

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* (select one):

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: _____ Specimen source: _____
(MM/DD/YYYY)

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

72-hour *C. auris* Screening Testing

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

Results: Negative (see attached report)
 Pending

Discharge *C. auris* Screening Testing

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

Results: Pending

Notes:

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