TEXAS Department of State Health Services

For questions regarding this form, call 1-800-705-8868
www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

NBS pt. ID: _____

Candida auris Investigation Form

Public Health Use Only ☐Confirmed ☐Not a case ☐Out of jurisdiction ☐Probable ☐Clinical ☐Colonization/screening

Patient's name: _____
Last **First** **MI**

Address: _____ ☐Homeless

City: _____ **State:** _____ **Zip:** _____ **County:** _____

Home #: (___) _____ **Work #:** (___) _____

Date of birth: _____ **Age:** _____ **Sex:** ☐Male ☐Female ☐UNK

Country of birth: _____ **Country of usual residence:** _____

Ethnicity: ☐Hispanic/Latino ☐Not Hispanic/Latino ☐UNK

Race: ☐Am.Indian/Alaskan Native ☐Asian ☐Black/African Am. ☐Native Hawaiian/ Pacific Isl. ☐White ☐UNK ☐Refused ☐Not asked ☐Other:_____

Current occupation: _____ **Current industry:** _____

Jurisdiction: _____

Investigation start date: _____

Investigated by: _____

Phone: ( ) _____

Reporting county: _____

Reporting source type: _____

Reporting organization: _____

Reporting provider: _____

Reported by: _____

Phone: ( )_____ **Date reported:** _____

HOSPITAL/FACILITY INFORMATION

Was the patient admitted to a healthcare facility (HCF)? ☐Yes, name of HCF: _____ HCF County _____ State ___ ☐No ☐UNK

Was visit due to an outpatient/ home health/ ER, etc. visit only? ☐ Yes, name of HCF: _____ ☐No

HCF admission: _____ **HCF discharge:** _____ **Date of outpatient visit:** _____

Were control measures (per EAIDG Guidance) implemented at the admitting HCF? ☐Yes ☐No ☐UNK ☐NA

Facility type patient came from: ☐Home ☐Acute care hospital ☐LTAC ☐LTCF/NH ☐Rehab ☐Hospice ☐UNK ☐NA ☐Other

Name of facility: _____ **Was this facility notified of MDRO?** ☐Yes ☐No ☐UNK

Were control measures (per EAIDG Guidance) implemented at the facility the patient came from? ☐Yes ☐No ☐UNK ☐NA

Discharged to: ☐Home ☐Acute care hospital ☐LTAC ☐LTCF/NH ☐Rehab ☐Hospice ☐UNK ☐NA ☐Other ☐Patient still admitted ☐Patient expired

Name of facility:_____ **Was this facility notified of MDRO?** ☐Yes ☐No ☐UNK

Were control measures (per EAIDG Guidance) implemented at the facility the patient was discharged to? ☐Yes ☐No ☐UNK ☐NA

Other Information

Diagnosis date: _____ **Date of symptom onset:** _____

Did patient die? ☐Yes, date of death: _____ ☐No ☐UNK

Did *C. auris* contribute to death? ☐Yes ☐No ☐UNK

Where was the disease acquired?:

☐Imported but unable to determine ☐In state, out of jurisdiction ☐Indigenous

☐International ☐Out of state ☐Unknown

Imported country: _____ Imported state: _____

Travel and Healthcare

Did the patient receive overnight healthcare within the USA, but outside of the patient's resident state, in the year prior to date of specimen collection? ☐Yes ☐No ☐UNK

List state(s):_____

Did the patient travel internationally in the year prior to the date of specimen collection? ☐Yes ☐No ☐UNK

List country(ies): _____

Did the patient receive overnight healthcare outside of the USA in the year prior to the date of specimen collection? ☐Yes ☐No ☐UNK

List country(ies): _____

LABORATORY DATA

Performing laboratory specimen ID#: _____ State laboratory specimen ID#: _____ WGS ID#:_____

Pathogen: ☐ ***C. auris*** ☐ ***C. haemulonii*** ☐ **Other:**_____

Date collected: _____ Specimen source: _____

Swab site(s), if applicable: ☐ NA ☐ Axilla ☐Groin ☐Nares ☐Ear ☐Oropharyngeal ☐Rectal ☐Wound ☐Other:_____

Test type: ☐PCR ☐ Automatic biochemical/phenotypic test ☐DNA sequencing ☐MALDI-TOF ☐Non-PCR culture-independent diagnostic test

☐Other, specify: _____

Test result: ☐ Positive ☐ Negative ☐Indeterminate ☐Unsatisfactory

Patient status at time of specimen collection (inpatient, LTAC, LTCF, outpatient, etc.):_____

County and state of facility where specimen was collected:_____

PREVIOUS HISTORY

Note: Case ID for Carbapenemase-producing (CP) CRE cases and clinical C. auris cases to be provided by regional HAI epidemiologist or DSHS Laboratory.

Clinical *C. auris* only: Patient previously counted as a colonization/screening case? ☐Yes ☐No ☐UNK If yes, case ID: _____

Was patient previously counted as a CP-CRE case? ☐Yes ☐No ☐UNK If yes, provide case ID: _____

Does the patient have a history of infection or colonization with another MDRO? ☐Yes ☐No ☐UNK If yes, specify: _____

EXPOSURE HISTORY

Additional information may be added using the Novel or Emerging Antibiotic Resistant Organisms supplemental investigation form.

Was the patient admitted to an intensive care unit? ☐Yes ☐No ☐UNK

At time of specimen collection, did patient have a tracheostomy tube? ☐Yes ☐No ☐UNK

At time of specimen collection, was patient on a ventilator? ☐Yes ☐No ☐UNK

Did the patient have a stay in a long-term care facility in the 90 days before specimen collection date? ☐Yes ☐No ☐UNK

If yes, facility type: _____ Facility Name: _____ Admission Date: _____ Discharge Date:_____