

Extrapulmonary Nontuberculous Mycobacterial Disease

ORPHEUS

- confirmed
- presumptive
- no case

Name _____
LAST, first, initials (a.k.a.)

COUNTY _____

Address _____
Street City Zip

Special housing _____

Phone number _____ / _____
home (H), work (W), cell (C), message (M) home (H), work (W), cell (C), message (M)

ALTERNATIVE CONTACT

Name _____ Phone(s) _____
LAST, first, initials home (H), work (W), cell (C), message

DEMOGRAPHICS PROVIDERS, FACILITIES AND LABS

DOB / /
m d y
 if DOB unknown, AGE _____
 Sex female male
 Language _____
 Country of birth _____
 Worksites/school/day care center _____
 Occupation/grade _____

RACE (check all that apply)
 white
 black
 Asian
 Pacific Islander
 American Indian/Alaska Native
 unknown
 other _____
 HISPANIC
 Yes No
 unknown declined

Reporter _____ Type (circle one)
name and phone number
 PMD Lab-fax
 MDx Lab-phone
 ER Lab-other
 ICP HCP
 Lab-ELR
 Reporter _____ Type (circle one)
name and phone number
 PMD Lab-fax
 MDx Lab-phone
 ER Lab-other
 ICP HCP
 Lab-ELR
 Ok to contact patient (only list once)
 Local epi_name _____
 Date report received by LHD / /
 LHD completion date / /

BASIS OF DIAGNOSIS

CLINICAL DATA
 Onset date / /
 Symptomatic Y N unk
 Body site of NTM _____
 Lymphadenitis Y N unk
if yes, include location of lymphadenitis

 Fever ≥37.8°C (100.0°F) Y N unk
 Bacteremia Y N unk
 Fatigue Y N unk
 Weight loss Y N unk
OUTCOMES
 hospitalized overnight? Y N unk
 hospital name _____
 admission / /
 discharge / /
 survived died unk
 date of death / /
 Notes: _____

PRIVATE LAB DATA
 Specimen collection date / /
 Lab _____
 Specimen source
 blood urine wound lymph node
 other _____
 culture
 date of result / /
 PCR pos neg
 date of result / /
 Type of mycobacterium _____
PUBLIC HEALTH LAB DATA
 Isolate sent to PHL/CDC Y N unk
 PHL specimenID _____
 Type of mycobacterium _____
 PCR pos neg
 date of result / /

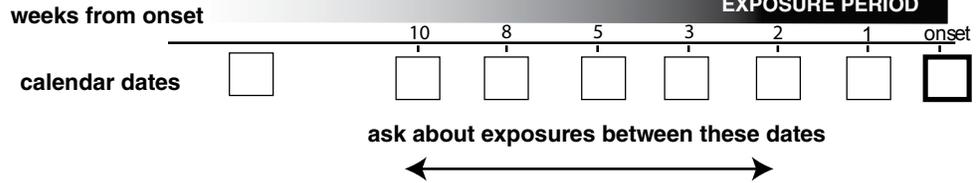
EPI LINKS
 At the time of initial report, case appears to be:
 sporadic Y N unk
 associated with a known outbreak?
 Y N unk
if yes, provide outbreak number

 Specify nature of link:
 salon spa hospital
 Have other cases been reported?
 Y N unk
if yes to any question, specify relevant names, dates, places, etc



INFECTION TIMELINE

Enter onset date in heavy box.
Count back to figure the probable
exposure period.



Interviewed yes no Interview date(s) _____ Interviewed by _____

Who patient provider parent other

case (or family proxy) could not be interviewed no risk factors identified

Interviewees case parent physician other HCP _____ Interview date(s) _____

RISKS

All questions except surgery refer to the 2 to 10-week exposure period. All "Potential Source" questions refer to exposure of the body site that has the NTM infection. "Where" refers to facility name or location.

POTENTIAL SOURCES

yes no ref unk

hot tub or spa

if yes, when ____ / ____ / ____

where _____

nail salon (manicure, pedicure, or waxing)

if yes, when ____ / ____ / ____

where _____

tattoo

if yes, when ____ / ____ / ____

where _____

fish tank

if yes, when ____ / ____ / ____

where _____

handle fish

if yes, when ____ / ____ / ____

where _____

work with purchased soil products

if yes, when ____ / ____ / ____

where _____

product name _____

trauma

if yes, when ____ / ____ / ____

where _____

POTENTIAL SOURCES

yes no ref unk

inject recreational drugs at infection site

other percutaneous procedures that broke skin (including piercing)

acupuncture or other needle exposure

if yes, when ____ / ____ / ____

where _____

health care injections or infusions

if yes, when ____ / ____ / ____

where _____

surgery (refers to any time before the NTM infection started)

if yes, when ____ / ____ / ____

where _____

immunosuppressive therapy (i.e. steroids, chemotherapy or monoclonal antibodies)

if yes, when ____ / ____ / ____

where _____

immunocompromised or immunosuppressive condition

(i.e., transplant, cancer, end-stage renal disease, liver disease, diabetes mellitus, other (specify) _____

if yes, when ____ / ____ / ____

where _____

yes no ref unk

health care associated infection

Mark yes, if case had surgery, health care injections or acupuncture at the site of infection



FOLLOW UP

SUMMARY OF FOLLOW-UP AND COMMENTS *Provide details as appropriate.*

- is an environmental inspection needed Y N unk
 education provided Y N unk

Does the case know about anyone else with a similar illness? Y N
If yes, get contact information, onsets, etc.

name	age	sex	relation to case	onset	comment
_____				___/___/___	-----
_____				___/___/___	-----

Other notes

ADMINISTRATION **ORPHEUS MARCH 2018**

Remember to copy patient's name to the top of this page.

Completed by _____ Date _____ Phone _____ Case report sent to OHA on ___/___/___
 Investigation sent to OHA on ___/___/___