

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis. Report to local health department within one working day.

DISEASE BEING REPORTED

Patient Name - Last Name		First Name		MI	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		
Home Address: Number, Street				Apt./Unit No.			
City			State	ZIP Code			
Home Telephone Number		Cell Telephone Number		Work Telephone Number			
Email Address			Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				
Birth Date (mm/dd/yyyy)		Age <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> M to F Transgender <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Other: _____			
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Est. Delivery Date (mm/dd/yyyy)		Country of Birth			
Occupation or Job Title				Occupational or Exposure Setting (check all that apply): <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> School <input type="checkbox"/> Other (specify): _____			

Date of Onset (mm/dd/yyyy)	Date of First Specimen Collection (mm/dd/yyyy)	Date of Diagnosis (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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Reporting Health Care Provider		Reporting Health Care Facility		REPORT TO:		
Address: Number, Street			Suite/Unit No.			
City		State	ZIP Code			
Telephone Number		Fax Number				
Submitted by		Date Submitted (mm/dd/yyyy)				

(Obtain additional forms from your local health department.)

Laboratory Name		City	State	ZIP Code
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TUBERCULOSIS (TB)		TB TREATMENT INFORMATION					
Status <input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Converter* * For TST, an increase of ≥10 mm in induration size during ≤2 years. Sites(s) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both		Mantoux TB Skin Test Date Placed (mm/dd/yyyy) Date Read (mm/dd/yyyy) Results: _____ mm <input type="checkbox"/> Not done <input type="checkbox"/> Pending <input type="checkbox"/> Not read Interferon Gamma Release Assay (IGRA) Date Collected: _____ (mm/dd/yyyy) Specify test name: _____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Not done <input type="checkbox"/> Indeterminate <input type="checkbox"/> Unknown <input type="checkbox"/> Negative Imaging: <input type="checkbox"/> Chest X-Ray <input type="checkbox"/> Chest CT Scan or Other Chest Imaging Study Date Performed: _____ (mm/dd/yyyy) Results: <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory <input type="checkbox"/> Not done		Bacteriology/Pathology Please mark positive on smear or culture if any of initial specimens obtained was positive Date Specimen Collected: _____ (mm/dd/yyyy) Source: _____ Smear for acid-fast bacilli: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Culture for <i>M. tuberculosis</i> complex: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Pathology suggests TB <input type="checkbox"/> Rapid Drug Resistance Assay <input type="checkbox"/> INH resistance <input type="checkbox"/> Not done <input type="checkbox"/> RIF resistance <input type="checkbox"/> No INH or RIF resistance detected Nucleic Acid Amplification/PCR Test for <i>M. tuberculosis</i> complex Specify test type: _____ Results: <input type="checkbox"/> Pos <input type="checkbox"/> Indeterminate <input type="checkbox"/> Neg <input type="checkbox"/> Not done Other test(s): _____		<input type="checkbox"/> Current Treatment (check all that apply) <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/> EMB <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Other: _____ Date Treatment Initiated: _____ (mm/dd/yyyy) <input type="checkbox"/> Drug resistance suspected <input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Patient refused treatment <input type="checkbox"/> Other: _____ <input type="checkbox"/> Referred to: _____	

Remarks: