



**EMERGING INFECTIONS PROGRAM  
PULMONARY NONTUBERCULOUS MYCOBACTERIA  
(NTM) SURVEILLANCE CASE REPORT FORM - 2025**

|                 |        |                   |           |
|-----------------|--------|-------------------|-----------|
| 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<br>NTM INITIALLY IDENTIFIED: | 6. PROVIDER ID WHO ORDERED<br>INDEX SPECIMEN COLLECTION: |
|-----------|------------|--------------|----------------|---|--|

|                   |   |   |
|-------------------|---|---|
| 7. DATE OF BIRTH: | 8. AGE:<br><input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Yrs | 9. SEX:<br><input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Missing value |
|-------------------|---|---|

10. RACE AND/OR ETHNICITY: (Check all that apply)

|   |  |  |                                  |
|---|--|--|----------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black or African American | <input type="checkbox"/> Middle Eastern or North African           | <input type="checkbox"/> White   |
| <input type="checkbox"/> Asian                            | <input type="checkbox"/> Hispanic or Latino        | <input type="checkbox"/> Native Hawaiian or Other Pacific Islander | <input type="checkbox"/> Unknown |

|   |  |  |  |
|---|--|--|--|
| 12. WEIGHT:<br>_____ lbs. _____ oz. OR<br>_____ kg <input type="checkbox"/> Unknown | 13. HEIGHT:<br>_____ ft. _____ in. OR<br>_____ cm <input type="checkbox"/> Unknown | 14. BMI: (record only if height or<br>weight is not available)<br><input type="checkbox"/> Unknown | 15. DATE OF PULMONARY INDEX<br>SPECIMEN COLLECTION (DISC):<br>_____ - _____ - _____ <input type="checkbox"/> Unknown |
|---|--|--|--|

|  |  |
|--|--|
| 16. LOCATION OF PULMONARY INDEX SPECIMEN COLLECTION:<br><input type="checkbox"/> <b>OUTPATIENT:</b><br>Facility ID: _____<br><input type="checkbox"/> Emergency room<br><input type="checkbox"/> Clinic/Doctor's office<br><input type="checkbox"/> Dialysis center<br><input type="checkbox"/> Surgery<br><input type="checkbox"/> Observational/Clinical decision unit<br><input type="checkbox"/> Other outpatient<br><input type="checkbox"/> <b>INPATIENT:</b><br>Facility ID: _____<br><input type="checkbox"/> ICU<br><input type="checkbox"/> OR<br><input type="checkbox"/> Radiology<br><input type="checkbox"/> Other inpatient<br><input type="checkbox"/> <b>LTCF:</b><br>Facility ID: _____<br><input type="checkbox"/> <b>LTACH:</b><br>Facility ID: _____<br><input type="checkbox"/> <b>Autopsy</b><br><input type="checkbox"/> <b>Other</b><br><input type="checkbox"/> <b>Unknown</b> | 17. PULMONARY INDEX SPECIMEN COLLECTION SITE<br>(Check all that apply):<br><input type="checkbox"/> BAL<br><input type="checkbox"/> Lung tissue<br><input type="checkbox"/> Sputum (expectorated or induced)<br><input type="checkbox"/> Tracheal aspirate<br><input type="checkbox"/> Other lower respiratory site (specify): _____<br>17a. Collected for: <input type="checkbox"/> TB evaluation <input type="checkbox"/> CF follow-up<br><input type="checkbox"/> Other/ not documented |
|--|--|

|   |  |
|---|--|
| 17b. <input type="checkbox"/> Index specimen(s) detected solely via multiplex/NGS lab-developed test? | 18. FINAL RESULT DATE: _____ - _____ - _____ |
|---|--|

