**Ontario *Candida auris* Investigation Tool**

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| **Legend** | **for interview with case ♦ System-Mandatory/Required Personal Health Information** |

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| **Cover Sheet***Note that this page can be autogenerated in iPHIS* | | |
| Date Printed: YYYY-MM-DD  Bring Forward Date: YYYY-MM-DD  iPHIS Client ID #: Enter number  **♦** Investigator: **Enter name**  **♦** Branch Office: **Enter office**  **♦** Reported Date: YYYY-MM-DD  **♦** Diagnosing Health Unit: Enter health unit  **♦** Disease: **CANDIDA AURIS**  **♦** Is this an outbreak-associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes, *OB #* ####-####-###  No, *link to* **OB # 0000-2025-00001** *in iPHIS*  Is the client in a high-risk occupation/environment?  Yes, specify: Specify  No | **♦** Client Name: **Enter name**  Alias: **Enter alias** | |
| **♦** Gender: Select an option | **♦** Age: **Age** |
| **♦** DOB:YYYY-MM-DD  Address:  **Enter address\_\_\_\_\_\_\_\_**  **Enter address \_\_\_\_\_\_\_\_**  Tel. 1:  **###-###-####**  Type:  Home  Mobile  Work  **Other, specify**  Tel. 2:  **###-###-####**  Type:  Home  Mobile  Work  **Other, specify**  Email 1: **Enter email address**  Email 2: **Enter email address** | |
| Is the client homeless?  Yes  No  New Address:  **Enter address**  **♦** Language:  **Specify \_ \_**  Translation required*?*  Yes  No  **Proxy respondent**  Name:  **Enter name \_ \_**  Parent/Guardian  Spouse/Partner  Other  **Specify \_ \_** | **♦** Physician’s Name: **Enter name \_ \_**  **♦** Role**:**  Attending Physician  Family Physician  Specialist  Walk-In Physician  Other  Unknown  **OPTIONAL**  Additional Physician’s Name: **Enter name \_**  Address:  **Enter address \_**  Tel:  **###-###-####**  Fax:  **###-###-####**  Role:  **Enter role \_ \_** | |

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| **Verification of Client’s Identity & Notice of Collection** |
| Client’s identity verified?  Yes, *specify*:  DOB  Postal Code  Physician  No |
| **Notice of Collection**  *Please consult with local privacy and legal counsel about PHU-specific Notice of Collection requirements under*  *PHIPA s. 16*. *Insert Notice of Collection, as necessary.* |

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| **Record of File** | | | | | |
| **♦ Responsible Health Unit** | **Date** | **♦ Investigator’s Name** | **Investigator’s Signature** | **Investigator’s Initials** | **Designation** |
| Specify | **♦** Investigation Start Date  YYYY-MM-DD | Specify | Specify | Specify | PHI  PHN  Other \_\_\_\_\_\_\_ |
| Specify | Assignment Date  YYYY-MM-DD | Specify | Specify | Specify | PHI  PHN  Other \_\_\_\_\_\_\_ |

| **Call Log Details** | | | | | | | |
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|  | **Date** | **Start Time** | **Type of Call** | **Call To/From** | | **Outcome**  (contact made, v/m, text, email, no answer, etc.) | **Investigator’s initials** |
| Call 1 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 2 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 3 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 4 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 5 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Date letter sent: YYYY-MM-DD | | | | | | | |

