

ATTACHMENT -E: Data Collection Instrument

Drug Susceptibility Test Results for *M. tuberculosis* complex Isolates Submitted for the CDC Molecular Detection of Drug Resistance Service

Instructions: Please provide the collection date and your complete drug susceptibility results for the following isolate that was submitted to CDC for MDDR testing. Include first and second-line drug susceptibility testing if known (in-house or referred) for the isolate associated with the MDDR submission. Do not include results from CDC.

Submitter Specimen Identifier: 11A00038

CDC Specimen ID: 2011101430

1) Was the initial drug susceptibility testing for this isolate performed in your laboratory?

Yes

Yes, but no useable results were obtained

No, isolate tested in another laboratory

Results available

Results not available

2) Date Specimen Collected: _____

3) Method used for conventional drug susceptibility testing for first-line drugs: _____

4) Method used for conventional drug susceptibility testing for second-line drugs: _____

5) Date of first report of rifampin susceptibility result : _____

‘Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D- 74, Atlanta, Georgia 30333; ATTN: PRA (0920-0879).’

6) Was this isolate referred to another laboratory other than CDC for repeat, confirmatory, or additional testing? Yes, conventional Yes, molecular No

If this isolate was referred to another laboratory for additional testing, were these results in agreement with your initial test result for rifampin and isoniazid?

Yes No

If your initial test results for rifampin and isoniazid do not agree with results from another laboratory providing repeat or confirmatory testing (other than CDC), please fill out separate forms for each set of results.

Drug Susceptibility Test Results:

	<u>Resistant</u>	<u>Susceptible</u>	<u>Not Done</u>	<u>Unknown</u>
Rifampin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isoniazid low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Isoniazid high	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Streptomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifabutin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rifapentine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethionamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Amikacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kanamycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Capreomycin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moxifloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Quinolones	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cycloserine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Para-Amino Salicylic Acid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>