Digitally Completing Case Report Forms

ADRIENNE SHERMAN, MPH

HAI/AR EPIDEMIOLOGIST, NJDOH, CDS

5 Quick Steps to Digitally Complete and Upload Case Report Forms (CRFs)

- ❑ **Download a PDF reader (Adobe Acrobat Reader DC recommended)**
- ❑ **Open the Case Report Form in the PDF reader (enabled for digital completion with fields highlighted in blue)**
- ❑ **If fillable fields do not appear in blue, select 'Fill and Sign'**
- ❑ **Complete CRF and save**
- ❑ **Upload completed PDF to http://healthsurveys.nj.gov/NoviSurvey/n/zz2g8.aspx**

Downloading a PDF Reader to Use to Digitally Complete CRFs

- Adobe Acrobat Reader DC is the recommended program to use for completing CRFs
  - It's FREE!
  - Visit: get.adobe.com/reader/
- Other PDF readers enabled for digital completion (with fields highlighted in blue) are also acceptable

Step 1 of 3: Download software

Acrobat DC. It's how the world gets work done.

View, sign, comment on, and share PDFs for free.

OPTIONAL OFFERS

McAfee

Yes, install the free McAfee Security Scan Plus utility to check the status of my PC security. It will not modify existing antivirus program or PC settings. Learn more

Yes, install McAfee Safe Connect to keep my online activities and personal info private and secure with a single tap. Learn more

GET MORE OUT OF ACROBAT:

Install the Acrobat Reader Chrome Extension

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Learn more

Adobe Acrobat Reader DC

The leading PDF viewer to print, sign, and annotate PDFs.

Download Acrobat Reader

308 MB

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Adobe Acrobat Pro DC

Do everything you can do in Acrobat Reader, plus create, protect, convert and edit your PDFs with a 7-day free trial. Continue viewing PDFs after trial ends.

Download Acrobat Pro Trial

912 MB

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Are you an IT manager or OEM?

Version 22.001.20169 · System requirements

Your system: Windows 10, English

Do you have a different language or operating system?

Choose your region (Change)

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AdChoices

Opening and Viewing the Blank CRF in a PDF Reader

- Open the Case Report Form in the PDF reader (enabled for digital completion with fields highlighted in blue)
- If fillable fields do not appear in blue, select ‘Fill and Sign’

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Candida auris Case Report Form
New Jersey Department of Health

NJDOH USE ONLY
Received date:
NJDOH ID:

REPORTING FACILITY INFORMATION
Date completed: Facility Name:
Facility Street Address: City: State: Zip:
Facility POC: Email: Phone: ext.
Facility type: ☐Acute care ☐Long-term acute care ☐Long-term care/skilled nursing with ventilator beds ☐Short-term rehabilitation ☐Long-term care/skilled nursing without ventilator beds ☐Other:

CASE INFORMATION
Patient First Name: Patient Last Name: Date of Birth:
Sex: ☐Male ☐Female ☐Unknown Ethnicity: ☐Hispanic and/or Latino ☐Not Hispanic and/or Latino ☐Unknown
Race (select all that apply): ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Asian ☐Native Hawaiian or Other Pacific Islander ☐Other: ☐Unknown
City of Residence: State of Residence: Is the patient living? ☐Yes ☐No ☐Unknown
If no, date of death: Cause of death: ☐Unknown

MYCOTIC CULTURE HISTORY
Date of first identification: Were any fungal cultures collected at your facility? ☐Yes ☐No ☐Unknown
Date of specimen collection: Specimen site/source:
If fungal cultures were collected, select the organisms that were identified below and append the final microbiology reports to this form:
☐Candida auris ☐Candida haemulonii ☐Candida parapsilosis ☐Candida albicans ☐Candida glabrata ☐Candida tropicalis ☐Candida (no speciation/unknown) ☐Yeast species ☐Other: ☐None of the above were identified

PATIENT MOVEMENT IN INQUIRED HEALTHCARE FACILITY *(List rooms & units in which the patient resided within your facility in the past 30 days)*

Admission/Move date	Unit	Room	Contact Precautions Yes	No	Unk	Roommates Yes	No	Unk	Shared Bathroom Yes	No	Unk	Discharge/Move date
01/01/2021	ICU	302	☐	☑	☐	☑	☐	☐	☑	☐	☐	01/22/2021

