CASE REPORT FORM

BioFire® FilmArray®
Gastrointestinal Panel

Thank you for sharing your case with BioFire! Please fill out to the best of your ability. At the end of the form, provide your electronic signature, and the submit button will populate an email for submission to marketingassistants@biofiredx.com.

Patient demographics

Geographical location (List state only) _____

☐ Male ☐ Female ☐ Urban ☐ Community

Age _____

Relevant medical history

Co-morbidities (Please list)

Current illness (Chief complaints and observations)

Duration of symptoms: _____

Physical exam (Include abnormal findings, vital signs, if known)

Heart rate _____ Blood pressure _____

Temperature _____ spO2 _____

Respiratory rate _____ Other _____

Abnormal findings _____

Legend:
Y=yes
N=no
UNK=unknown
P=positive
N=negative

BIOFIRE® BY BIOMÉRIEUX

Related procedures (If applicable)

Abdominal radiology ○ Yes ○ No _____

Endoscopy ○ Yes ○ No _____

Non-abdominal radiology ○ Yes ○ No _____

Other related procedures ○ Yes ○ No _____

BioFire GI Panel results

☐ *Campylobacter*	☐ Enteroaggregative *E.coli* (EAEC)	☐ Norovirus GI/GII
☐ *Clostridium difficile*	☐ Enteropathogenic *E.coli* (EPEC)	☐ Rotavirus A
☐ *Plesiomonas shigelloides*	☐ Enterotoxigenic *E.coli* (ETEC) *lt/st*	☐ Sapovirus (I, II, IV, and V)
☐ *Salmonella*	☐ Shiga-like toxin-producing *E.coli* (STEC) *stx1/stx2*	☐ *Cryptosporidium*
☐ *Vibrio*	☐ *E.coli* O157	☐ *Cyclospora cayetanensis*
☐ *Vibrio cholerae*	☐ *Shigella*/Enteroinvasive *E.coli* (EIEC)	☐ *Entamoeba histolytica*
☐ *Yersinia enterocolitica*	☐ Adenovirus F40/41	☐ *Giardia lamblia*
☐ Diarrheagenic *E.coli/Shigella*	☐ Astrovirus	

Other diagnostics ordered and results

Impression (Including 1–3 differential diagnoses)

1. _____

2. _____

3. _____

Treatment & duration

Empiric antimicrobial regimen: _____

Antimotility therapy initiated ○ Yes ○ No

Bacterial (If applicable): _____

Viral (If applicable): _____

Fungal (If applicable): _____

Steroid therapy initiated ○ Yes ○ No

Initiation/alteration of initial therapy based on BioFire GI Panel result (If applicable): _____

Initiation/alteration of initial therapy based on culture (If applicable): _____

Initiation/alteration of therapy based on other test (If applicable): _____

Infection control

Was patient placed in isolation before BioFire GI Panel result? ☐ Yes ☐ No Duration _____

Was patient placed in isolation after BioFire GI Panel result? ☐ Yes ☐ No Duration _____

Was patient removed from isolation based on BioFire GI Panel result? ☐ Yes ☐ No Duration _____

Comment or rationale for infection control:

Outcomes

Please give a description of the patient's progression or clinical courses given.

Did the BioFire GI Panel impact patient care? If so, please explain.

Facility description (Check all that apply that best describes your facility)

☐ Tertiary care hospital ☐ Teaching hospital ☐ University hospital

☐ Community hospital ☐ Urgent care center ☐ Emergency center

☐ Clinic ☐ Physician office ☐ Other _____

☐ Adults/pediatrics ☐ Adults only ☐ Pediatrics only

Facility size (Number of beds) _____

Location (List state only) _____

Legal authorization to provide non-PHI data (Data use: check all that are permitted)

☐ Case report for BioFire internal training purposes only

☐ Case report for BioFire customer-facing materials

Please list any other restrictions: _____

Can we use geographical region of facility: ☐ Yes ☐ No

If yes, please select from the following US regions:

☐ Northeast ☐ Mid-Atlantic ☐ Southeast

☐ Midwest ☐ Gulf States ☐ Southwest

☐ Pacific Northwest ☐ Other (Specify) _____

Would you be interested in presenting your case as a poster with a short presentation? ☐ Yes ☐ No

Where? _____

Would you be interested in publishing your case? ☐ Yes ☐ No

What journal? _____

By providing this information, I and my institution agree that the information contained in this Case Report Form may be used by BioFire Diagnostics, LLC (BioFire) for marketing purposes, subject to the following limitations (if any):

Please omit the following information from any marketing use by BioFire:

☐ Physician specialty

☐ Type of hospital/facility (Size, teaching hospital, etc.)

☐ Year of case

☐ Location (List state only)

I also represent and warrant that I have the authority to permit BioFire to use the information contained herein.
I understand that all identifying patient information will be removed prior to submission of this form to BioFire.

Name: _____ Signature: _____

SUBMIT FORM

BIOFIRE®
BY BIOMÉRIEUX