Mucormycosis Clinical assessment form

1. Patient study no. __________________

2. Clinician/Mycologist Name: _______________________________________________
   Telephone: ________________________________
   Fax: ________________________________
   E-mail: ________________________________

3. a) Name of hospital: _______________________________________________
   b) Name of clinical consultant: ________________________________

4. Demographics
   Age: ________ years
   Sex: Male/ Female
   Weight: ______Kg

5. Date of admission to the hospital: (DD/MM/YYYY) ________________________________

6. Admitted in ward/ ICU:

7. Types of ICU/Ward facility
   - Neonates
   - Pediatric
   - Adult
   - Surgical
   - Medical
   - Others

8. Reason for Ward/ICU admission:
   ________________________________________________________________
   ________________________________________________________________
9. Date of first positive tissue wet film examination or culture: (DD/MM/YYYY) _________

10. **Risk factors:**

**Diabetes mellitus**
- Duration: _________ years
- Treatment: OHA/Insulin
- Controlled / uncontrolled, HBA1c value________
- Ketoacidosis

**Treatment with glucocorticoids**
- Duration:
- Continuous / intermittent
- Reason for use

**Malignancy**
- Hematologic malignancy
- Solid organ malignancy
- Other malignancy (mention) -
- On chemotherapy/Not on chemotherapy

**Hemopoietic stem cell transplant**
- Duration of Tx: ____________
- Allogenic / Autologus
- Reason for Tx: Leukemia/ Lymphoma/ other malignancy
- Disease in remission/ Relapsed disease
- Immunosuppressives used
- GVHD occurred : Yes/No

**Solid organ transplant**
- Duration of Tx:
- Organ: Kidney/ Liver/ Lung/ Heart
- Immunosuppressives used: Tacrolimus (dose/day)______, MMF (dose/day), Prednisolone (Dose/day), Sirolimus (dose/day), Azathioprin (Dose/day), Other agents, Biologics etc

**Treatment with deferoxamine**
- Duration:
- Frequency of administration:
- Reason:

**Iron overload**
- Reason
AIDS
- HIV/AIDS diagnosis: (DD/MM/YYYY) ____________________________
- CD4 count at the time of diagnosis of mucormycosis: _____ cells/cmm
- ART:
- Other OIs:

IV drug abuse
Duration _______

Trauma/Road Traffic accident
- Types of trauma: _______
- Date when trauma occurred: (DD/MM/YYYY) ______________________
- Treatment: Surgery / Conservative

Burns
- Superficial / Deep
- Electric /other
- Days:

Malnutrition - Yes/No

Surgery
- Site of surgery:
- Emergency / Planned
- Date of surgery
- ABX/antifungal used

Prior Use of Voriconazole
- Which antifungal used
- Reason for use
- Duration

No underlying risk factors

11. Other co-morbidities:
- Cardiovascular
- Renal
- Pulmonary
- Hepatic
- Neurologic
- Other
12. Evaluation of Mucormycosis

- Date of diagnosis (DD/MM/YYYY) __________________________

- Site of infection:
  - Paranasal sinuses with brain involvement
  - Paranasal sinuses without brain involvement
  - Pulmonary
  - Skin & soft tissue
  - Kidney
  - Abdominal
  - Disseminated disease
  - Other site:

- Source of infection:

- Diagnosis:
  - Wet film examination
  - Culture
  - Histopathology

- Clinical presentation:
  ______ Fever, ______ headache, ______ facial pain-unilateral/bilateral, ______ facial swelling, ______ proptosis, ______ Visual disturbances, ______ oral ulcer, ______ eschar over face, ______ palatal eschar, ______ cough, ______ chest pain, ______ hemoptysis, ______ dyspnea, ______ erythematous macule over skin, ______ necrotic skin eschar, ______ GI bleeding- upper/lower, ______ GI perforation, ______ typhilitis, ______ Sepsis

- Radiological findings:
  - CT/MRI brain with/without paranasal sinuses
  - CT thorax
  - X-ray chest
  - CT abdomen
  - USG of abdomen