



EMERGING INFECTIONS PROGRAM  
EXTRAPULMONARY NONTUBERCULOUS MYCOBACTERIA  
(NTM) SURVEILLANCE CASE REPORT FORM - 2025

Patient's Name:		Phone no. (      )	
Address:		MRN:	
City:	State:	ZIP:	Facility:

-PATIENT IDENTIFIER INFORMATION IS NOT TRANSMITTED TO CDC-

1. STATE: _____	2. COUNTY: _____	3. STATE ID: _____	4. PATIENT ID: _____	5. LABORATORY ID WHERE NTM INITIALLY IDENTIFIED: _____	6. PROVIDER ID WHO ORDERED INDEX SPECIMEN COLLECTION: _____																
7. DATE OF BIRTH: ____-____-____		8. AGE: _____ <input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Yrs		9. SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Missing value																	
10. RACE AND/OR ETHNICITY: (Check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Unknown																					
11. WEIGHT: _____ lbs. _____ oz. OR _____ kg <input type="checkbox"/> Unknown		12. HEIGHT: _____ ft. _____ in. OR _____ cm <input type="checkbox"/> Unknown		13. BMI: (record only if height or weight is not available) _____ <input type="checkbox"/> Unknown																	
14. DATE OF EXTRAPULMONARY INDEX SPECIMEN COLLECTION (DISC): ____-____-____ <input type="checkbox"/> Unknown																					
15. LOCATION OF EXTRAPULMONARY INDEX SPECIMEN COLLECTION: <table><tr><td><input type="checkbox"/> <b>OUTPATIENT:</b> Facility ID: _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Dialysis center <input type="checkbox"/> Surgery <input type="checkbox"/> Observational/Clinical decision unit <input type="checkbox"/> Other outpatient</td><td><input type="checkbox"/> <b>INPATIENT:</b> Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient</td><td><input type="checkbox"/> <b>LTCF:</b> Facility ID: _____ <input type="checkbox"/> <b>LTACH:</b> Facility ID: _____ <input type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> <b>Other</b> <input type="checkbox"/> <b>Unknown</b></td></tr></table>						<input type="checkbox"/> <b>OUTPATIENT:</b> Facility ID: _____ <input type="checkbox"/> Emergency room <input type="checkbox"/> Clinic/Doctor's office <input type="checkbox"/> Dialysis center <input type="checkbox"/> Surgery <input type="checkbox"/> Observational/Clinical decision unit <input type="checkbox"/> Other outpatient	<input type="checkbox"/> <b>INPATIENT:</b> Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient	<input type="checkbox"/> <b>LTCF:</b> Facility ID: _____ <input type="checkbox"/> <b>LTACH:</b> Facility ID: _____ <input type="checkbox"/> <b>Autopsy</b> <input type="checkbox"/> <b>Other</b> <input type="checkbox"/> <b>Unknown</b>													
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16. EXTRAPULMONARY INDEX SPECIMEN COLLECTION SITE (Check all that apply): <table><tr><td><input type="checkbox"/> Blood</td><td><input type="checkbox"/> Muscle</td><td><input type="checkbox"/> Skin</td><td><input type="checkbox"/> Wound, non-surgical</td></tr><tr><td><input type="checkbox"/> Bone</td><td><input type="checkbox"/> Pericardial fluid</td><td><input type="checkbox"/> Soft tissue</td><td><input type="checkbox"/> Wound, surgical</td></tr><tr><td><input type="checkbox"/> Joint/Synovial fluid</td><td><input type="checkbox"/> Peritoneal fluid</td><td><input type="checkbox"/> Urine</td><td><input type="checkbox"/> Other site: _____</td></tr><tr><td><input type="checkbox"/> Lymph node: _____</td><td><input type="checkbox"/> Pleural