Candida auris Reporting Form

Please submit one report per patient per admission within 72 hours. Attach all laboratory results including antibiotic susceptibility test results. Fax form to Indiana Department of Health (317)-234-2812 or upload to NBS Morbidity Report.

Reporting Facility: ______________________ Reporter Name: ______________________

Address: ______________________________ Phone Number: ______________________

Patient information

Patient name:	**NBS ID:**
DOB:	**Phone:**
Address:	**County:**
Did the patient die? ☐ Yes ☐ No	**Date of death:**

Laboratory Information ******Attach all laboratory reports and antibiotic susceptibility testing results.*** ***

Organism:	**Collection date:**
Specimen site:	☐ Clinical culture ☐ Colonization culture

*Clinical information ***Attach all history and physical reports available. ****

Admission date: From: ☐ Transfer form used upon admission		**Discharge date:** To: ☐ Transfer form used upon discharge	
Contact precautions start date: Were bleach cleaning products used? ☐ Yes ☐ No		**Roommates**: ☐ Yes ☐ No Dates:	
Invasive devices at time of specimen collection ☐ Central venus line ☐ Mechanical vent ☐ Tracheostomy ☐ Urinary catheter ☐ Wound VAC ☐ Other:	**Invasive procedures in past 6 months:**	**History of MDROs** ☐ MRSA ☐ VRSA ☐ VRE ☐ ESBL ☐ CRE ☐ Drug-resistant PA ☐ Drug-resistant AB	**Recent travel history** ☐ Yes ☐ No Where: When:
Hospitalized in the last 3 months in acute care hospital or long-term care facility? ☐ Yes ☐ No Facility name:	**Resident of a long-term care facility?** ☐ Yes ☐ No Facility name:	**Antibiotic use in past 30 days** Antibiotic: Start date: Stop date:	**Treatment** Antibiotic: Start date: Stop date:
Preexisting Conditions: ☐ None ☐ Unknown ☐ Diabetes mellitus ☐ Heart failure/CHF ☐ Emphysema/COPD ☐ Chronic renal insufficiency/chronic renal disease ☐ Obesity ☐ Acute/Chronic respiratory failure ☐ Peri/Hemi/Quadriplegia ☐ Wound/Ulcer/Abscess ☐ Chronic/Recurring UTI ☐ Cancer/Malignancy ☐ Other:			

Recommendations

We recommend placing the patient in enhanced barrier contact precautions (if applicable).

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We recommend the use of an approved cleaning product from EPA List P.
We recommend flagging the patient chart in case the patient is readmitted to limit transmission.
We recommend utilizing a transfer form if patient is transferred.
If the patient had a roommate, we have a concern of transmission. Screening may be recommended.
If you would like additional resources, please visit the HAI/AR Website.