

Queensland Infection Prevention and Control Unit

HEATER-COOLER DEVICE DETECTION with NON-TUBERCULOUS MYCOBACTERIA -*Mycobacterium chimaera* REPORTING FORM

Purpose

This form is used to notify the Queensland Infection Prevention and Control Unit (QIPCU) of suspected or confirmed contamination of heater-cooler devices (HCDs) with Non-tuberculous Mycobacteria (NTM), including *Mycobacterium chimaera*. Refer to the [National Infection Control Guidance: Non-tuberculous Mycobacterium infections associated with heater-cooler devices](#) for further guidance.

When to Submit

- Confirmed NTM detection contamination of a heater-cooler device
- Confirmed or suspected patient infection linked to HCD exposure

How to submit

Send the completed form and supporting documentation e.g. copy of test result to QIPCU@health.qld.gov.au with the subject line: “**URGENT: Heater-Cooler Device NTM Notification – [Facility Name]**”

Reporting Information Required

Facility Details				
Facility name, Hospital and Health Service (HHS)				
Facility address (for non-QH facilities)				
Contact person:		Phone/Mobile:		
Position:		Email:		
Device Information				
Manufacturer, model, and serial/asset number				
Clinical location (e.g., theatre/unit)				
Commission date				
Last clinical use date				
Current device status	<input type="checkbox"/> Removed	<input type="checkbox"/> Quarantined	<input type="checkbox"/> Under investigation	<input type="checkbox"/> In service
Specimen testing details				
Detection date:		Confirmed date:		Organism:
Reason for testing Date:	<input type="checkbox"/> Surveillance <input type="checkbox"/> Commissioning	<input type="checkbox"/> Clinical case <input type="checkbox"/> Maintenance finding	<input type="checkbox"/> Maintenance advisory	
Testing laboratory	<input type="checkbox"/> Pathology QLD <input type="checkbox"/> SNP	<input type="checkbox"/> QML	<input type="checkbox"/> Other Specify:	
Type of testing performed Date:	<input type="checkbox"/> Culture	<input type="checkbox"/> PCR	<input type="checkbox"/> Water testing	
Previous bacterial surveillance	Prior sample date:	Type of sample:	Result/ Organism identified:	

Submitted by	
Name:	Position:
Email:	Phone/Mobile:
Date:	