fluid</td><td></td><td></td></tr></table>						<input type="checkbox"/> Blood	<input type="checkbox"/> Muscle	<input type="checkbox"/> Skin	<input type="checkbox"/> Wound, non-surgical	<input type="checkbox"/> Bone	<input type="checkbox"/> Pericardial fluid	<input type="checkbox"/> Soft tissue	<input type="checkbox"/> Wound, surgical	<input type="checkbox"/> Joint/Synovial fluid	<input type="checkbox"/> Peritoneal fluid	<input type="checkbox"/> Urine	<input type="checkbox"/> Other site: _____	<input type="checkbox"/> Lymph node: _____	<input type="checkbox"/> Pleural fluid		
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<input type="checkbox"/> Lymph node: _____	<input type="checkbox"/> Pleural fluid																				
16a. <input type="checkbox"/> Index specimen(s) detected solely via multiplex/NGS lab-developed test?				17. FINAL RESULT DATE: ____-____-____																	
18. NTM SPECIES IDENTIFIED FROM EXTRAPULMONARY INDEX SPECIMEN: <table><tr><td><input type="checkbox"/> <b>M. avium complex (MAC)</b> <input type="checkbox"/> M. avium (AVI) <input type="checkbox"/> M. intracellulare subsp. chimaera (CHIM) <input type="checkbox"/> M. intracellulare subsp. intracellulare (INT) <input type="checkbox"/> Other MAC, specify: _____ (MOTH) <input type="checkbox"/> MAC, not otherwise specified (MND)</td><td><input type="checkbox"/> <b>Non-M. avium complex (NMAC)</b> <input type="checkbox"/> M. abscessus (ABS) <input type="checkbox"/> M. abscessus subsp. abscessus <input type="checkbox"/> M. abscessus subsp. bolletii <input type="checkbox"/> M. abscessus subsp. massiliense <input type="checkbox"/> M. abscessus subsp. identification not performed <input type="checkbox"/> M. chelonae complex (CHEL) <input type="checkbox"/> M. fortuitum complex (FOR) <input type="checkbox"/> M. kansasii complex (KAN) <input type="checkbox"/> M. marinum (MAR) <input type="checkbox"/> Other non-MAC, specify: _____ (NOTH) <input type="checkbox"/> Non-MAC, not otherwise specified (NND)</td><td><input type="checkbox"/> <b>Not TB, not characterized further (NTB)</b></td></tr></table>						<input type="checkbox"/> <b>M. avium complex (MAC)</b> <input type="checkbox"/> M. avium (AVI) <input type="checkbox"/> M. intracellulare subsp. chimaera (CHIM) <input type="checkbox"/> M. intracellulare subsp. intracellulare (INT) <input type="checkbox"/> Other MAC, specify: _____ (MOTH) <input type="checkbox"/> MAC, not otherwise specified (MND)	<input type="checkbox"/> <b>Non-M. avium complex (NMAC)</b> <input type="checkbox"/> M. abscessus (ABS) <input type="checkbox"/> M. abscessus subsp. abscessus <input type="checkbox"/> M. abscessus subsp. bolletii <input type="checkbox"/> M. abscessus subsp. massiliense <input type="checkbox"/> M. abscessus subsp. identification not performed <input type="checkbox"/> M. chelonae complex (CHEL) <input type="checkbox"/> M. fortuitum complex (FOR) <input type="checkbox"/> M. kansasii complex (KAN) <input type="checkbox"/> M. marinum (MAR) <input type="checkbox"/> Other non-MAC, specify: _____ (NOTH) <input type="checkbox"/> Non-MAC, not otherwise specified (NND)	<input type="checkbox"/> <b>Not TB, not characterized further (NTB)</b>													
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19. WERE MICROBIOLOGICAL TESTS OF EXTRAPULMONARY SPECIMENS POSITIVE FOR NTM IN THE 12 MONTHS BEFORE THE DISC?

