Confidential
Surveillance of *Candida auris* (*C. auris*): Part A

Department of Health

Please return completed form within 2 days of *C. auris* notification to the department by faxing 1300 651 170. For enquiries please email amr.secretariat@health.vic.gov.au.

Please ensure the case (1) has been informed of their diagnosis, (2) has been advised that this information is being provided to the department (as required by the *Health Records Act 2001*), and (3) has been informed that the department may contact them for further information about their illness. Commonwealth and State privacy legislation does not negate the responsibility to notify the specified conditions or to provide the information requested on this form.

Case details—please answer all questions

Last name

First name(s)

Date of birth

Medicare or other healthcare identifier

Sex
- ☐ Male
- ☐ Female
- ☐ Other, specify >

Identified gender
- ☐ Male
- ☐ Female
- ☐ Non-binary
- ☐ They use a different term, please specify >
- ☐ Unknown

Residential address

Suburb/town

Postcode

Tel home

Tel mobile

Parent/guardian/next of kin name and contact number

Is the case of Aboriginal or Torres Strait Islander origin
- ☐ No
- ☐ Aboriginal
- ☐ Torres Strait Islander
- ☐ Both Aboriginal and Torres Strait Islander
- ☐ Unknown

Country of birth ...country

...year arrived in Australia
- ☐ Australia
- ☐ Unknown
- ☐ Overseas >

Language spoken at home

Interpreter required
- ☐ No
- ☐ Yes

C. auris specimen details

Specimen collection date

Specimen ID (local lab)

Location of case at time of specimen collection
- ☐ Acute hospital — admitted
- ☐ Acute hospital — emergency
- ☐ General practice
- ☐ Outpatient
- ☐ Residential aged care
- ☐ Sub-acute (e.g. rehabilitation)
- ☐ Unknown
- ☐ Other, specify >

Facility name

Date presented to this location

Patient identifier (UR number)

Treating unit/ward

Case presented to this location from
- ☐ Home
- ☐ Transferred from hospital outside of Australia, specify country below >
- ☐ Acute hospital within Australia, specify hospital and date of presentation to this previous hospital below >
- ☐ Day procedure
- ☐ Emergency department
- ☐ Residential aged care
- ☐ Sub-acute (e.g. rehabilitation), specify facility >
- ☐ Unknown
- ☐ Other, specify >

Reason for specimen collection
- ☐ Clinically indicated
- ☐ Screening — Routine IPC activities
- ☐ Screening — Admission to overseas hospital
- ☐ Screening — Other overseas exposure
- ☐ Screening — *C. auris* contact
- ☐ Screening — Transmission risk area
- ☐ Other, specify >

Notifier (your) details

Name

Medicare provider no.

Practice/Facility name and Address

City

Postcode

Telephone

Fax

Date

Department use only

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Date of form completion

Please identify the case on every page

Full name or UR | Date of birth | Office use only 320

Clinical details

Isolation of *C. auris* from this case represents
- ☐ Colonisation
- ☐ Infection
- ☐ Unknown

If *C. auris* isolation represents infection, what is the site of infection (tick all that apply)
- ☐ Bacteraemia — IV device related
- ☐ Bacteraemia — with focus, specify >
- ☐ Bacteraemia — without obvious focus
- ☐ Central nervous system
- ☐ Genital tract
- ☐ Infection of prosthetic material
- ☐ Intra-abdominal
- ☐ Respiratory tract
- ☐ Skin/soft tissue
- ☐ Surgical wound
- ☐ Urinary tract
- ☐ Other, specify >

Current admission status
- ☐ Current inpatient
- ☐ Discharged, specify discharge date >
- ☐ Not applicable

Is the case deceased
- ☐ No
- ☐ Yes, specify date of death >

Clinical comments or cause of death

GP details

Full name

Facility name (laboratory / health care / aged care / medical practice)

Address

City | **Postcode**

Telephone | **Fax**

Risk history

Who was the risk history obtained from
- ☐ The case
- ☐ Other person, specify name of person and relationship to case below

Person interviewed

Relationship to case

Why wasn't the case interviewed

Risk history (continued)

