Candida auris Report Form

Philadelphia Department of Public Health
Division of Disease Control
1101 Market St.,12th Floor
Philadelphia, PA 19107
Telephone: (215) 685-6748
Fax: (215) 238-6947
Form available at hip.phila.gov

PATIENT DEMOGRAPHIC INFORMATION

PATIENT'S NAME (LAST, FIRST)	D.O.B.	AGE (years)	SEX
	____/____/____	____	☐Male ☐Female ☐Other

RACE ☐African-American ☐White ☐Asian ☐Pacific Islander ☐Native-American ☐Unknown ☐Other ____ HISPANIC ☐Yes ☐No ☐UNK

CURRENT ADDRESS ☐Private Residence ☐Healthcare/Assisted Living Facility	ZIP CODE	PATIENT TELEPHONE ☐Work ☐Cell ☐Home

FACILITY NAME, if residing in a healthcare/assisted living facility	WAS FACILITY NOTIFIED ☐Yes ☐No ☐Unknown	PART OF OUTBREAK/CLUSTER ☐Yes ☐No ☐Unknown

CLINICAL DATA

HOSPITALIZED ☐Yes ☐No	HOSPITAL NAME	ADMIT DATE	DISCHARGE DATE	Admitted to Intensive Care Unit ☐Yes ☐No ☐UNK Fatal ☐Yes ☐No ☐Unknown Date of Death: ____/____/____
		____/____/____	____/____/____	

REASON FOR TESTING ☐Screening/Surveillance ☐Signs/Symptoms of Infection	SIGNS/SYMPTOMS ONSET DATE, if infection: ____/____/____	History of *C. auris* ☐Y ☐N ☐UNK Date of first positive: ____/____/____

INFECTION(S) ASSOCIATED WITH CULTURE(S) (Check all that apply) ☐None ☐Candidemia (blood) ☐Respiratory Tract Infection ☐Urinary Tract Infection (UTI) ☐Organ Space/Abscess ☐Skin/Soft Tissue Infection or Wound ☐Other:____

UNDERLYING MEDICAL CONDITIONS (Check all that apply or **attach problems list or pertinent sections of medical records**)
☐Chronic Heart/Cardiovascular Disease ☐Kidney Disease; ☐Dialysis in Past Year ☐Wound(s), specify:____
☐Diabetes ☐Neurological, specify:____ ☐Other, specify:____
☐COPD ☐Immunosuppression, specify:____ ☐None ☐Unknown

RISK FACTORS

IF AVAILABLE, HISTORY OF HEALTHCARE STAYS IN THE UNITED STATES IN THE PREVIOUS YEAR **(List where the patient was transferred from first)**
Facility:____ Admission/Discharge Dates: ____/____/____ - ____/____/____
Facility:____ Admission/Discharge Dates: ____/____/____ - ____/____/____
Facility:____ Admission/Discharge Dates: ____/____/____ - ____/____/____

HISTORY OF INTERNATIONAL TRAVEL and/or MEDICAL CARE ABROAD IN PREVIOUS YEAR (Check all that apply)
☐International Travel ☐Medical Care Abroad ☐No ☐Unknown Dates of travel: ____/____/____ - ____/____/____
If yes, location(s):____

SURGERY/PROCEDURE INVOLVING A SCOPING DEVICE IN THE PAST YEAR? ☐Yes ☐No ☐Unknown If yes, date: ____/____/____

☐ ☐ ☐

LABORATORY (Please attach culture and sensitivity results and any other applicable test results available)

SPECIMEN COLLECTION DATE: ____/____/____ RESULT DATE: ____/____/____
GENUS and SPECIES: ☐*Candida auris* ☐*Candida haemulonii* ☐Other:____

SPECIMEN TYPE (Check all that apply)
☐Blood ☐Urine
☐Wound ☐Respiratory Secretions
☐Skin ☐Ear
☐Groin ☐Axilla
☐Other, specify:____

DIAGNOSTIC METHOD
☐MALDI-TOF ☐VITEK 2 YST
☐MALDI Biotyper ☐API 20c AUX
☐BD Phoenix ☐MicroScan
☐Whole Genome Sequencing (WGS)
☐Other:____

RESISTANT/INTERMEDIATE TO AT LEAST ONE DRUG IN THE CLASS: (Check all that apply)
☐Azoles (e.g. Fluconazole) ☐5-flyiricytosine
☐Polyenes (e.g. Amphotericin B) ☐Pandrug-Resistant
☐Echinocandins (e.g. anidula-, caspo-, mica-fungin) ☐None
☐Allylamines (e.g. terbinafine, amorolfin, naftifine) ☐Unknown

REPORTER INFORMATION

REPORT DATE	REPORTER NAME	FACILITY NAME	REPORTER PHONE # & EMAIL
____/____/____	Role: ☐DO/MD ☐CP ☐PA/NP ☐RN ☐Other:____		

PLEASE FAX REPORT TO (215) 238-6947 UPON COMPLETION. RETAIN ISOLATE FOR ONE MONTH

Form Updated: 05/03/2018

Reporting Guidelines for *Candida auris*

Report **all** positive cultures of *Candida auris* and *Candida haemulonii* (*Candida auris* is frequently misidentified as *Candida haemulonii*).

Report cultures from all body sites (including but not limited to blood, wound, skin, ear, urine, rectum, and respiratory secretions) that were collected for diagnostic purposes as well as surveillance/screening purposes.

All positive test results should be reported to PDPH **within 24 hours**. Please call PDPH at (215) 685-6748 [after-hours (215) 686-4514] to report a case of *Candida auris*. A *Candida auris* case report form should also be filled out and faxed to PDPH at (215) 238-6947 after reporting the case via phone.

Isolates should be retained for one month. PDPH will follow up to coordinate further testing as needed.