



**EMERGING INFECTIONS PROGRAM  
PULMONARY NONTUBERCULOUS MYCOBACTERIA  
(NTM) SURVEILLANCE CASE REPORT FORM - 2023**

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: _____
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7. DATE OF BIRTH: __-__-__	8. AGE: _____ <input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Yrs	9. SEX AT BIRTH: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Check if transgender
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10. RACE: (Check all that apply) <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown	11. ETHNIC ORIGIN: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown
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12. WEIGHT: _____ lbs. _____ oz. OR _____ kg <input type="checkbox"/> Unknown	13. HEIGHT: _____ ft. _____ in. OR _____ cm <input type="checkbox"/> Unknown	14. BMI: (record only if height or weight is not available) _____ <input type="checkbox"/> Unknown	15. DATE OF PULMONARY INDEX SPECIMEN COLLECTION (DISC): __-__-__ <input type="checkbox"/> Unknown
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16. LOCATION OF PULMONARY INDEX SPECIMEN COLLECTION: <input type="checkbox"/> OUTPATIENT: 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"/> INPATIENT: Facility ID: _____ <input type="checkbox"/> ICU <input type="checkbox"/> OR <input type="checkbox"/> Radiology <input type="checkbox"/> Other inpatient	<input type="checkbox"/> LTCF: Facility ID: _____ <input type="checkbox"/> LTACH: Facility ID: _____ <input type="checkbox"/> Autopsy <input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> Unknown	17. PULMONARY INDEX SPECIMEN COLLECTION SITE (Check all that apply): <input type="checkbox"/> BAL <input type="checkbox"/> Lung tissue <input type="checkbox"/> Sputum (expectorated or induced) <input type="checkbox"/> Tracheal aspirate <input type="checkbox"/> Other lower respiratory site (specify): _____
			18. FINAL RESULT DATE: __-__-__

19. NTM SPECIES IDENTIFIED FROM PULMONARY INDEX SPECIMEN:		
<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 complex (ABS) <input type="checkbox"/> M. chelonae complex (CHEL) <input type="checkbox"/> M. fortuitum group (FOR) <input type="checkbox"/> M. kansasii (KAN) <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>

20. CLINICIAN-DIAGNOSED PULMONARY NTM DISEASE? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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21. WERE MICROBIOLOGICAL TESTS OF PULMONARY SPECIMENS POSITIVE FOR NTM IN THE 12 MONTHS BEFORE THE DISC? <input type="checkbox"/> No microbiological tests, and NO medical record documentation that infection was present →INCIDENT CASE <input type="checkbox"/> No microbiological tests, but medical record documentation indicates infection WAS PRESENT →PREVALENT CASE <input type="checkbox"/> Yes→PREVALENT CASE (complete table below) <input type="checkbox"/> Unknown
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IF YES, INDICATE SITE(S), DATE(S) OF COLLECTION, AND SPECIES:						
	Date #1	Species	Date #2	Species	Date #3	Species
<input type="checkbox"/> BAL	__-__-__	_____	__-__-__	_____	__-__-__	_____
<input type="checkbox"/> Lung tissue	__-__-__	_____	__-__-__	_____	__-__-__	_____
<input type="checkbox"/> Sputum	__-__-__	_____	__-__-__	_____	__-__-__	_____
<input type="checkbox"/> Tracheal aspirate	__-__-__	_____	__-__-__	_____	__-__-__	_____
<input type="checkbox"/> Other, specify: _____	__-__-__	_____	__-__-__	_____	__-__-__	_____

**22. USING THE INFORMATION IN QUESTIONS 17 AND 21, INDICATE WHICH PULMONARY NTM CRITERIA WERE MET AS OF THE DISC**  
 (Check all that apply):

- A. NTM identified from microbiological testing (culture or culture independent diagnostic test [CIDT]) of ≥1 BAL or bronchial wash specimen or lung tissue specimen—**CONFIRMED CASE**
- B. NTM identified from microbiological testing (culture or CIDT) of ≥2 sputum specimens or tracheal aspirates—**CONFIRMED CASE**
- C. Lung biopsy specimen with histopathologic features (granulomatous inflammation or acid-fast bacilli) PLUS NTM identified from microbiological testing (culture or CIDT) of ≥1 pulmonary specimen—**CONFIRMED CASE**
- D. NTM identified from microbiological testing (culture or CIDT) of 1 sputum specimen or tracheal aspirate only—**POSSIBLE CASE**

