



Candida auris Reporting Form

Please submit one report per patient per admission within one working day. Attach all laboratory results including antibiotic susceptibility test results. Fax form with the Confidential Report 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of death:

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

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

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

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

Recommendations



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We recommend placing the patient in enhanced barrier contact 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 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](#).