19. NTM SPECIES IDENTIFIED FROM PULMONARY INDEX SPECIMEN:

|  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>M. avium complex (MAC)</b><br><input type="checkbox"/> M. avium (AVI)<br><input type="checkbox"/> M. intracellulare subsp. chimaera (CHIM)<br><input type="checkbox"/> M. intracellulare subsp. intracellulare (INT)<br><input type="checkbox"/> Other MAC, specify: _____ (MOTH)<br><input type="checkbox"/> MAC, not otherwise specified (MND) | <input type="checkbox"/> <b>Non-M. avium complex (NMAC)</b><br><input type="checkbox"/> M. abscessus complex (ABS)<br><input type="checkbox"/> M. abscessus subsp. abscessus<br><input type="checkbox"/> M. abscessus subsp. bolletii<br><input type="checkbox"/> M. abscessus subsp. massiliense<br><input type="checkbox"/> M. abscessus subsp. identification not performed<br><input type="checkbox"/> M. chelonae complex (CHEL)<br><input type="checkbox"/> M. fortuitum complex (FOR)<br><input type="checkbox"/> M. kansasii complex (KAN)<br><input type="checkbox"/> M. marinum (MAR)<br><input type="checkbox"/> Other non-MAC, specify: _____ (NOTH)<br><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 | 20a. <input type="checkbox"/> Contamination or colonization suspected |
|--|---|

21. WERE MICROBIOLOGICAL TESTS OF PULMONARY SPECIMENS POSITIVE FOR NTM IN THE 12 MONTHS BEFORE THE DISC?

No microbiological tests, and NO medical record documentation that infection was present → **INCIDENT CASE**

No microbiological tests, but medical record documentation indicates infection WAS PRESENT → **PREVALENT CASE**

Yes → **PREVALENT CASE** (complete table below)

Unknown

**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 16 AND 20, 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): \_\_\_\_\_  
 Specimen(s) detected solely via multiplex/NGS lab-developed test?
- 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  |
|---------------|---|---------------------------------------|---|
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|               | <input type="checkbox"/> BMD <input type="checkbox"/> DD <input type="checkbox"/> ADE <input type="checkbox"/> Oth                              |                                       |   |

| MOLECULAR METHODS:  |   |   |  |
|---|---|---|--|
| Gene name   | Test method   | Result  | Interpretation   |
| <input type="checkbox"/> <i>erm</i><br><input type="checkbox"/> <i>rpoB</i><br><input type="checkbox"/> <i>rrl</i><br><input type="checkbox"/> <i>rrs</i><br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Line Probe<br><input type="checkbox"/> PCR<br><input type="checkbox"/> Sanger Sequencing<br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Gene absent<br><input type="checkbox"/> Indeterminate<br><input type="checkbox"/> Mutations/variants, specify: _____<br><input type="checkbox"/> Other abnormal result, specify: _____<br><input type="checkbox"/> No abnormal results<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Suggests resistance/ Resistance is predicted<br><input type="checkbox"/> Suggests susceptibility/ Resistance not predicted<br><input type="checkbox"/> Other interpretation, specify: _____<br><input type="checkbox"/> Unknown |
| <input type="checkbox"/> <i>erm</i><br><input type="checkbox"/> <i>rpoB</i><br><input type="checkbox"/> <i>rrl</i><br><input type="checkbox"/> <i>rrs</i><br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Line Probe<br><input type="checkbox"/> PCR<br><input type="checkbox"/> Sanger Sequencing<br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Gene absent<br><input type="checkbox"/> Indeterminate<br><input type="checkbox"/> Mutations/variants, specify: _____<br><input type="checkbox"/> Other abnormal result, specify: _____<br><input type="checkbox"/> No abnormal results<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Suggests resistance/ Resistance is predicted<br><input type="checkbox"/> Suggests susceptibility/ Resistance not predicted<br><input type="checkbox"/> Other interpretation, specify: _____<br><input type="checkbox"/> Unknown |
| <input type="checkbox"/> <i>erm</i><br><input type="checkbox"/> <i>rpoB</i><br><input type="checkbox"/> <i>rrl</i><br><input type="checkbox"/> <i>rrs</i><br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Line Probe<br><input type="checkbox"/> PCR<br><input type="checkbox"/> Sanger Sequencing<br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Gene absent<br><input type="checkbox"/> Indeterminate<br><input type="checkbox"/> Mutations/variants, specify: _____<br><input type="checkbox"/> Other abnormal result, specify: _____<br><input type="checkbox"/> No abnormal results<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Suggests resistance/ Resistance is predicted<br><input type="checkbox"/> Suggests susceptibility/ Resistance not predicted<br><input type="checkbox"/> Other interpretation, specify: _____<br><input type="checkbox"/> Unknown |
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| <input type="checkbox"/> <i>erm</i><br><input type="checkbox"/> <i>rpoB</i><br><input type="checkbox"/> <i>rrl</i><br><input type="checkbox"/> <i>rrs</i><br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Line Probe<br><input type="checkbox"/> PCR<br><input type="checkbox"/> Sanger Sequencing<br><input type="checkbox"/> Other, specify: _____ | <input type="checkbox"/> Gene absent<br><input type="checkbox"/> Indeterminate<br><input type="checkbox"/> Mutations/variants, specify: _____<br><input type="checkbox"/> Other abnormal result, specify: _____<br><input type="checkbox"/> No abnormal results<br><input type="checkbox"/> Unknown | <input type="checkbox"/> Suggests resistance/ Resistance is predicted<br><input type="checkbox"/> Suggests susceptibility/ Resistance not predicted<br><input type="checkbox"/> Other interpretation, specify: _____<br><input type="checkbox"/> Unknown |

