County of Los Angeles Public Health

EXTRAPULMONARY NON-TUBERCULOUS MYCOBACTERIUM (NTM) REPORT FORM

Fax completed form and laboratory results to Morbidity Unit at (888) 397-3778

PATIENT INFORMATION

Patient Name- Last, First	Facility name (if not living at home):	Date of birth	Age

Address- Number, Street, Apt #	City of Residence	State	ZIP Code

Patient's current gender identity?
☐ Male ☐ Female
☐ Female-to-Male (FTM)/Transgender Male/Trans Man ☐ Male-to-Female (MTF)/Transgender Female/Trans Woman
☐ Genderqueer, neither exclusively male nor female ☐ Other: _____ ☐ Prefer not to state

Patient's sex at birth?
☐ Male ☐ Female ☐ Non-Binary or X
☐ Other: _____ ☐ Prefer not to answer

Patient's race or ethnicity? (check all that apply)
☐ White ☐ Hispanic/Latino/Spanish origin ☐ Black/African-American ☐ Asian ☐ American Indian/Alaskan Native ☐ Native Hawaiian/Other Pacific Islander
☐ Other: _____ ☐ Refused

CLINICAL INFORMATION

Onset date

Symptoms (check all that apply)
☐ Fever (≥37.8°C/100°F) ☐ Granulomas ☐ Lymphadenitis
☐ Bacteremia ☐ Sepsis ☐ Failure to thrive
☐ Fatigue ☐ Osteomyelitis ☐ Other: _____
☐ Surgical site infection ☐ Wound infection
☐ Cellulitis ☐ Weight loss

Site of infection (do NOT report pulmonary infections)
☐ Skin or soft tissue ☐ Blood
☐ Lymph node ☐ Other sterile site (e.g. spinal fluid, bone marrow, abdominal fluid, pleural fluid, bone): _____
☐ Urine ☐ Other: _____

LABORATORY INFORMATION

Accession Number	Specimen Collection Date	Result Date	Laboratory Name/Performing Facility

Specimen source:
☐ Skin or soft tissue ☐ Blood
☐ Lymph node ☐ Other sterile site (e.g. spinal fluid, bone marrow, abdominal fluid, pleural fluid, bone): _____
☐ Urine ☐ Other: _____

Organism identified:
☐ *Mycobacterium chelonae* ☐ *Mycobacterium fortuitum* ☐ Other (NOT *M. leprae*): _____
☐ *Mycobacterium avium* complex ☐ *Mycobacterium abscessus*

Testing Method: (check one only) ☐ Polymerase chain reaction (PCR) ☐ Culture ☐ Other: _____

HEALTHCARE-ASSOCIATED INFECTION

Did the case have surgery, health care injections or acupuncture at the site of infection? ☐ Yes ☐ No ☐ Unknown

REMARKS

Submitter's Name (print)	Date Completed	Telephone Number ( )

Facility Name	Email Address