- ☐ No microbiological tests, and NO medical record documentation that infection was present →INCIDENT CASE
- ☐ No microbiological tests, but medical record documentation indicates infection WAS PRESENT →PREVALENT CASE
- ☐ Yes→PREVALENT CASE (complete table below)
- ☐ Unknown

IF YES, INDICATE SITE(S), DATE(S) OF COLLECTION, AND SPECIES:

	Date #1	Species	Date #2	Species	Date #3	Species
<input type="checkbox"/> Site #1:	- -		- -		- -	
<input type="checkbox"/> Site #2:	- -		- -		- -	
<input type="checkbox"/> Site #3:	- -		- -		- -	
<input type="checkbox"/> Site #4:	- -		- -		- -	
<input type="checkbox"/> Site #5:	- -		- -		- -	

20. IF EXTRAPULMONARY NTM ISOLATE(S) SENT TO CDC, ISOLATE IDs: 1. 2.

21. NTM ANTIMICROBIAL SUSCEPTIBILITY TEST (AST) RESULTS: ☐ None ☐ Unknown

LABORATORY ID WHERE AST TESTING PERFORMED:

NTM SPECIES: DATE OF COLLECTION: - - -

NON-MOLECULAR METHODS:

Antimicrobial	Test method	If BMD enter MIC (mg/ml)	Interpretation
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
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	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
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	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown
	<input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth <input type="checkbox"/> Unk	or <input type="checkbox"/> Unk	<input type="checkbox"/> S <input type="checkbox"/> I <input type="checkbox"/> R <input type="checkbox"/> Unknown

MOLECULAR METHODS:			
Gene name	Test method	Result	Interpretation
<input type="checkbox"/> <i>erm</i> <input type="checkbox"/> <i>rpoB</i> <input type="checkbox"/> <i>rrl</i> <input type="checkbox"/> <i>rrs</i> <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Line Probe <input type="checkbox"/> PCR <input type="checkbox"/> Sanger Sequencing <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Gene absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Mutations/variants, specify: _____ <input type="checkbox"/> Other abnormal result, specify: _____ <input type="checkbox"/> No abnormal results <input type="checkbox"/> Unknown	<input type="checkbox"/> Suggests resistance/ Resistance is predicted <input type="checkbox"/> Suggests susceptibility/ Resistance not predicted <input type="checkbox"/> Other interpretation, specify: _____ <input type="checkbox"/> Unknown
<input type="checkbox"/> <i>erm</i> <input type="checkbox"/> <i>rpoB</i> <input type="checkbox"/> <i>rrl</i> <input type="checkbox"/> <i>rrs</i> <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Line Probe <input type="checkbox"/> PCR <input type="checkbox"/> Sanger Sequencing <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Gene absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Mutations/variants, specify: _____ <input type="checkbox"/> Other abnormal result, specify: _____ <input type="checkbox"/> No abnormal results <input type="checkbox"/> Unknown	<input type="checkbox"/> Suggests resistance/ Resistance is predicted <input type="checkbox"/> Suggests susceptibility/ Resistance not predicted <input type="checkbox"/> Other interpretation, specify: _____ <input type="checkbox"/> Unknown
<input type="checkbox"/> <i>erm</i> <input type="checkbox"/> <i>rpoB</i> <input type="checkbox"/> <i>rrl</i> <input type="checkbox"/> <i>rrs</i> <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Line Probe <input type="checkbox"/> PCR <input type="checkbox"/> Sanger Sequencing <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Gene absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Mutations/variants, specify: _____ <input type="checkbox"/> Other abnormal result, specify: _____ <input type="checkbox"/> No abnormal results <input type="checkbox"/> Unknown	<input type="checkbox"/> Suggests resistance/ Resistance is predicted <input type="checkbox"/> Suggests susceptibility/ Resistance not predicted <input type="checkbox"/> Other interpretation, specify: _____ <input type="checkbox"/> Unknown
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<b>22. DID THE PATIENT RECEIVE CARE FROM OR WERE THEY REFERRED TO A SPECIALIST FOR NTM EVALUATION OR MANAGEMENT WITHIN 12 MONTHS BEFORE TO 90 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?</b> (Check all that apply): <input type="checkbox"/> Infectious diseases specialist <input type="checkbox"/> Pulmonary specialist <input type="checkbox"/> Surgeon <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown			<b>22a. WERE ANY REFERRALS WITHIN 12 MONTHS BEFORE TO 30 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>23. DID THE PATIENT UNDERGO SURGERY TO MANAGE NTM INFECTION ON THE DISC THROUGH 90 DAYS OF INDEX SPECIMEN RESULT DATE?</b> <input type="checkbox"/> Yes; specify type of surgery: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown			
<b>24. NTM SIGNS &amp; SYMPTOMS IN THE 14 DAYS BEFORE THE DISC</b> (Check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Redness or swelling <input type="checkbox"/> Cough <input type="checkbox"/> Pain at infection site <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue or malaise <input type="checkbox"/> Positive imaging <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Fever <input type="checkbox"/> Pus, drainage, abscess		<b>25. CLINICIAN-DIAGNOSED EXTRAPULMONARY NTM DISEASE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>25a.</b> <input type="checkbox"/> Contamination or colonization suspected <b>26. WERE MICROBIOLOGICAL TESTS OF PULMONARY SPECIMENS POSITIVE FOR NTM IN THE 12 MONTHS BEFORE THE DISC THROUGH 90 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>27. IMMUNOSUPPRESSIVE MEDICATION IN THE 90 DAYS BEFORE THE DISC</b> (Check all that apply): <input type="checkbox"/> None of the below <input type="checkbox"/> Unknown <input type="checkbox"/> Abatacept/Orencia <input type="checkbox"/> Checkpoint inhibitor <input type="checkbox"/> IL-6 blocker <input type="checkbox"/> JAK inhibitor <input type="checkbox"/> S1PR modulator <input type="checkbox"/> Tacrolimus <input type="checkbox"/> Azathioprine <input type="checkbox"/> Cyclophosphamide <input type="checkbox"/> IL-17 inhibitor <input type="checkbox"/> Mycophenolate <input type="checkbox"/> Steroid, IV, IM, or oral <input type="checkbox"/> TNF-α inhibitor <input type="checkbox"/> B cell depletion agent <input type="checkbox"/> Deucravacitinib <input type="checkbox"/> IL-23 blocker <input type="checkbox"/> Other chemotherapy			