**\*\*\*If CONFIRMED CASE, complete CRF. If POSSIBLE CASE, then pulmonary NTM criteria are NOT YET MET\*\*\***

**23. WERE EITHER E OR F (BELOW) REPORTED IN THE 12 MONTHS AFTER THE DISC?**

- Not applicable—already a confirmed case
- E. Lung biopsy specimen with mycobacterial histopathologic features (granulomatous inflammation or acid-fast bacilli)—**CONFIRMED CASE, complete CRF**  
Date of collection \_\_\_\_-\_\_\_\_-\_\_\_\_
- F. NTM identified from microbiological testing (culture or CIDT) of ≥1 pulmonary specimen other than index specimen—**CONFIRMED CASE, complete CRF**  
Date of collection \_\_\_\_-\_\_\_\_-\_\_\_\_ Species: \_\_\_\_\_  
Site:  BAL  Lung tissue  Sputum (expectorated or induced)  Tracheal aspirate  Other lower respiratory site (specify): \_\_\_\_\_
- No→STOP ABSTRACTION  Unknown→STOP ABSTRACTION

**\*\*\*Complete CRF for CONFIRMED CASES\*\*\***

**24. 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
_____	_____	<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	Interpretation
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown

**25. NTM SIGNS & SYMPTOMS IN THE 14 DAYS BEFORE THE DISC** (Check all that apply):  None  Unknown  Prevalent case, no symptoms found

Chest Pain  Dyspnea/Shortness of breath  Fever  Night sweats  Weight loss  Other, specify: \_\_\_\_\_

Cough  Fatigue or malaise  Hemoptysis  Sputum production  Wheezing

**26. IMMUNOSUPPRESSIVE MEDICATION IN THE 90 DAYS BEFORE THE DISC** (Check all that apply):  None of the below  Unknown

Abatacept/Orencia  Azathioprine  B Cell depletion agent  Cyclophosphamide  IL-6 blocker  JAK inhibitor

Mycophenolate  Steroid, IV, IM, or oral  Steroid, inhaled  Tacrolimus  TNF-α inhibitor

**27. HOSPITALIZATION(S) IN THE 12 MONTHS BEFORE TO 30 DAYS AFTER THE DISC:**  Yes  No  Unknown

Admission date	Discharge date	Due to NTM infection?
____-____-____ <input type="checkbox"/> Unknown	____-____-____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
____-____-____ <input type="checkbox"/> Unknown	____-____-____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
____-____-____ <input type="checkbox"/> Unknown	____-____-____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
____-____-____ <input type="checkbox"/> Unknown	____-____-____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
____-____-____ <input type="checkbox"/> Unknown	____-____-____ <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

**28. LAST KNOWN STATUS WITHIN 180 DAYS OF THE DISC:**

Alive

Died

Unknown

Date of last known status: \_\_\_\_\_

**29. DID 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?** (Check all that apply):

Infectious diseases specialist  Pulmonary specialist  Surgeon

Other, specify: \_\_\_\_\_  None  Unknown

**29a. WERE ANY REFERRALS WITHIN 12 MONTHS BEFORE TO 30 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?**

Yes  No  Unknown

**29b. DID THE PATIENT UNDERGO SURGERY TO MANAGE NTM INFECTION ON THE DISC THROUGH 180 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?**