Has the case ever been hospitalised at any facility in Australia (including emergency or day procedure) since 2000
- ☐ No
- ☐ Unknown
- ☐ Yes, specify ALL facilities below (additional facilities can be listed in the *Notes* section)

	Approximate year
Facility 1	
Facility 2	
Facility 3	
Facility 4	
Facility 5	
Facility 6	

Has the case ever been a resident of a long-term residential care facility in Australia (including respite)
- ☐ Yes, specify all facilities >
- ☐ No
- ☐ Unknown

Has the case ever been engaged in healthcare work
- ☐ Yes
- ☐ No
- ☐ Unknown

Does the case know if they have ever had contact with a known *C. auris* positive case
- ☐ Yes, specify >
- ☐ No
- ☐ Unknown

Name and DOB of positive case

Did the case have any household contact with a recently returned traveller or an overseas visitor within the last 4 years
- ☐ Yes, specify >
- ☐ No
- ☐ Unknown

Country

Was the contact admitted to a healthcare facility overseas
- ☐ Yes, specify country >
- ☐ No
- ☐ Unknown

Has the case spent time outside of Australia in the last 4 years
- ☐ Yes, Australian resident travelling overseas
- ☐ Yes, overseas resident
- ☐ No
- ☐ Unknown

If "Yes" to the above question, complete an 'Overseas exposures' column for each country visited.

Has the case had any other high-risk travel outside Australia in the past 10 years (e.g. visiting friends or relatives, resident (>3 months), or significant illness or healthcare contact) not already documented in the *Overseas Exposures* section of this form
- ☐ Yes, specify >
- ☐ No
- ☐ Unknown

Please identify the case on every page

Full name or UR | Date of birth | Office use only 320

Overseas exposures - Complete only for time spent outside of Australia in the last 4 years

Complete one column for every country visited. Copy this page if required for additional countries.

Country

Arrived **Departed**

Reason for time spent in this country (tick all that apply)
- ☐ Holiday or business
- ☐ Residence in country of birth
- ☐ Residence in country other than birth
- ☐ Visiting friends and relatives
- ☐ Other, specify >

Did the case travel with the *intention* of receiving medical, dental or other healthcare in this country
- ☐ Yes — Dental
- ☐ Yes — Medical
- ☐ Yes — Other
- ☐ No
- ☐ Unknown

Did the case have contact with a healthcare facility in this country (tick all that apply)
- ☐ Yes — as a patient, specify location below
- ☐ Yes — as staff, specify location below
- ☐ Yes — visiting a patient, specify location below
- ☐ No
- ☐ Unknown

Location within facility	Visit/admitted	Discharged
☐ Acute hospital admission		
☐ Acute hospital emergency		
☐ Acute hospital outpatients		
☐ Day procedure centre		
☐ Dental practice/surgery		
☐ General practice		
☐ Other, specify type >		

Did the case receive any medical treatment or procedures in this country
- ☐ Yes, specify >
- ☐ No
- ☐ Unknown

Any further details on travel in this country

Country

Arrived **Departed**

Reason for time spent in this country (tick all that apply)
- ☐ Holiday or business
- ☐ Residence in country of birth
- ☐ Residence in country other than birth
- ☐ Visiting friends and relatives
- ☐ Other, specify >

Did the case travel with the *intention* of receiving medical, dental or other healthcare in this country
- ☐ Yes — Dental
- ☐ Yes — Medical
- ☐ Yes — Other
- ☐ No
- ☐ Unknown

Did the case have contact with a healthcare facility in this country (tick all that apply)
- ☐ Yes — as a patient, specify location below
- ☐ Yes — as staff, specify location below
- ☐ Yes — visiting a patient, specify location below
- ☐ No
- ☐ Unknown

Location within facility	Visit/admitted	Discharged
☐ Acute hospital admission		
☐ Acute hospital emergency		
☐ Acute hospital outpatients		
☐ Day procedure centre		
☐ Dental practice/surgery		
☐ General practice		
☐ Other, specify type >		

Did the case receive any medical treatment or procedures in this country
- ☐ Yes, specify >
- ☐ No
- ☐ Unknown

Any further details on travel in this country

Notes