CASE REPORT FORM

BioFire® FilmArray®
Blood Culture Identification 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)

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

Heart rate _____ Blood pressure _____

Temperature _____ spO2 _____

Respiratory rate _____ SOFA score _____

Abnormal findings _____

Imaging (If applicable)

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

BIOFIRE
BY BIOMÉRIEUX

BioFire BCID Panel Results (Check all that apply)

- ☐ *Acinetobacter baumannii*
- ☐ *Enterobacteriaceae*
- ☐ *Enterobacter cloacae* complex
- ☐ *Escherichia coli*
- ☐ *Klebsiella oxytoca*
- ☐ *Klebsiella pneumoniae*
- ☐ *Proteus*
- ☐ *Serratia marcescens*
- ☐ *Haemophilus influenzae*
- ☐ *Neisseria meningitidis*
- ☐ *Pseudomonas aeruginosa*
- ☐ *Enterococcus*
- ☐ *Listeria monocytogenes*
- ☐ *Staphylococcus*
- ☐ *Staphylococcus aureus*
- ☐ *Streptococcus*
- ☐ *Streptococcus agalactiae*
- ☐ *Streptococcus pneumoniae*
- ☐ *Streptococcus pyogenes*
- ☐ *Candida albicans*
- ☐ *Candida glabrata*
- ☐ *Candida krusei*
- ☐ *Candida parapsilosis*
- ☐ *Candida tropicalis*
- ☐ KPC – carbapenem resistance
- ☐ *mecA* – methicillin resistance
- ☐ *vanA/B* – vancomycin resistance

Other BioFire® FilmArray® Panels _____

Other diagnostics ordered and results

Gram stain results: _____

CBC results: _____

Culture results: _____

Antimicrobial susceptibility results: _____

Other testing conducted for pathogen identification: _____

Impression (Including 1–3 differential diagnoses)

1. _____
2. _____
3. _____

Treatment

Initial antimicrobial therapy: _____

Describe the rational for therapy (e.g. risk factors for MRSA):

_____

_____

Steroid therapy initiated ○ Yes ○ No

Was antimicrobial therapy initiated prior to sample collection? ○ Yes ○ No

Change to antimicrobial therapy: _____

Describe the rational for the change (e.g. change in clinical picture or diagnostic results):

Intervention

Was there an antimicrobial stewardship intervention? If so, please provide details.

Infection Control

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

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

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

Outcomes

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

Did the results of the BioFire BCID Panel impact patient management? 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