Yes; specify type of surgery: \_\_\_\_\_

No  Unknown

**29c. INFECTION TYPE**

Disseminated

Not disseminated

Unknown

**30. UNDERLYING CONDITIONS** (Check all that apply):  None  Unknown

<p><b>CHRONIC LUNG DISEASE</b></p> <p><input type="checkbox"/> Cystic fibrosis</p> <p><input type="checkbox"/> Chronic pulmonary disease</p> <p><b>CHRONIC METABOLIC DISEASE</b></p> <p><input type="checkbox"/> Diabetes mellitus</p> <p><input type="checkbox"/> With chronic complications</p> <p><b>CARDIOVASCULAR DISEASE</b></p> <p><input type="checkbox"/> CVA/Stroke/TIA</p> <p><input type="checkbox"/> Congenital heart disease</p> <p><input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> Myocardial infarction</p> <p><input type="checkbox"/> Peripheral vascular disease (PVD)</p> <p><b>GASTROINTESTINAL DISEASE</b></p> <p><input type="checkbox"/> Diverticular disease</p> <p><input type="checkbox"/> Inflammatory bowel disease</p> <p><input type="checkbox"/> Peptic ulcer disease</p> <p><input type="checkbox"/> Short gut syndrome</p>	<p><b>IMMUNOCOMPROMISED CONDITION</b></p> <p><input type="checkbox"/> HIV infection</p> <p><input type="checkbox"/> AIDS/CD4 count &lt; 200</p> <p><input type="checkbox"/> Primary immunodeficiency</p> <p><input type="checkbox"/> Transplant, hematopoietic stem cell</p> <p><input type="checkbox"/> Transplant, solid organ</p> <p><b>LIVER DISEASE</b></p> <p><input type="checkbox"/> Chronic liver disease</p> <p><input type="checkbox"/> Ascites</p> <p><input type="checkbox"/> Cirrhosis</p> <p><input type="checkbox"/> Hepatic encephalopathy</p> <p><input type="checkbox"/> Variceal bleeding</p> <p><input type="checkbox"/> Hepatitis C</p> <p><input type="checkbox"/> Treated, in SVR</p> <p><input type="checkbox"/> Current, chronic</p> <p><b>MALIGNANCY</b></p> <p><input type="checkbox"/> Malignancy, hematologic</p> <p><input type="checkbox"/> Malignancy, solid organ (non-metastatic)</p> <p><input type="checkbox"/> Malignancy, solid organ (metastatic)</p>	<p><b>NEUROLOGIC CONDITION</b></p> <p><input type="checkbox"/> Cerebral palsy</p> <p><input type="checkbox"/> Chronic cognitive deficit</p> <p><input type="checkbox"/> Dementia</p> <p><input type="checkbox"/> Epilepsy/seizure/seizure disorder</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Neuropathy</p> <p><input type="checkbox"/> Parkinson's disease</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><b>PLEGIAS/PARALYSIS</b></p> <p><input type="checkbox"/> Hemiplegia</p> <p><input type="checkbox"/> Paraplegia</p> <p><input type="checkbox"/> Quadriplegia</p>	<p><b>RENAL DISEASE</b></p> <p><input type="checkbox"/> Chronic kidney disease</p> <p><input type="checkbox"/> End-stage renal disease</p> <p><input type="checkbox"/> Acute kidney injury</p> <p><b>SKIN CONDITION</b></p> <p><input type="checkbox"/> Burn</p> <p><input type="checkbox"/> Decubitus/pressure ulcer</p> <p><input type="checkbox"/> Surgical wound</p> <p><input type="checkbox"/> Other chronic ulcer or chronic wound</p> <p><input type="checkbox"/> Other (specify): _____</p> <p><b>OTHER</b></p> <p><input type="checkbox"/> Connective tissue disease</p> <p><input type="checkbox"/> Obesity or morbid obesity</p> <p><input type="checkbox"/> Pregnant</p>
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<b>31. OTHER UNDERLYING CONDITIONS</b> (Check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Cough suppression disorder <input type="checkbox"/> History of tuberculosis <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Chest wall deformity (e.g., pectus excavatum) <input type="checkbox"/> Emphysema <input type="checkbox"/> Lung cancer / History of lung cancer <input type="checkbox"/> Scoliosis <input type="checkbox"/> COPD <input type="checkbox"/> GERD <input type="checkbox"/> Mitral valve prolapse				
<b>32. SUBSTANCE USE</b> <b>SMOKING</b> (Check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-nicotine delivery system <input type="checkbox"/> Marijuana		<b>HISTORY OF SMOKING</b> (Check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Tobacco <input type="checkbox"/> E-nicotine delivery system <input type="checkbox"/> Marijuana		<b>ALCOHOL ABUSE:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>33. INDICATE EXPOSURES DOCUMENTED IN MEDICAL RECORDS IN THE 12 MONTHS BEFORE THE DISC:</b> <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Bird contact <input type="checkbox"/> Homelessness <input type="checkbox"/> Nail salon <input type="checkbox"/> Bronchoscopy <input type="checkbox"/> Hot tub <input type="checkbox"/> Nebulizer <input type="checkbox"/> Construction <input type="checkbox"/> Humidifier use <input type="checkbox"/> Neti pot <input type="checkbox"/> Cystic fibrosis clinic <input type="checkbox"/> Incarceration <input type="checkbox"/> Nursing home residence <input type="checkbox"/> Dental procedure <input type="checkbox"/> Injection/infusion <input type="checkbox"/> Surgical procedure <input type="checkbox"/> Gardening or landscaping <input type="checkbox"/> Livestock <input type="checkbox"/> Swimming pool <input type="checkbox"/> Fish tank <input type="checkbox"/> Medical device <input type="checkbox"/> Other, specify: _____				
<b>34. CHEST IMAGING</b> <b>Chest imaging 90 days before to 180 days after the DISC</b> (Check all that apply): <input type="checkbox"/> Chest CT scan <input type="checkbox"/> None of the above <input type="checkbox"/> Chest x-ray <input type="checkbox"/> Unknown		<b>34a. Did any of this imaging take place within 90 days before or after the DISC?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>34b. If chest CT scan and/or chest x-ray, chest imaging findings</b> (Check all that apply): <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> Nodular opacities <input type="checkbox"/> Cavity or cavitation <input type="checkbox"/> Nodules <input type="checkbox"/> Consolidation <input type="checkbox"/> Tree-in-bud <input type="checkbox"/> Infiltrate	
<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>COVID-NET CASE ID:</b> _____				
<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 THIS PATIENT PREVIOUSLY REPORTED TO HAIC NTM SURVEILLANCE?</b> 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>    				

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
_____	<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	Interpretation
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> 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
_____	<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	Interpretation
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown
_____	_____	<input type="checkbox"/> Present <input type="checkbox"/> Absent <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown