Candida auris Transfer Information Sheet

Immediately place this patient on transmission based precautions.

Acute Care or Long-term Care Hospital Settings: Contact Precautions only
Nursing Home Settings: Contact Precautions or Enhanced Barrier Precautions (EBP), depending on the situation (refer to health dept for more information).

Patient name: _____ (Last, First)

Date of birth: _____ (MM/DD/YYYY)

Discharging facility: _____

Date completed: _____ (MM/DD/YYYY)

Reporter name: _____

Contact number: _____ (XXX-XXX-XXXX)

☐ **This patient was identified with *Candida auris* (see attached lab report):**

- ◯ Infection: Identification during clinical testing
  - ☐ This infection has been treated or determined treatment not needed
  - ☐ Treatment is ongoing
- ◯ Colonization: Identification during surveillance testing

Specimen collection date: _____ (MM/DD/YYYY)

Specimen source: _____

☐ **This patient's *Candida auris* status is under investigation, further laboratory results are pending**

***C. auris* Screening Testing**

Specimen collection date: _____ (MM/DD/YYYY)

Results: ☐ Pending

Notes:

_____

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If you have additional questions, please contact your local health department or the MDHHS Surveillance for Healthcare-Associated and Resistant Pathogens Unit (SHARP) at: 517-335-8165