Contra Costa Health Services

Case Report Form for Patients with Lab-confirmed or Suspect Rapidly Growing *Mycobacterium* Infection of the Lower Extremities

Case Definition for "Suspect": Physician evaluation consistent with mycobacterial infection but culture not done or negative.

Patient Demographic Information

Name (Last, First, MI): ______________________________

Address: ______________________________

City, State, Zip: ______________________________

County______________________________

Home Phone: (_____) _____- ______________

Work Phone: (_____) _____- ______________

Age: _________ or DOB: ____/_____/______

Sex: M F

Is the patient Latino or Hispanic?
Yes No

Race:
White
Black or African American
Asian
American Indian or Alaskan Native
Native Hawaiian or Other Pacific Islander
Other ______________________________ (specify)
Unknown

Clinical Information

Suspect Lab-confirmed

Number of Lesions
Left Leg ________ Right Leg ________

Approximate diameter of largest lesion
__________mm

1) Was the infection at the site of a prior wound or surgery?
Yes No Unknown
a) If no, please describe wound:
Boil Other Skin Infection __________________ (specify)

2) Date of Onset: ____/____/_______

3) Reporting Clinician: ______________________________ (contact info-next line)

4) Phone: (____) _____- _______ Pager/Cell: (_____) _____- ________

5) Date Reported to LHD: _____/_____/_______

6) Lab that identified *Mycobacterium* species__________________________
a) Lab Phone #: (_____) _____- _________ (if "suspect" do not fill out)

b) Species Identified______________________________ Unknown

8) Treatment received: Antibiotics Surgery None Unknown

9) Relapses after treatment?
Yes No Unknown

Risk Factors

1) **Before** developing lesions, did the patient have a pedicure with a whirlpool footbath at a nail salon?
Yes No Unknown **If yes, please list salons in table below.**

2) In the months prior to onset, about how many times per month did the patient get pedicures?
Not at all Once/month 2-3 times/month ×4 times/month

3) Did the patient routinely shave the legs on the same day or within 24 hours prior to getting a pedicure?
Yes No Unknown

4) Prior to symptom onset, had the patient used a spa/whirlpool at a non-salon venue, e.g., private residence, gym, hotel, etc.?
Yes No Unknown

5) Does the patient have any immuno-compromising or chronic medical conditions?
If yes, please list: ____

Salon Usage Prior to Infection (Name, City)	**Frequency of use (per month)**	**Whirlpool Use**
	Once 2-3 times ×4 times	Yes No Sometimes Unknown
	Once 2-3 times ×4 times	Yes No Sometimes Unknown
	Once 2-3 times ×4 times	Yes No Sometimes Unknown
	Once 2-3 times ×4 times	Yes No Sometimes Unknown

LHD Contact

Person completing this form: ___________________________ Local H.D. ______________________ Date: ___/___/_______

Work (_____) _____-__________ Pager (_____) _____-__________ Cell (_____) _____-__________

Please fax this form to Contra Costa Communicable Disease, 925-313-6465.