Other Substances (Check all that apply):

☐ None

☐ Unknown

Documented Use Disorder (DUD/Abuse):

☐ Marijuana, cannabinoid (other than smoking)

☐ Opioid, DEA schedule I (e.g., Heroin)

☐ Opioid, DEA schedule II-IV (e.g., methadone, oxycodone)

☐ Opioid, NOS

☐ Cocaine

☐ Methamphetamine

☐ Other (specify): \_\_\_\_\_

☐ Unknown substance

☐ DUD or abuse

☐ DUD or abuse

☐ DUD or abuse

☐ DUD or abuse

☐ DUD or abuse

☐ DUD or abuse

☐ DUD or abuse

Mode of Delivery (Check all that apply):

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

☐ IDU☐ Skin popping☐ Non-IDU☐ Unknown

During the current hospitalization did the patient receive medication assisted treatment (MAT) for opioid use disorder?

☐ Yes

☐ No

☐ N/A (patient did not have DUD)

33. IS CASE ASSOCIATED WITH A KNOWN OUTBREAK?

☐ Yes

☐ No

If yes, indicate outbreak source: \_\_\_\_\_ Date of exposure: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ OR ☐ Date unknown

State: \_\_\_\_\_ OR Country of exposure: \_\_\_\_\_ ☐ Unknown

34. FOR NON-OUTBREAK CASES, INDICATE EXPOSURES DOCUMENTED IN MEDICAL RECORDS IN THE 12 MONTHS BEFORE THE DISC:

☐ Not applicable—OUTBREAK case

☐ None

☐ Unknown

At site of infection?	At site of infection?
<div><input type="checkbox"/> Bird contact</div>	<div><input type="checkbox"/> Livestock</div>
<div><input type="checkbox"/> Construction</div>	<div><input type="checkbox"/> Medical device/ Implant<div><div><input type="checkbox"/> Yes</div><div><input type="checkbox"/> No</div><div><input type="checkbox"/> Unknown</div></div>If yes, specify device:<div><div><input type="checkbox"/> Cardiac device<input type="checkbox"/> Drain<input type="checkbox"/> Ear tube(s)</div><div><input type="checkbox"/> G tube<input type="checkbox"/> Orthopedic implant/hardware</div><div><input type="checkbox"/> PD catheter<input type="checkbox"/> Urinary catheter</div><div><input type="checkbox"/> Other: _____</div><div><input type="checkbox"/> Unknown</div></div>Date device implanted ____ - ____ - ____ <input type="checkbox"/> Unknown</div>

| ☐ Cystic fibrosis clinic |  |
| ☐ Dental procedure ☐ Yes  ☐ No  ☐ Unknown If yes, specify procedure: \_\_\_\_\_ ☐ Unknown  Date of procedure \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ☐ Unknown |

  || ☐ Fish tank |  |
| ☐ Gardening or landscaping | ☐ Nail salon ☐ Yes  ☐ No  ☐ Unknown If yes, date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ☐ Unknown |

☐ Homelessness	
☐ Hot tub	☐ Neti pot ☐ Yes  ☐ No  ☐ Unknown
☐ Humidifier use	☐ Nursing home residence
☐ Injection drug use ☐ Yes  ☐ No  ☐ Unknown ☐ Other injection ☐ Yes  ☐ No  ☐ Unknown If yes, substance injected: \_\_\_\_\_ ☐ Unknown  Date of injection \_\_\_\_ - \_\_\_\_ - \_\_\_\_ ☐ Unknown  Purpose: ☐ Medical ☐ non-Medical ☐ Unknown  If medical, administered by: ☐ Medical professional  ☐ Self  ☐ Unknown	