| **Case DetailsEach new clade is reportable as a new case.** | | | | | | | | |
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| **♦ Aetiologic Agent** | Candida auris | | | |  | | | |
| **♦ Clade**  *Select the clade if provided on the lab slip.* | Clade I  Clade II  Clade III  Clade IV  Clade V  Clade VI | | |  | | | | |
| **♦ Classification** | Confirmed  Person Under Investigation  Does Not Meet Definition  *Do not close case as PUI* | | | | | | **♦ Classification Date** | YYYY-MM-DD |
| **♦ Outbreak Case Classification** | Confirmed  Person Under Investigation  Does Not Meet Definition  *Do not close case as PUI* | | | | | | **♦ Outbreak Classification Date** | YYYY-MM-DD |
| **♦ Disposition** | Complete  Closed-Duplicate-Do Not Use  Entered In Error  Lost to Follow Up  Does Not Meet Definition  Untraceable | | | | | | **♦ Disposition Date** | YYYY-MM-DD |
| **♦ Status** | Closed | |  | | | | **♦ Status Date** | YYYY-MM-DD |
| Open (re-opened) | |  | | | | **♦ Status Date** | YYYY-MM-DD |
| Closed | |  | | | | **♦ Status Date** | YYYY-MM-DD |
| **♦ Priority** | High | Medium  Low | | | | *(At health unit’s discretion)* | | |

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| **Laboratory** |  | |  |
| **Test Information** |  | |  |
| **♦ Placer Requisition ID** | ***Note:*** *For Public Health Ontario Laboratory (PHOL) requisitions, this number will take the following format: year, laboratory initial, specimen number (e.g., 19C000123). For all other laboratories, use the unique specimen identifier that they provide followed by the lab requisition year (-YYYY) (e.g., 100189-2019).* | | |
| **♦ Specimen Type** | Blood  Sputum  Swab  Tissue  Urine  Other, specify: | | **Specimen Collection Date:**  Reported Date: |
| **♦ Body Site**  *→* *For iPHIS entry, select the Body Site if the specimen type* ***Swab*** *or* ***Tissue*** *was selected above* | Ear  Central line exit site  IV exit site  Urinary catheter exit site  Wound  Tracheotomy  Other, specify: | | ***Note: This list is not comprehensive. There are additional Body Sites available in iPHIS.*** |
| **Result Information**  *→* *For iPHIS entry, select* ***CD-Other*** *for the* ***Resulted Test Group Code****.* | | |  |
| **Resulted Test Code** | MALDI-ToF MS (in-house)  *C. auris* NAAT (in-house)  MALDI-ToF MS performed at a reference laboratory  *C. auris* NAAT performed at a reference laboratory  Whole genome sequence analysis  Other, specify | | |
| **♦ Result** | POSITIVE  TO BE CONFIRMED | INCONCLUSIVE  NEGATIVE – *Candida auris* NOT DETECTED | |
| **Drug Information**  *→* *For iPHIS entry, select each drug reported and enter its corresponding “Amount” and “Sensitivity”* | | | |
| **Drug** | AMPHOTERICIN B  ANIDULAFUNGIN  CAPSOFUNGIN  5-FLUCYTOSINE  FLUCONAZOLE  ISAVUCONAZOLEO  MICAFUNGIN  POSACONAZOLE  VORICONZOLE  OTHER, SPECIFY | | |
| **Amount** | Free text (e.g., 10) |  | |
| **Sensitivity** | µg/ml MIC |  | |

