**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

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