PATIENT ADMISSION/DISCHARGE IN OTHER HEALTHCARE FACILITIES *(List all admissions and discharges from your facility in the past 30 days)*

Location *from* which the patient was sent to your facility (Each row represents a different admission to your facility) Facility Name or "Home"	Date Received	Location *to* which the patient was sent from your facility (Each row represents a different discharge from your facility) Facility Name, "Home", or "Still Admitted"	Date Discharged
Facility X	12/17/2020	Facility Y	01/01/2021

ROOMMATES *(List all known roommates of the patient at your facility)*

Roommate First Name	Roommate Last Name	Roommate Date of Birth	Notes
John	Doe	06/13/1960	Roommate stayed with patient from 1/15 – 1/22; transferred to another facility on 1/22

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Updated September 2021 1

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Candida auris Case Report Form
New Jersey Department of Health

NJDOH USE ONLY	
Received date:	
NJDOH ID:	

REPORTING FACILITY INFORMATION

Date completed: 07/25/2022 Facility Name: Hospital A

Facility Street Address: 135 E State Street City: Trenton State: NJ Zip: 00000

Facility POC: Infection Preventionist Email: IP@HospitalA.org Phone: 555-555-5555 ext. 123

Facility type: ☑ Acute care ☐ Long-term acute care ☐ Long-term care/skilled nursing with ventilator beds ☐ Short-term rehabilitation ☐ Long-term care/skilled nursing without ventilator beds ☐ Other:

CASE INFORMATION

Patient First Name: John Patient Last Name: Doe Date of Birth: 01/01/1990

Sex: ☑ Male ☐ Female ☐ Unknown Ethnicity: ☐ Hispanic and/or Latino ☑ Not Hispanic and/or Latino ☐ Unknown

Race (select all that apply): ☑ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Other: ☐ Unknown

City of Residence: Trenton State of Residence: NJ Is the patient living? ☑ Yes ☐ No ☐ Unknown

If no, date of death: Cause of death: ☐ Unknown

MYCOTIC CULTURE HISTORY

Date of first identification: 07/25/2022 Were any fungal cultures collected at your facility? ☑ Yes ☐ No ☐ Unknown

Date of specimen collection: 07/18/2022 Specimen site/source: Nares/Axilla/Groin swab

If fungal cultures were collected, select the organisms that were identified below and append the final microbiology reports to this form:

☑ Candida auris ☐ Candida haemulonii ☐ Candida parapsilosis ☐ Candida albicans ☐ Candida glabrata ☐ Candida tropicalis ☐ Candida (no speciation/unknown) ☐ Yeast species ☐ Other: ☐ None of the above were identified

PATIENT MOVEMENT IN INQUIRED HEALTHCARE FACILITY *(List rooms & units in which the patient resided within your facility in the past 30 days)*

Admission/Move date	Unit	Room	Contact Precautions			Roommates			Shared Bathroom			Discharge/Move date
			Yes	No	Unk	Yes	No	Unk	Yes	No	Unk	
01/01/2021	*ICU*	*302*	☐	☑	☐	☑	☐	☐	☑	☐	☐	*01/22/2021*
06/05/2022	ICU	300	☐	☑	☐	☐	☑	☐	☐	☑	☐	06/20/2022
06/20/2022	CCU	401	☐	☑	☐	☐	☑	☐	☐	☑	☐	07/13/2022
07/13/2022	Telemetry	222	☐	☑	☐	☑	☐	☐	☑	☐	☐	07/24/2022
			☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	
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			☐	☐	☐	☐	☐	☐	☐	☐	☐	
			☐	☐	☐	☐	☐	☐	☐	☐	☐	

PATIENT ADMISSION/DISCHARGE IN OTHER HEALTHCARE FACILITIES *(List all admissions and discharges from your facility in the past 30 days)*

Location *from* which the patient was sent to your facility (Each row represents a different admission to your facility)		Location *to* which the patient was sent from your facility (Each row represents a different discharge from your facility)	
Facility Name or "Home"	Date Received	Facility Name, "Home", or "Still Admitted"	Date Discharged
Facility X	*12/17/2020*	*Facility Y*	*01/01/2021*
Home	06/05/2022	LTCF A	07/24/2022

