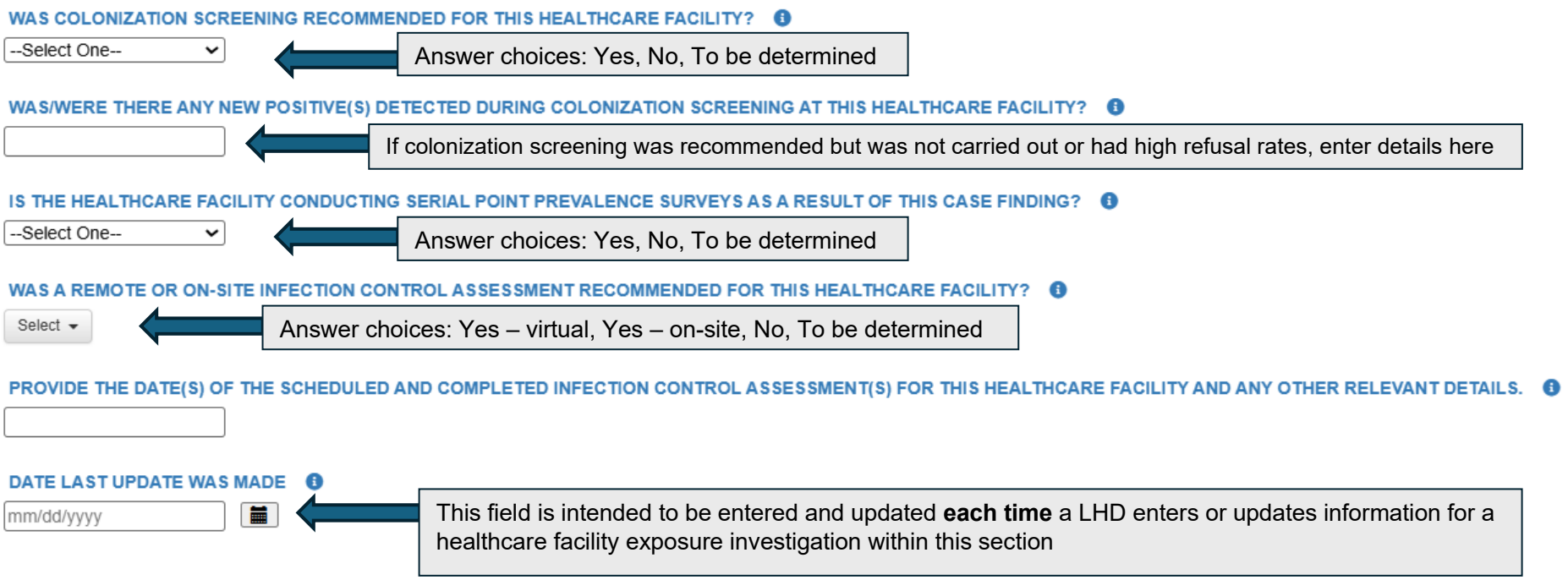
★ DID THIS PATIENT RECEIVE CARE AT ANY OUTPATIENT HEALTHCARE FACILITIES IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION?	**Yes**
★ SPECIFY THE NAME(S) AND LOCATION(S) OF THE OUTPATIENT FACILITY/FACILITIES WHERE THE PATIENT RECEIVED CARE IN THE 30 DAYS PRIOR TO POSITIVE SPECIMEN COLLECTION	**Summit Health Urology Voorhees**

Please utilize the comments section within CDRSS to document any additional information, such as admissions to additional healthcare facilities in the 30 days prior to positive specimen collection or subsequent admissions to healthcare facilities where the patient's *C. auris* status was not known or appropriate precautions were not implemented.

Facility Exposure Investigation Status and Updates

The Facility Exposure Investigation Status and Updates section is intended to track and monitor the status of each healthcare facility investigation stemming from the identification of the case. This section will be completed and updated by each local health department with a healthcare facility in their jurisdiction that requires a healthcare facility exposure investigation (i.e., healthcare facilities where the case patient received care in the 30 days prior to positive specimen collection and from the earliest positive specimen collection date until appropriate precautions were implemented). This section includes a series of 12 questions that repeat a total of five times to enable documentation of up to five different healthcare facility exposure investigations for a given case patient. Completion of this section by all involved LHDs helps to indicate whether the LHD leading the case investigation can close out the case or if the case must remain open until all facility investigations have been completed and documented appropriately.




WAS COLONIZATION SCREENING RECOMMENDED FOR THIS HEALTHCARE FACILITY?
--Select One--
Answer choices: Yes, No, To be determined
WAS/WERE THERE ANY NEW POSITIVE(S) DETECTED DURING COLONIZATION SCREENING AT THIS HEALTHCARE FACILITY?
If colonization screening was recommended but was not carried out or had high refusal rates, enter details here
IS THE HEALTHCARE FACILITY CONDUCTING SERIAL POINT PREVALENCE SURVEYS AS A RESULT OF THIS CASE FINDING?
--Select One--
Answer choices: Yes, No, To be determined
WAS A REMOTE OR ON-SITE INFECTION CONTROL ASSESSMENT RECOMMENDED FOR THIS HEALTHCARE FACILITY?
Select
Answer choices: Yes – virtual, Yes – on-site, No, To be determined
PROVIDE THE DATE(S) OF THE SCHEDULED AND COMPLETED INFECTION CONTROL ASSESSMENT(S) FOR THIS HEALTHCARE FACILITY AND ANY OTHER RELEVANT DETAILS.
DATE LAST UPDATE WAS MADE
mm/dd/yyyy
This field is intended to be entered and updated **each time** a LHD enters or updates information for a healthcare facility exposure investigation within this section