| **Medical Risk Factors**  *Select the relevant response for applicable risk(s)* | **Response** | | | | **Details**  *iPHIS character limit: 50*  *Specify details as required.* | **Date** |
| --- | --- | --- | --- | --- | --- | --- |
| **Yes** | **No** | **Unknown** | **Not asked** |
| Inpatient hospitalization at time of testing (specify hospital and admission date) |  |  |  |  | (specify hospital) | (specify admission date) |
| Previous hospitalization at the reporting hospital in the last 12 months (specify hospital and admission date) |  |  |  |  | (specify hospital) | (specify admission date) |
| Resident of a long-term care home at time of testing (specify facility) |  |  |  |  | (specify facility) | (specify admission date) |
| Resident of a retirement home at the time of testing (specify facility) |  |  |  |  | (specify facility) | (specify admission date) |
| Inpatient of a rehab hospital at time of testing (specify hospital and admission date) |  |  |  |  | (specify hospital) | (specify admission date) |
| Previously an inpatient of a rehab hospital in the last 12 months (specify hospital and admission date) |  |  |  |  | (specify hospital) |  |
| Specimen collected >48 hours following admission to the reporting health care facility |  |  |  |  |  |  |
| Previous colonization with  *C. auris* |  |  |  |  |  |  |
| Previous treatment with antifungal agent |  |  |  |  |  |  |
| Medical/surgical procedure in Canada in the last 12 months |  |  |  |  | (specify procedure and hospital/clinic) |  |
| Other inpatient hospitalization in Canada in the last 12 months (specify city and hospital) |  |  |  |  | (specify city and hospital) |  |
| ICU admission in Canada in the last 12 months (specify city and hospital) |  |  |  |  | (specify city and hospital) |  |
| Medical/surgical procedure outside of Canada in the last 12 months (specify country) |  |  |  |  | (specify country) |  |
| Hospitalization outside of Canada in the last 12 months (specify country) |  |  |  |  | (specify country) |  |
| Chronic illness/underlying medical condition (specify) |  |  |  |  |  |  |
| Presence of invasive devices (e.g., IV, central line) |  |  |  |  | **(specify device type)** |  |
| Reason for specimen collection: admission testing |  |  |  |  |  |  |
| Reason for specimen collection: prevalence testing |  |  |  |  |  |  |
| Reason for specimen collection: clinical specimen |  |  |  |  |  |  |
| Reason for specimen collection: contact of a case/outbreak investigation |  |  |  |  |  |  |
| Reason for specimen collection: other (specify) |  |  |  |  |  |  |
| Other (specify) |  |  |  |  |  |  |
| Unknown |  |  | *→ For iPHIS data entry – check Yes for Unknown if all other Medical Risk Factors are Unknown.* | | |  |

| **Behavioural Social Risk Factors**  *Ensure that Risk Factors in* ***bold font*** *are asked* | **♦ Response** | | | | **Details**  *iPHIS character limit: 50* |
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| **Yes** | **No** | **Unknown** | **Not asked** |
| **Travel outside Canada in the last 12 months (specify country)** |  |  |  |  |  |
| **Known contact with a confirmed case in the last 12 months** |  |  |  |  |  |
| **Resident of long-term care** |  |  |  |  |  |
| **Resident of retirement home** |  |  |  |  |  |
| **Travel outside Canada in the last 12 months (specify country)** |  |  |  |  |  |
| Other (specify) |  |  |  |  | Specify |
| Unknown |  |  | *→ For iPHIS data entry – check Yes for Unknown if all other Behavioural Social Risk Factors are Unknown.* | | |

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| **Exposures**  ***Note****: Create new exposures for hospitals or institutions that can be attributed as the most likely source of C. auris acquisition/transmission.* *Exposure Name format*: HOSPITAL OR INSITUTION NAME - ADDRESS - YYYY-MM-DD  *In addition, if the client was hospitalized at the time of C. auris diagnosis, enter details of the hospitalization in the relevant risk factors listed in* ***Cases > Case > Risks.***  **For cases with unknown exposure, link to Exposure ID 232854.**  **Exposure Name:** 01-UNKNOWN-Candida auris-DO NOT MODIFY | |
| **♦ Exposure Level** | Case only  Outbreak only  Outbreak and case  Unknown |
| **♦ Exposure Type** | Person/Contact  Travel  Item/fomite  Unknown |
| **♦ Exposure Name**  *→For iPHIS entry,* ***Exposure Name*** *format:*  ‘HOSPITAL/INSTITUTION NAME - ADDRESS - YYYY-MM-DD’ |  |
| **♦ Earliest Exposure Date**  (e.g., Provide date of hospital admission, date of specimen collection for clients in long-term care, date of first contact with positive case) | YYYY-MM-DD |
| **♦ Exposure Mode** | Acquisition  Transmission |