ROOMMATES *(List all known roommates of the patient at your facility)*

Roommate First Name	Roommate Last Name	Roommate Date of Birth	Notes
John	*Doe*	*06/13/1960*	*Roommate stayed with patient from 1/15 – 1/22; transferred to another facility on 1/22*
Jack	Smith	05/05/1955	Roommate from 7/13-7/20; transferred to LTCF B on 7/20

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HEALTHCARE SERVICES *(Select all healthcare services provided to the patient within the past 30 days)*

☐ Chemotherapy ☐ ECMO ☑ Imaging ☐ Inpatient dialysis ☐ IVIG ☐ Outpatient dialysis ☐ Rehabilitation ☑ Respiratory therapy ☑ Wound care ☑ Ultrasound ☐ Other:

MEDICAL CONDITIONS *(Select all of the patient's present medical conditions and those existing 14 days prior to the day of report)*

☐ Autoimmune disorder ☑ Bacteremia ☐ Bone marrow transplant ☐ Cancer (hematogenous) ☐ Cancer (solid) ☐ Cardiovascular disease ☐ Chronic kidney disease ☑ Chronic wounds ☑ COVID-19 (or history of COVID-19) ☐ Diabetes ☑ History of MDR infection ☐ HIV/AIDS ☐ Kidney failure ☐ Liver disease ☐ Neurologic disease ☐ Obesity ☑ Respiratory disease (Non-COVID) ☐ Sepsis ☐ Solid organ transplant ☐ Tuberculosis ☑ Ventilator dependent ☐ Other:

MEDICAL DEVICES *(Select all of the patient's present medical devices)*

☑ Abdominal feeding tube ☑ Central venous catheter ☐ Colostomy ☐ Hemodialysis catheter ☐ Intraabdominal drain/catheter ☑ Mechanical ventilator ☐ Nephrostomy ☐ Port(s) ☐ Surgical drain ☐ Tracheostomy/tracheostomy collar ☑ Urinary catheter ☐ Other:

MEDICAL PROCEDURES

Did the patient undergo medical procedures in the past 30 days (If yes, list the procedures below)? ☑ Yes ☐ No ☐ Unknown

Date	Procedure	Location	Facility
01/01/2021	*Line placement (PICC)*	*Interventional Radiology*	*Example Facility*
06/05/2022	CT Imaging	Interventional Radiology Ste 6	Hospital A
06/06/2022	Intubation	Bedside, ICU Rm 300	Hospital A

ANTIBIOTIC EXPOSURES *(Select all of the patient's present antibiotics and those administered 14 days prior to the day of report)*

Which (if any) of the following classes of antibiotics was the patient exposed to? ☐ Unknown ☐ None

☐ **Aminoglycosides:** ☐ **Oxazolidinones:**
☑ **Carbapenems:** Doripenem ☐ **Penicillins:**
☐ **Cephalosporins:** ☐ **Polypeptides:**
☐ **Fluoroquinolones:** ☐ **Rifamycins:**
☐ **Glycopeptides:** ☐ **Sulfonamides:**
☐ **Macrolides:** ☐ **Tetracyclines:**
☐ **Monobactams:** ☐ Other:

ANTIFUNGAL EXPOSURES *(Select all of the patient's present antifungals and those administered 14 days prior to the day of report)*

Which (if any) of the following classes of antifungals was the patient exposed to? ☐ Unknown ☐ None

☐ **Allylamines:** ☑ **Echinocandins:** Micafungin
☐ **Azoles:** ☐ **Polyenes:**

TRAVEL HISTORY

Did the patient receive any international healthcare during travel in the past year? ☐ Yes ☑ No ☐ Unknown

COMMENTS

PLEASE REMEMBER TO APPEND FINAL MICROBIOLOGY REPORTS TO THIS FORM

Correctly completed CRFs should resemble the images above

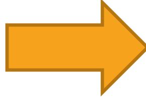
Saving Digitally Completed CRFs

- Go to File > Save As
  - Select a location to save the completed form on your local device
  - Update file name and save completed CRF

Candida auris Case Report Form_September 2021_v2.pdf - Adobe Acrobat Reader DC (32-bit)

