Mucormycosis Surveillance Reporting Format
Department of Health Services
Epidemiology and Disease Control Division

Reporting institute/state/districts:
Reported by:

s.no	Date	Name	Age	Gender (M/F/O)	Date of PCR positive for COVID-19	Date of Admission	Number of days in facility (during COVID- 19 Treatment)	Mucormycosis type	Date of Diagnosis	Comorbidity/ Risk factors	Lab findings	Status /outcome	Remarks

Mucormycosis type: 1.Rhino-orbital-cerebral, 2.Cutaneous, 3.Pulmonary, 4.Gastrointestinal, 5.Disseminated

Comorbidity/Risk factors: 1. Uncontrolled Diabetes mellitus, 2. Hematologic disease, 3. Prolonged neutropenia, 4. Prolonged ICU stay, 5. Post-transplant/malignancy, 6. Kidney disease, 7. Heart disease, 8. High dose Steroid therapy during treatment of COVID, 9. Broad spectrum antibiotic for more than 7 days during COVID infection, 10. Any other, 11. None identified

Status/ outcome: Improving, Deteriorating, Discharged, Death

Please provide this reporting to ewarsedcd@gmail.com