**Ontario *Candida auris* Investigation Tool**

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

|  |
| --- |
| **Cover Sheet***Note that this page can be autogenerated in iPHIS* |
| Date Printed: YYYY-MM-DDBring Forward Date: YYYY-MM-DDiPHIS 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 \_ \_** |

|  |
| --- |
| **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.* |

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

| **Call Log Details**  |
| --- |
|  | **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.** |
| --- |
| **♦ 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)* |

|  |  |  |
| --- | --- | --- |
| **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* |
| --- | --- | --- |
|  | **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.* |

|  |
| --- |
| **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 |

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

|  |
| --- |
| **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 ClockHH: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.*** |

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

|  |
| --- |
| **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-DDRoute 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*** |

|  |
| --- |
| **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 DateYYYY-MM-DD** | **♦ End DateYYYY-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.*** |

|  |
| --- |
| **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** |

|  |
| --- |
| **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. |