Form Approved 0MB No. 0920-20OT Expiration Date: XX/XX/XXXX

Mycoplasma genitalium Treatment Failure Registry

CASE REPORT FORM

The purpose of this form is to collect clinical information on cases of *Mycoplasma genitalium* that fail antibiotic therapy

All reported information will be maintained in the strictest confidence. Questions? Contact xxx at XXX@cdc.gov

PLEASE COMPLETE BY__/__/____and fax to our confidential fax line (xxx)xxx-xxxx.

PROVIDER INFORMATION:

Provider Name	Provider Phone #	Provider Fax #	
Provider Email Address	Practice/Clinic Name		
Address	City	State	Zip

PATIENT UNIQUE IDENTIFIER* (First Initial, Last initial, 2-digit year of birth, last 4 digits of Medical Record Number) Example: John Smith, born 1973, MRN 1234567 = JS734567

PATIENT AGE:

PATIENT PREVIOUSLY REPORTED TO THE REGISTRY? ☐ Yes ☐ No

PATIENT DEMOGRAPHIC INFORMATION:

1. Race (check all that apply)
☐ Unknown
☐ White
☐ Asian
☐ Black or African American
☐ American Indian / Alaska Native
☐ Native Hawaiian / Other Pacific Islander
☐ Other _____

2. Ethnicity
☐ Unknown ☐ Hispanic / Latino ☐ Not Hispanic / Latino

3a. Sex assigned at birth
☐ Male
☐ Female

3b. Gender identity
☐ Male
☐ Female
☐ Transgender female
☐ Transgender male
☐ Gender non-binary
☐ Unknown

4. Gender of sex partners in past year (check all that apply)
☐ Male
☐ Female
☐ Transgender female
☐ Transgender male
☐ Gender non-binary
☐ Unknown

5. HIV Status
☐ HIV-positive
☐ HIV-negative
☐ Unknown/Never tested

DIAGNOSTICS/ TREATMENT

Indication for M. genitalium testing (check all that apply): 1) Symptoms: ☐Urogenital (e.g., discharge, dysuria) ☐Anorectal (tenesmus, discharge, pain) ☐Pelvic/abdominal (pain, dyspareunia) 2) Clinical Syndrome (w/ objective findings): ☐Urethritis (documented discharge or pyuria) ☐Cervicitis (discharge, friability, + swab test) ☐PID ☐Proctitis ☐Other _____

M. genitalium diagnosis confirmed with nucleic acid amplification test? ☐ Yes ☐ No ☐ Unknown	**Laboratory performing M. genitalium testing. (e.g., Quest, LabCorp, name of hospital, etc)** _____	**Testing for macrolide resistance performed?** ☐Yes ☐ No **If yes, mutation detected?** ☐Yes ☐ No

Testing for fluroquinolone resistance performed? ☐Yes ☐ No
If yes, mutations detected: ☐S83I ☐parC unspecified

Date of initial treatment initiation ____/____/_____ ☐ Unknown	**Date of 2nd course treatment initiation** ____/____/_____ ☐ Unknown	**Date of 3rd course treatment initiation** ____/____/_____ ☐ Unknown
Initial treatment prescribed (check all that apply), and dose/frequency/duration (e.g., doxycycline 100 mg po BID x 7 days) ☐ Azithromycin _____x days ☐ Doxycycline _____x days ☐ Moxifloxacin _____x days ☐ Minocycline _____x days ☐ Other _____x days	**Second treatment prescribed (check all that apply), and dose/frequency/duration** ☐ Azithromycin _____x days ☐ Doxycycline _____x days ☐ Moxifloxacin _____x days ☐ Minocycline _____x days ☐ Other _____x days	**Third treatment prescribed (check all that apply), and dose/frequency/duration** ☐ Azithromycin _____x days ☐ Doxycycline _____x days ☐ Moxifloxacin _____x days ☐ Minocycline _____x days ☐ Other _____x days

Response to initial therapy (check all that apply)	**Response to second therapy (check all that apply)**	**Response to third therapy (check all that apply)**
□ Persistent symptoms (subjective only) □ Persistent symptoms (subjective) plus objective findings (e.g, discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment	□ Resolution of symptoms □ Persistent symptoms (subjective only) □ Persistent symptoms (subjective & objective findings, e.g., discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment	□ Resolution of symptoms □ Persistent symptoms (subjective only) □ Persistent symptoms (subjective and objective findings, e.g., discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment
Date of 4th course treatment initiation ____/____/_____ □ Unknown	**Date of 5th course treatment initiation** ____/____/_____ □ Unknown	**Date of 6th course treatment initiation** ____/____/_____ □ Unknown
Fourth treatment prescribed (check all that apply), and dose/frequency/duration □ Azithromycin _____x days □ Doxycycline _____x days □ Moxifloxacin _____x days □ Minocycline _____x days □ Other _____x days	**Fifth treatment prescribed (check all that apply), and dose/frequency/duration** □ Azithromycin _____x days □ Doxycycline _____x days □ Moxifloxacin _____x days □ Minocycline _____x days □ Other _____x days	**Sixth treatment prescribed (check all that apply), and dose/frequency/duration** □ Azithromycin _____x days □ Doxycycline _____x days □ Moxifloxacin _____x days □ Minocycline _____x days □ Other _____x days
Response to fourth therapy (check all that apply) □ Resolution of symptoms □ Persistent symptoms (subjective only) □ Persistent symptoms (subjective and objective findings, e.g., discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment	**Response to fifth therapy (check all that apply)** □ Resolution of symptoms □ Persistent symptoms (subjective only) □ Persistent symptoms (subjective and objective findings, e.g., discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment	**Response to sixth therapy (check all that apply)** □ Resolution of symptoms □ Persistent symptoms (subjective only) □ Persistent symptoms (subjective and objective findings, e.g., discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment

PARTNER TREATMENT

Does patient have a primary sexual partner? □□Yes □ No □ Unknown

If yes, was the primary partner symptomatic? □□Yes □ No □ Unknown

Was the primary partner treated? □□Yes □ No □ Unknown

If yes, was the primary partner examined by you or another clinician prior to treatment? □□Yes □ No □ Unknown

Partner treatment prescribed (check all that apply), and dose/frequency/duration	**Partner response to therapy (Check all that apply)**
□ Azithromycin _____x days □ Doxycycline _____x days □ Moxifloxacin _____x days □ Minocycline _____x days □ Other _____x days	□ Resolution of symptoms □ Persistent symptoms (subjective only) □ Persistent symptoms (subjective and objective findings, e.g., discharge, +urine dip, elevated WBC) □ Positive NAAT post treatment □ Unknown, partner not examined **If partner has persistent symptoms or NAAT following therapy, please complete a separate case report form for the partner.**

Notes:

Version date 05/08/2020