File Edit View Sign Window Help

- Open... Ctrl+O
- Reopen PDFs from last session
- Create PDF
- Combine Files
- Insert Pages
- Save Ctrl+S
- Save As... Shift+Ctrl+S
- Convert to Word, Excel or PowerPoint
- Save as Text...
- Compress File
- Password Protect
- Request E-signatures
- Share File
- Revert
- Close File Ctrl+W
- Properties... Ctrl+D
- Print... Ctrl+P



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Candida auris **Case Report Form**
New Jersey Department of Health

NJDOH USE ONLY
Received date:
NJDOH ID:

REPORTING FACILITY INFORMATION

Date completed: 07/25/2022 Facility Name: Hospital A
Facility Street Address: 135 E State Street City: Trenton State: NJ Zip: 00000
Facility POC: Infection Preventionist Email: IP@HospitalA.org Phone: 555-555-5555 ext. 123
Facility type: ✓ Acute care ☐ Long-term acute care ☐ Long-term care/skilled nursing with ventilator beds ☐ Short-term rehabilitation
☐ Long-term care/skilled nursing without ventilator beds ☐ Other:

CASE INFORMATION

Patient First Name: John Patient Last Name: Doe Date of Birth: 01/01/1990
Sex: ✓ Male ☐ Female ☐ Unknown Ethnicity: ☐ Hispanic and/or Latino ✓ Not Hispanic and/or Latino ☐ Unknown
Race (select all that apply): ✓ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian
☐ Native Hawaiian or Other Pacific Islander ☐ Other: ☐ Unknown
City of Residence: Trenton State of Residence: NJ Is the patient living? ✓ Yes ☐ No ☐ Unknown
If no, date of death: Cause of death: ☐ Unknown

MYCOTIC CULTURE HISTORY

Date of first identification: 07/25/2022 Were any fungal cultures collected at your facility? ✓ Yes ☐ No ☐ Unknown
Date of specimen collection: 07/18/2022 Specimen site/source: Nares/Axilla/Groin swab
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☐ Candida (no speciation/unknown) ☐ Yeast species ☐ Other: ☐ None of the above were identified

PATIENT MOVEMENT IN INQUIRED HEALTHCARE FACILITY *(List rooms & units in which the patient resided within your facility in the past 30 days)*

Contact Precautions Roommates Shared Bathroom

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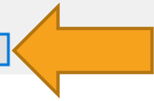
File Edit View Sign Window Help

Save As

This PC › Windows (C:) › Users › Adrienne › Downloads Search Downloads

File name: JOHN DOE_Candida auris Case Report Form_September 2021_v2
Save as type: Adobe PDF Files (*.pdf)

Browse Folders Save



Save completed CRFs as shown above

Uploading Digitally Completed CRFs

- Navigate to the encrypted file drop webpage: http://healthsurveys.nj.gov/NoviSurvey/n/zz2g8.aspx
- Provide submitter's contact information and facility name and location on page 1

NJ Health New Jersey Department of Health

Encrypt File Drop

Page 1 of 2

As instructed by Communicable Disease Service staff, please complete the below information and upload your file.

If you have not notified staff with the Communicable Disease Service that you plan to submit isolates or specimens for testing, please notify us via email or at 609-826-5964.

Please direct any questions to our team at 609-826-5964. Thank you.

1. Healthcare Facility Information *

Facility Name: Hospital A

Facility City: Trenton

2. Submitter Information

First name *: Sally

Last name *: Jones

Email *: IP@hospitalA.org

Click next to upload the documents

Uploading Digitally Completed CRFs

- Proceed to page 2, where you will select the file(s) from your local device to upload and attach
  - Microbiology lab results are encouraged to be submitted as a separate, additional attachment
  - Please **do not** scan or combine completed CRFs and labs into one file
- Once files have been selected and uploaded, proceed to the next page to complete the submission

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Encrypt File Drop
Page 2 of 2

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Please direct any questions to our team at 609-826-5964. Thank you.

3. Attach documentation below

Document 1 Choose File No file chosen
EXAMPLE CRF_Candida auris Case Report Form_September 2021_v2.pdf Delete

Document 2 Choose File No file chosen
Micro Labs.pdf Delete

Document 3 Choose File No file chosen

Document 4 Choose File No file chosen

4. Please any comments or additional information below.

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Uploading Digitally Completed CRFs

- The following message will appear indicating successful completion of file upload(s):