

## University Hospital Cologne - ECMM European Excellence Center for Invasive Fungal Infections – Myco-Board Request Form

Request from

Date:

|                     |  |
|---------------------|--|
| Hospital/Department |  |
| Physician name      |  |
| Email               |  |
| Phone number        |  |

Urgent consultation? ☐ Yes ☐ NoHas this patient been discussed previously? ☐ Yes ☐ No

Date of prior consultation:

|                                  |
|----------------------------------|
| Question for the case conference |
|                                  |

Do you require a microbiological assessment? ☐ Yes ☐ NoDo you require a histopathological assessment? ☐ Yes ☐ NoDo you require radiological case presentation? ☐ Yes ☐ No

If yes, please provide access to imaging data or present the images yourself.

Do you require a surgical assessment? ☐ Yes ☐ No

Please note: the University Hospital of Cologne ECMM Excellence Center **Myco-Board is every Monday at 2.30 – 3.30 pm (CET / CEST) online via Zoom Conference** – please be available in that timeframe to discuss your case or send a colleague. Login Data will be provided a few hours before start via e-mail to the requesting person.

## Patient Data

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| Weight/height<br>.....kg .....cm                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | Sex: <input type="checkbox"/> female <input type="checkbox"/> male <input type="checkbox"/> other |
| Reason for admission (if applicable)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Date of admission:                                                                                |
| If relevant: underlying hematologic/oncologic disease:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                   |
| (suspected) invasive fungal disease diagnosis:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                   |
| Short epicrisis and current signs/symptoms for fungal infection                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                   |
| Risk factors for fungal infection:<br><br>Neutropenia? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Hematologic malignancy? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>SOT recipient? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Allogeneic stem cell transplantation? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Prolonged (i.e. > 2 weeks) use of corticosteroids? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Treatment with T-cell immunosuppressants? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Treatment with B-cell immunosuppressants? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Inherited severe immunodeficiency? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Acute graft-versus-host disease grade III or IV? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Influenza? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>COVID-19? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Moderate/severe COPD? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Decompensated liver cirrhosis? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>HIV with CD4 cell count < 200/mm <sup>3</sup> ? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Solid tumors? <input type="checkbox"/> Yes <input type="checkbox"/> No |                                                                                                   |
| Current Immunosuppressive medication regimen:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                   |

## Diagnostics

Identified fungal pathogens:

Please limit the following list to invasive fungal diseases.  
Results can be entered in the list or attached.

| Sampling date | Material | Results (culture, PCR, histopathology, direct microscopy) |
|---------------|----------|-----------------------------------------------------------|
|               |          |                                                           |
|               |          |                                                           |
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|               |          |                                                           |
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|               |          |                                                           |
|               |          |                                                           |

| Sampling date | Biomarker | Serology |
|---------------|-----------|----------|
|               |           |          |
|               |           |          |
|               |           |          |
|               |           |          |

| Date | Imaging Modality | Body site | Finding |
|------|------------------|-----------|---------|
|      |                  |           |         |
|      |                  |           |         |
|      |                  |           |         |
|      |                  |           |         |
|      |                  |           |         |
|      |                  |           |         |

## Treatment

| Antifungal treatment |           |      |                       |                                              |
|----------------------|-----------|------|-----------------------|----------------------------------------------|
| Start date           | Stop date | Drug | Treatment/Prophylaxis | Therapeutic Drug Monitoring results and date |
|                      |           |      |                       |                                              |
|                      |           |      |                       |                                              |
|                      |           |      |                       |                                              |
|                      |           |      |                       |                                              |
|                      |           |      |                       |                                              |

Please indicate if there are any suspected side effects: .....

## Additional Interventions

| Date | Adjunct treatments |  |
|------|--------------------|--|
|      |                    |  |
|      |                    |  |
|      |                    |  |
|      |                    |  |