



## CANDIDA AURIS REPORTING

State Form 57822 (R / 7-26)  
INDIANA DEPARTMENT OF HEALTH



**Indiana**  
Department  
of  
**Health**

**Reset Form**

### INSTRUCTIONS:

Please submit one report per patient per case within one working day receiving lab result. Attach laboratory results, recent History and Physical and Infectious Disease Consult. If faxing, include Confidential Report of Communicable disease form and send to Indiana Department of Health (317)-234-2812 or upload to NBS Morbidity Report.

Facility of Specimen Collection: \_\_\_\_\_

Address: \_\_\_\_\_ Reporter's Name: \_\_\_\_\_

Reporter's Contact Information: \_\_\_\_\_

### Patient Information

|                                                                               |                |
|-------------------------------------------------------------------------------|----------------|
| Patient name:                                                                 | NBS ID:        |
| DOB:                                                                          | Phone:         |
| Address:                                                                      | County:        |
| Did the patient die? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of death: |

### Laboratory Information

|                |                                                                                         |
|----------------|-----------------------------------------------------------------------------------------|
| Organism:      | Collection date:                                                                        |
| Specimen site: | <input type="checkbox"/> Clinical culture <input type="checkbox"/> Colonization culture |

### Clinical information

|                                                                                                  |                                                                            |
|--------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------|
| Admission date: _____                                                                            | Discharge date: _____                                                      |
| Facility admitted from: _____                                                                    | Facility discharged to: _____                                              |
| <input type="checkbox"/> Transfer form used upon admission                                       | <input type="checkbox"/> Transfer form used upon discharge                 |
| Admitted to ICU during stay? <input type="checkbox"/> Yes <input type="checkbox"/> No            |                                                                            |
| Contact or EBP start date:                                                                       | Roommates: <input type="checkbox"/> Yes <input type="checkbox"/> No Dates: |
| Were EPA List P cleaning products used? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                            |

|                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------|
| <b>History of MDRO:</b><br><input type="checkbox"/> MRSA<br><input type="checkbox"/> VRE<br><input type="checkbox"/> CPO<br><input type="checkbox"/> CRE<br><input type="checkbox"/> VRSA<br><input type="checkbox"/> ESBL<br><input type="checkbox"/> Drug-resistant PA<br><input type="checkbox"/> Drug-resistant AB<br><input type="checkbox"/> C difficile<br><input type="checkbox"/> Other:<br><input type="checkbox"/> None | <b>Invasive devices:</b><br><input type="checkbox"/> Central or PICC line<br><input type="checkbox"/> G and/or J Tube<br><input type="checkbox"/> Hemodialysis Port<br><input type="checkbox"/> Mechanical Ventilator<br><input type="checkbox"/> PEG Tube<br><input type="checkbox"/> Urinary Catheter<br><input type="checkbox"/> Wound Vac<br><input type="checkbox"/> Tracheostomy<br><input type="checkbox"/> Other:<br><input type="checkbox"/> None | <b>Conditions:</b><br><div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Renal disease<br/> <input type="checkbox"/> Diabetes mellitus<br/> <input type="checkbox"/> Emphysema/COPD<br/> <input type="checkbox"/> Heart failure/CHF<br/> <input type="checkbox"/> Respiratory failure<br/> <input type="checkbox"/> Peri/Hemi/Quadriplegia<br/> <input type="checkbox"/> Obesity (BMI <math>\geq</math> 30)           </div> <div> <input type="checkbox"/> Wound/Ulcer/Abscess<br/> <input type="checkbox"/> Chronic/Recurring UTI<br/> <input type="checkbox"/> Cancer/Malignancy<br/> <input type="checkbox"/> CVA/TBI<br/> <input type="checkbox"/> Other:<br/> <input type="checkbox"/> None           </div> </div> |                                                                               |
| <b>Hospitalized or LTC in the last 3 months?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Facility name:                                                                                                                                                                                                                                                                                                     | <b>Resident of a long-term care facility?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Facility name:                                                                                                                                                                                                                                                                                                                                | <b>Antimicrobial use 30 days prior to diagnosis?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br><input type="checkbox"/> Unknown                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | <b>Treatment after diagnosis:</b><br>Antifungal:<br>Start date:<br>Stop date: |
| <b>Invasive Medical Procedures in the past 6 months:</b>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Out of state/country travel in past 12 months?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>Where:<br>Dates:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                               |

We recommend placing the patient in contact or enhanced barrier precautions (if applicable).  
 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 communicating with transferring facilities about patient's MDRO status or need for transmission-based precautions.  
 If you have concerns about transmission to other patients, please contact us for available screening options.  
 If you would like additional resources, please visit the [HAI/AR Website](#).