<b>34a. FOR NON-OUTBREAK CASES WITH AN IV INFUSION AND/ OR A HEALTHCARE PROCEDURE AT THE SITE OF INFECTION (E.G., DENTAL PROCEDURE, OTHER INJECTION, SURGERY, OTHER HEALTHCARE EXPOSURE), DID ANY OCCUR OUTSIDE THE PATIENT'S STATE OF RESIDENCE?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (no IV infusion or healthcare procedure at site of infection) <input type="checkbox"/> Unknown  If yes, which exposure(s)? <input type="checkbox"/> Dental procedure <input type="checkbox"/> Other injection <input type="checkbox"/> Intravenous (IV) infusion <input type="checkbox"/> Surgical procedure <input type="checkbox"/> Other: _____ State: _____ and/or Country of exposure: _____ <input type="checkbox"/> Unknown				
<b>34b. FOR NON-OUTBREAK CASES, WERE ANY EXPOSURES &gt;12 MONTHS BEFORE THE DISC DOCUMENTED IN THE MEDICAL RECORD AS ASSOCIATED WITH INFECTION?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable—OUTBREAK case <input type="checkbox"/> Unknown If yes, specify: _____ Date of exposure: ____ - ____ - ____ <input type="checkbox"/> Unknown At site of infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown State _____ OR Country of exposure: _____ <input type="checkbox"/> Unknown				
<b>35. DID THE PATIENT HAVE A POSITIVE TEST(S) FOR SARS-CoV-2 (MOLECULAR ASSAY, ANTIGEN, OR OTHER VIRAL TEST; EXCLUDING SEROLOGY) IN THE 90 DAYS BEFORE OR DAY OF THE DISC?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>SPECIMEN COLLECTION DATES FOR POSITIVE TESTS IN THE 90 DAYS BEFORE OR DAY OF DISC:</b>  FIRST POSITIVE TEST: ____ - ____ - ____ OR <input type="checkbox"/> Date unknown  MOST RECENT POSITIVE TEST: ____ - ____ - ____ OR <input type="checkbox"/> Date unknown		
<b>36. WAS CASE FIRST IDENTIFIED THROUGH AUDIT?</b>  <input type="checkbox"/> Yes  <input type="checkbox"/> No  <input type="checkbox"/> Unknown	<b>37. CRF STATUS</b>  <input type="checkbox"/> Complete <input type="checkbox"/> Pending <input type="checkbox"/> Chart unavailable after 3 requests	<b>38. WAS PATIENT PREVIOUSLY REPORTED TO HAIC NTM SURVEILLANCE?</b>  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  <b>IF YES, PREVIOUS (1ST) STATEID:</b> _____	<b>39. DATE OF ABSTRACTION:</b> ____ - ____ - ____	<b>40. SO INITIALS:</b> _____
<b>41. COMMENTS:</b>				



<input type="checkbox"/> <i>erm</i> <input type="checkbox"/> <i>rpoB</i> <input type="checkbox"/> <i>rrl</i> <input type="checkbox"/> <i>rrs</i> <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Line Probe <input type="checkbox"/> PCR <input type="checkbox"/> Sanger Sequencing <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Gene absent	<input type="checkbox"/> Indeterminate <input type="checkbox"/> Mutations/variants, specify: _____ <input type="checkbox"/> Other abnormal result, specify: _____ <input type="checkbox"/> No abnormal results <input type="checkbox"/> Unknown	<input type="checkbox"/> Suggests resistance/ Resistance is predicted <input type="checkbox"/> Suggests susceptibility/ Resistance not predicted <input type="checkbox"/> Other interpretation, specify: _____ <input type="checkbox"/> Unknown
<input type="checkbox"/> <i>erm</i> <input type="checkbox"/> <i>rpoB</i> <input type="checkbox"/> <i>rrl</i> <input type="checkbox"/> <i>rrs</i> <input type="checkbox"/> Other, specify: _____	<input type="checkbox"/> Line Probe <input type="checkbox"/> PCR <input type="checkbox"/> Sanger Sequencing <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Gene absent	<input type="checkbox"/> Indeterminate <input type="checkbox"/> Mutations/variants, specify: _____ <input type="checkbox"/> Other abnormal result, specify: _____ <input type="checkbox"/> No abnormal results <input type="checkbox"/> Unknown	<input type="checkbox"/> Suggests resistance/ Resistance is predicted <input type="checkbox"/> Suggests susceptibility/ Resistance not predicted <input type="checkbox"/> Other interpretation, specify: _____ <input type="checkbox"/> Unknown

[illegible]