**25. NTM SIGNS & SYMPTOMS IN THE 90 DAYS BEFORE THE DISC** (Check all that apply):  None  Unknown  Prevalent case, no symptoms found

- |                                     |  |  |  |
|-------------------------------------|--|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Dyspnea/Shortness of breath | <input type="checkbox"/> Hemoptysis        | <input type="checkbox"/> Weight loss           |
| <input type="checkbox"/> Chills     | <input type="checkbox"/> Fatigue or malaise          | <input type="checkbox"/> Night sweats      | <input type="checkbox"/> Wheezing              |
| <input type="checkbox"/> Cough      | <input type="checkbox"/> Fever                       | <input type="checkbox"/> Sputum production | <input type="checkbox"/> Other, specify: _____ |

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

- |   |   |  |   |   |
|---|---|--|---|---|
| <input type="checkbox"/> Abatacept/Orencia      | <input type="checkbox"/> Cyclophosphamide | <input type="checkbox"/> IL-23 blocker | <input type="checkbox"/> Other chemotherapy       | <input type="checkbox"/> Steroid, inhaled |
| <input type="checkbox"/> Azathioprine           | <input type="checkbox"/> Deucravacitinib  | <input type="checkbox"/> JAK inhibitor | <input type="checkbox"/> S1PR modulator           | <input type="checkbox"/> Tacrolimus       |
| <input type="checkbox"/> B Cell depletion agent | <input type="checkbox"/> IL-6 blocker     | <input type="checkbox"/> Mycophenolate | <input type="checkbox"/> Steroid, IV, IM, or oral | <input type="checkbox"/> TNF-α inhibitor  |
| <input type="checkbox"/> Checkpoint inhibitor   | <input type="checkbox"/> IL-17 inhibitor  |  |   |   |

**27. HOSPITALIZATION(S) IN THE 12 MONTHS BEFORE T O 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:  
 \_\_\_\_ - \_\_\_\_ - \_\_\_\_

