County of Los Angeles Public Health
Acute Communicable Disease Control
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publichealth.lacounty.gov/acd/

CANDIDA AURIS CASE REPORT FORM

Form is to be submitted for newly identified *C. auris*-positive cases.
Include final lab report(s), including antifungal susceptibility testing (AST) results.
All sections required unless otherwise noted.

Reset Form

PATIENT INFORMATION

Patient Name- Last, First	Facility name (if not living at home):	Date of birth	Age

Address- Number, Street, Apt #	City of Residence	State	ZIP Code

Patient's current gender identity? (check one)
☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Gender Non-Binary, Gender Non-Conforming ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth? (check one)
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: _____ ☐ Prefer not to answer

Patient's sexual orientation? (check one)
☐ Gay or Lesbian ☐ Bisexual ☐ Straight or Heterosexual ☐ Not sure ☐ Something else: _____
☐ Don't understand the question ☐ Prefer not to answer

Patient's race or ethnicity? (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African American ☐ Asian ☐ American Indian/Alaskan Native
☐ Native Hawaiian/Other Pacific Islander ☐ Other: _____ ☐ Refused

LABORATORY INFORMATION

Date of specimen collection

Date of final result

Organism identified:
☐ *C. auris*

Presumptive *C. auris**:
☐ *C. catenulate* ☐ *C. guilliermondii* ☐ *C. parapsilosis*
☐ *C. duobushaemulonii* ☐ *C. haemulonii* ☐ *Rhodotorula glutinis*
☐ *C. intermedia* ☐ *C. sake* ☐ *Saccharomyces kluyveri*
☐ *C. famata* ☐ *C. lusitaniae* ☐ No ID (*Candida* spp.)

Specimen source: ☐ Blood ☐ GI ☐ Nasal swab ☐ Rectal swab ☐ Respiratory ☐ Skin swab
☐ Urine ☐ Wound, open (non-sterile) ☐ Wound, surgical (sterile) ☐ Other - specify:_____

To your knowledge, has this patient tested positive for *C. auris* before the current positive identification being reported? ☐ Yes ☐ No ☐ Unknown
If Yes, date of first ever positive specimen: _____

HEALTHCARE PRESENTATION

Reporting Facility Name

Facility type: ☐ Hospital ☐ Long-Term Acute Care Hospital (LTACH)
☐ Skilled Nursing Facility (SNF) ☐ Outpatient setting
☐ Other (specify type): _____

Date of ☐ admission OR ☐ outpatient visit *(check one)*	Medical Record Number	Location/Unit when specimen collected

Where was the patient/resident admitted from prior to their current positive test?
☐ Hospital ☐ LTACH ☐ SNF Specify Facility Name: _____ ☐ Other _____ ☐ Home
If from Home, was the patient discharged from another HCF within the past 12 months? ☐ Yes ☐ No ☐ Unknown

Disposition: ☐ Current patient/resident ☐ Discharged to: (☐ Home OR ☐ Facility- name: _____) ☐ Expired
If Discharged, Date of discharge: _____
If Expired, Date of death: _____

Linked to another case (e.g., roommate, contact with a known case, shared procedures)? ☐ Yes ☐ No ☐ Unknown
If Yes, Case name(s) & birthdate: _____
If Yes, Likely date(s) & location(s) of exposure: _____

Has the patient stayed overnight in a healthcare facility outside of California within the past 12 months? ☐ Yes ☐ No ☐ Unknown
If Yes, Specify state/country: _____

EPIDEMIOLOGIC LINKS/ RISK FACTORS (optional)

History of carbapenemase-producing organism? ☐ Yes (specify organism and date of collection): _____
☐ No ☐ Unknown

Presence of the following at time of (or during 14 days prior to) specimen collection (*check all that apply)*
☐ Ventilator/mechanical ventilation ☐ Tracheostomy ☐ Wound(s) ☐ Hemodialysis ☐ Central line ☐ Urinary catheter ☐ TPN
☐ PEG/J-tube ☐ Antifungal therapy ☐ Chlorhexidine bathing ☐ COVID-19 ☐ MDRO (specify): _____

REMARKS

Submitter's name (print)	Date completed	Telephone number

Candida auris can be misidentified as other organisms by some identification methods. See https://www.cdc.gov/fungal/candida-auris/identification.html for a summary. If the organism was identified as one of these presumptive organisms, check that box when reporting the suspect *C. auris*.