



SNHD MDRO and *C. auris* Case Report Form

Please fill this form out completely and fax to 702-759-1414. For questions or urgent reports call 702-759-1300.

**If all the information below is contained in your facility medical record (MR), please send MR in lieu of this form. If additional information is needed for an investigation, SNHD will request it.*

Demographics	Patient name: _____ Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other Race <input type="checkbox"/> Unknown	DOB: _____ Address: _____ Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Birth sex: _____
Reporting Facility	Reporting facility: _____ Provider reporting name: _____ Phone number: _____ Date of report: _____ Isolation precautions: <input type="checkbox"/> Y <input type="checkbox"/> N If yes, type of precautions and date of initiation: _____ Did the patient have a roommate prior to isolation? <input type="checkbox"/> Y <input type="checkbox"/> N Antimicrobial medication: <input type="checkbox"/> Y <input type="checkbox"/> N (If yes, please attach medication list)		
Transfers	Facility patient was transferred from (include location): _____		Date of transfer: _____
	Facility patient was discharged to (include location): _____		Date of discharge: _____