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| **Exposure Address** |  |
| **Hospital/Institution Name** |  |
| **Full Street Address**  **♦ City/Province, Postal Code**  **♦ Country** |  |

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| **Symptoms** | | | | | | | | | |
| ***Incubation period*** *for exposure-to-illness onset is undefined. Individuals colonized with Candida auris may remain asymptomatic if they are in good health but can still act as a reservoir for transmission to others.*  ***Communicability:*** *The period of communicability of Candida auris persists as long as the organism is present in the gastrointestinal tract of the patient. Patients can be intermittently positive on repeat screening and may be colonized for months to years.* | | | | | | | | | |
| ***Specimen collection date:*** YYYY-MM-DD | | | | | | | | | |
| **♦ Symptom**  *Ensure that symptoms in* ***bold font*** *are asked* | **♦ Response** | | | | | **Use as Onset** | **♦ Onset Date**  YYYY-MM-DD | **Onset Time**  24-HR Clock  HH:MM  *(discretionary)* | **Recovery Date**  YYYY-MM-DD  *(one date is sufficient)* |
| **Yes** | **No** | **Do not Know** | **Not Asked** | **Refused** |
| **Fever** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Chills |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Hypotension |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Cough** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Ear, painful** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Ear, drainage** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Discharge, purulent** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Erythema, wound** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Pain, wound** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Gross hematuria** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Flank pain, new** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Suprapubic pain or tenderness, new** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Urinary frequency, new or increased** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Urinary urgency, new or increased** |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Other, *specify* |  |  |  |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| ***Note: This list is not comprehensive. There are additional symptoms available in iPHIS.*** | | | | | | | | | |

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| ♦ **Complications:** |
| ☐ Ear Infection  None  Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Pneumonia  Sepsis ☐Urinary Tract Infection ☐ Wound infection  Unknown |

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| **Treatment** *Mandatory in iPHIS only if admitted to hospital* | | |
| Were antifungals or medication prescribed to treat this infection illness? | Yes  No  Don’t recall | If yes, Medication: Enter name  Start date: YYYY-MM-DDEnd date: YYYY-MM-DD  Route of administration: Enter route Dosage: Enter dosage |
| *Treatment information can be entered in iPHIS under* ***Cases > Case > Rx/Treatments>Treatment as per current iPHIS User Guide*** | | |

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| **Interventions**  ***Note****: Enter Interventions if client was admitted to hospital or a resident of a health care facility.* | | | | |
| **Intervention Type** | **Intervention implemented (check all that apply)** | **Investigator’s initials** | ♦ **Start Date YYYY-MM-DD** | **♦ End Date YYYY-MM-DD** |
| Cohorting: Patients |  |  |  |  |
| Cohorting: Staff |  |  |  |  |
| Contact Precautions |  |  |  |  |
| Dedicated Equipment |  |  |  |  |
| Education (e.g., hand hygiene) |  |  |  |  |
| Single room |  |  |  |  |
| *→**For iPHIS data entry – enter information under* ***Cases > Case > Interventions.*** | | | | |

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| **Outcome** *Mandatory in iPHIS only if Outcome is Fatal within 30 days* | |
| ☐ ♦ Fatal *If fatal, please complete additional required fields in iPHIS.* ☐ Unknown  ☐ Ill ☐ Residual effects  ☐ Pending ☐ Recovered | |
| **Outcome date** | YYYY-MM-DD |
| ♦**Type of Death**  *Complete this field if outcome was fatal* | ☐ **The reportable disease contributed to but was not underlying cause of death**  ☐ **The reportable disease was underlying cause of death**  ☐ **The reportable disease was unrelated to cause of death**  ☐ **Unknown** |

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| **Thank you** |
| Thank you for your time. This information will be used to help prevent future illnesses caused by *C. auris*. Please note that another investigator may contact you again to ask additional questions if it is identified that there is a possibility that you are included in an outbreak. |