**Extrapulmonary Non-tuberculous Mycobacterial Infection Surveillance Form**

Please complete for any patient meeting the following case definition and return to the Healthcare Associated Infections & Antimicrobial Resistance team, Tennessee Department of Health

* *Mycobacterium avium complex, M. intracellulare, or M. chimaera* endocarditis, surgical site infection, or disseminated infection

AND

* Who has had cardiopulmonary bypass (cardiothoracic surgery or any other procedure involving the use of a heater-cooler unit) in the 6 years prior to symptom onset

|  |  |
| --- | --- |
| Name of Reporter |  |
| Facility |  |
| Email Address |  |
| Phone |  |
| Date Completed  |  |
| **Patient Details** |
| First Name |  | Last Name |  |
| Date of Birth |  | Sex: Male □ Female □ |
| **Clinical Details** |
|  | Check all that apply | Date of Presentation and Comments |
| Localized Infection |  |  |
|  Endocarditis |  |  |
|  Prosthetic valve endocarditis |  |  |
|  Prosthetic vascular graft infection |  |  |
|  Deep wound infection |  |  |
|  Superficial wound infection |  |  |
|  Mediastinitis |  |  |
| Other deep organ space infection (e.g., empyema, pocket infection around LVAD or other implantable device); SPECIFY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |
| Disseminated infection |  |  |
|  Bacteremia |  |  |
| Embolic or immunologic manifestations (e.g., splenomegaly, arthritis, osteomyelitis, bone marrow involvement with cytopenia, chorioretinitis, cerebral vasculitis, myocarditis, hepatitis, nephritis);SPECIFY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |

Please fax completed forms to the Tennessee Department of Health at 615-741-3857

|  |
| --- |
| **Patient Outcome** |
| Still Ill | Yes □ No □ |
| Died | Yes □ No □ | If yes, when? / /  |
| Recovered | Yes □ No □ |  |  |  |
| Was death attributable to mycobacterial infection? | Yes □ No □ |  |  |  |
| **Laboratory Results: Please include first mycobacterial culture and all instances where mycobacteria were identified from invasive specimens (i.e. blood culture, valve)** |
| Date of Specimen | Specimen Source | Organism Identified | How was the organism identified? (e.g. PCR, culture) | Name of Laboratory |
|  |  | *Mycobacterium chimaera* □*M. intracellulare* □*M. avium-intracellulare-scrofulaceum* □*Other, specify:* □*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  |  |
|  |  | *Mycobacterium chimaera* □*M. intracellulare* □*M. avium-intracellulare-scrofulaceum* □*Other, specify:* □*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  |  |
|  |  | *Mycobacterium chimaera* □*M. intracellulare* □*M. avium-intracellulare-scrofulaceum* □*Other, specify:* □*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |  |  |
| **Exposures: Please note exposure(s) to cardiopulmonary bypass during the previous 6 years.** |
| Yes □ No □ If yes, please detail all surgical procedures involving cardiopulmonary bypass that occurred before mycobacterial infection diagnosis |
| Date of Surgery | Hospital | Surgical Procedure | Was an implant used (Y/N) | Heater-Cooler make and model | Date Unit was inserviced | Machine Test Results |
|  / / |  |  |  |  |  |  |
|  / / |  |  |  |  |  |  |
|  / / |  |  |  |  |  |  |
| If patient had a graft or implant above, please specify:  |

Form filled out by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /20

Please fax completed forms to the Tennessee Department of Health at 615-741-3857