Candidozyma (formerly *Candida*) *auris* (*C. auris*)

West Virginia Department of HEALTH
BUREAU FOR PUBLIC HEALTH

PATIENT DEMOGRAPHICS

Name (last, first): ____
Address: ______________________________ **Homeless**: ________
City/State/Zip: ____
Phone (home): ________________ **Phone** (work): ___________________
Occupation/grade: ____________________ **Employer/School**: ____________________

Alternate contact: ☐*Parent/Guardian* ☐*Spouse* ☐*Other*
Name: __________________________ *Phone*: __________________________

Birth date: __ / __ / ____ **Age**: _____
Sex: ☐Male ☐Female ☐Unk
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unk
Race: ☐White ☐Black/Afr. Amer. ☐Am. Ind/AK Native ☐Native HI/Other PI ☐Asian ☐ Unk

INVESTIGATION SUMMARY

Local Health Department (Jurisdiction): ____
Investigation Start Date: __ / __ / ____
Earliest date reported to LHD: __ / __ / ____
Earliest date reported to OEPS: __ / __ / __
Is this the first time the patient has been diagnosed with C. *auris*? If 'no', when was the initial date of diagnosis? __/__/____

Entered in WVEDSS? ☐Yes ☐No ☐Unk
Case Classification:
☐ Confirmed ☐ Not a case ☐ Unknown

REPORT SOURCE/HEALTHCARE PROVIDER (HCP)

Report Source: ☐Laboratory ☐Hospital ☐HCP ☐Public Health Agency ☐Other
Reporter Name: ____ **Reporter Phone:** ______________________
Primary HCP Name: ____________________________________ **Phone Number**: ______________________

LABORATORY *Attach laboratory confirmation. *

Organism: ____
Culture type: ☐ Surveillance ☐ Clinical **Specimen Source**: __________________________ **Collection date**: __ / __ / ____

EPIDEMIOLOGIC

Y	N	U	
☐	☐	☐	Was the patient hospitalized at the time of specimen collection? If YES: Hospital Name: ________________________________ Date of Admission: ___/___/_____
☐	☐	☐	To which type of unit was the patient admitted (i.e., ICU, burn unit, oncology, dialysis, medical, surgical, or other)? Type of Unit: ___________________ Room#: ________________ Date of Discharge: ____/____/______
☐	☐	☐	Does patient reside in (or will be discharged to) a nursing home or other long-term care facility? If YES: LTCF Name: __________________________________ LTCF Address: ______________________________
☐	☐	☐	Has the patient utilized home health services in the last six months? If YES: Agency Name: __________________________________
☐	☐	☐	Did patient die? If YES, date of death: ___________
☐	☐	☐	Did patient visit any other healthcare facilities in the six months before their diagnosis (physician offices, dialysis clinics, etc)?

Facility Name and Address	Admission/ Move Date	Unit	Room #	Transmission-Based Precautions			Roommate			Shared Bathroom			Discharge/ Move Date
				Y	N	U	Y	N	U	Y	N	U	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	
				☐	☐	☐	☐	☐	☐	☐	☐	☐	

PUBLIC HEALTH ISSUES

Y	N	U	
☐	☐	☐	Epi-linked to another confirmed case of *C. auris*
☐	☐	☐	Case is part of an outbreak
☐	☐	☐	Other:

PUBLIC HEALTH ACTIONS

Y	N	U	
☐	☐	☐	*C. auris* initial assessment conducted with Healthcare Facility
☐	☐	☐	Patient and/or family interviewed and given education
☐	☐	☐	Outpatient healthcare provider given education
☐	☐	☐	Patient is lost to follow-up
☐	☐	☐	Other:

EXPOSURE

Y	N	U	
☐	☐	☐	Any indwelling device in place at any time in the two calendar days prior to initial culture?

If YES, check all that apply: ☐ Peripheral IV ☐ Central venous catheter ☐ Dialysis catheter
☐ Urinary catheter ☐ ET/NT tube ☐ Gastrostomy tube ☐ NG tube
☐ Tracheostomy ☐ Nephrostomy tube ☐ Surgical drain
☐ Other (specify): _____

Y	N	U	
☐	☐	☐	Was the patient prescribed antibiotics or antifungals more than two times in six months?

Notes

Recommendations

- We recommend placing the patient in transmission-based precautions. (Contact or Enhanced Barrier) https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html
- We recommend the use of an approved cleaning product from the EPA List P. https://www.epa.gov/pesticide-registration/epas-registered-antimicrobial-products-effective-against-candida-auris-list
- We recommend flagging the patient chart to limit transmission.
- We recommend utilizing a transfer form if patient is transferred. https://oeps.wv.gov/hai/Documents/LHD/(OEPS-24-10)-WV-Inter-facility-Infection-Control-Form_APPROVED.pdf
- 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 OEPS *Candida auris* Website https://oeps.wv.gov/c_auris/Pages/default.aspx