|   |  |  |  |
|---|--|--|--|
| <b>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?</b><br><i>(Check all that apply):</i><br><input type="checkbox"/> Infectious diseases specialist <input type="checkbox"/> Pulmonary specialist <input type="checkbox"/> Surgeon<br><input type="checkbox"/> Other, specify: _____ <input type="checkbox"/> None <input type="checkbox"/> Unknown |  | <b>29a. WERE ANY REFERRALS WITHIN 12 MONTHS BEFORE TO 30 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   |  |
| <b>29b. DID THE PATIENT UNDERGO SURGERY TO MANAGE NTM INFECTION ON THE DISC THROUGH 180 DAYS AFTER THE INDEX SPECIMEN RESULT DATE?</b><br><input type="checkbox"/> Yes; specify type of surgery: _____<br><input type="checkbox"/> No <input type="checkbox"/> Unknown  |  | <b>29c. INFECTION TYPE</b><br><input type="checkbox"/> Disseminated<br><input type="checkbox"/> Not disseminated<br><input type="checkbox"/> Unknown   |  |
| <b>30. UNDERLYING CONDITIONS</b> <i>(Check all that apply):</i> <input type="checkbox"/> None <input type="checkbox"/> Unknown  |  |  |  |
| <b>Chronic Lung Disease</b><br><input type="checkbox"/> Cystic fibrosis<br><input type="checkbox"/> Chronic pulmonary disease   | <b>Immunocompromised Condition</b><br><input type="checkbox"/> HIV infection<br><input type="checkbox"/> AIDS/CD4 count <200<br><input type="checkbox"/> Primary immunodeficiency<br><input type="checkbox"/> Transplant, hematopoietic stem cell<br><input type="checkbox"/> Transplant, solid organ (specify): _____ | <b>Malignancy</b><br><input type="checkbox"/> Malignancy, hematologic<br><input type="checkbox"/> Malignancy, solid organ (non-metastatic)<br><input type="checkbox"/> Malignancy, solid organ (metastatic)<br><b>Neurologic Condition</b><br><input type="checkbox"/> Cerebral palsy<br><input type="checkbox"/> Chronic cognitive deficit<br><input type="checkbox"/> Dementia<br><input type="checkbox"/> Epilepsy/seizure/seizure disorder<br><input type="checkbox"/> Multiple sclerosis<br><input type="checkbox"/> Neuropathy<br><input type="checkbox"/> Paresis<br><input type="checkbox"/> Parkinson's disease<br><input type="checkbox"/> Spinal cord injury<br><b>Plegias/Paralysis</b><br><input type="checkbox"/> Hemiplegia<br><input type="checkbox"/> Paraplegia<br><input type="checkbox"/> Quadriplegia | <b>Renal Disease</b><br><input type="checkbox"/> Chronic kidney disease<br><input type="checkbox"/> Lowest serum creatinine: _____ mg/dL<br><input type="checkbox"/> Unknown or not done<br><b>Skin Condition</b><br><input type="checkbox"/> Blistering disease<br><input type="checkbox"/> Burn<br><input type="checkbox"/> Decubitus/pressure ulcer<br><input type="checkbox"/> Eczema<br><input type="checkbox"/> Psoriasis<br><input type="checkbox"/> Surgical wound<br><input type="checkbox"/> Other chronic ulcer or chronic wound<br><b>Other</b><br><input type="checkbox"/> Connective tissue disease<br><input type="checkbox"/> Obesity or morbid obesity<br><input type="checkbox"/> Pregnant |
| <b>31. OTHER UNDERLYING CONDITIONS</b> <i>(Check all that apply):</i> <input type="checkbox"/> None <input type="checkbox"/> Unknown  |  |  |  |
| <input type="checkbox"/> Bronchiectasis<br><input type="checkbox"/> Chest wall deformity (e.g., pectus excavatum)<br><input type="checkbox"/> COPD<br><input type="checkbox"/> Cough suppression disorder<br><input type="checkbox"/> Emphysema   | <input type="checkbox"/> GERD<br><input type="checkbox"/> History of tuberculosis<br><input type="checkbox"/> Lung cancer / History of lung cancer<br><input type="checkbox"/> Mitral valve prolapse   | <input type="checkbox"/> Pulmonary surgical procedure<br>Specify surgery: _____<br><input type="checkbox"/> Unknown<br>Date of surgery: ____ - ____ - ____<br><input type="checkbox"/> Unknown   |  |
| <b>32. SUBSTANCE USE</b><br><b>SMOKING</b> <i>(Check all that apply):</i><br><input type="checkbox"/> None documented <input type="checkbox"/> Unknown<br><input type="checkbox"/> Tobacco <input type="checkbox"/> E-nicotine delivery system <input type="checkbox"/> Marijuana   | <b>HISTORY OF SMOKING</b> <i>(Check all that apply):</i><br><input type="checkbox"/> None documented <input type="checkbox"/> Unknown<br><input type="checkbox"/> Tobacco <input type="checkbox"/> E-nicotine delivery system <input type="checkbox"/> Marijuana   | <b>ALCOHOL ABUSE:</b><br><input type="checkbox"/> Yes<br><input type="checkbox"/> None documented<br><input type="checkbox"/> Unknown  |  |
| <b>33. WAS THE PATIENT HOMELESS IN THE YEAR BEFORE THE DISC?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown   | <b>33a. OVERNIGHT STAY IN LTCF IN THE YEAR BEFORE THE DISC?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown<br><b>IF YES, FACILITY ID:</b> _____  | <b>33b. WAS THE PATIENT IN A CORRECTIONAL OR DETENTION FACILITY IN THE YEAR BEFORE THE DISC?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown  |  |





