

# CONFIDENTIAL MORBIDITY REPORT

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

## DISEASE BEING REPORTED

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

<b>Date of Onset (mm/dd/yyyy)</b>	<b>Date of First Specimen Collection (mm/dd/yyyy)</b>	<b>Date of Diagnosis (mm/dd/yyyy)</b>	<b>Date of Death (mm/dd/yyyy)</b>
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<b>Reporting Health Care Provider</b>		<b>Reporting Health Care Facility</b>		<b>REPORT TO:</b>		
<b>Address: Number, Street</b>			<b>Suite/Unit No.</b>			
<b>City</b>		<b>State</b>	<b>ZIP Code</b>			
<b>Telephone Number</b>		<b>Fax Number</b>				
<b>Submitted by</b>		<b>Date Submitted (mm/dd/yyyy)</b>				
(Obtain additional forms from your local health department.)						

<b>Laboratory Name</b>		<b>City</b>	<b>State</b>	<b>ZIP Code</b>
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TUBERCULOSIS (TB)	Mantoux TB Skin Test	Bacteriology/Pathology	TB TREATMENT INFORMATION
<b>Status</b> <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.  <b>Sites(s)</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both	<b>Mantoux TB Skin Test</b>  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  <b>Interferon Gamma Release Assay (IGRA)</b>  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  <b>Imaging:</b> <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	<b>Bacteriology/Pathology</b> 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  <b>Nucleic Acid Amplification/PCR Test for <i>M. tuberculosis</i> complex</b>  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"/> <b>Current Treatment (check all that apply)</b> <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: _____  <b>Date Treatment Initiated:</b> _____ (mm/dd/yyyy)  <input type="checkbox"/> <b>Drug resistance suspected</b>  <input type="checkbox"/> <b>Untreated</b> <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:**