

CONFIDENTIAL MORBIDITY REPORT

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

DISEASE BEING REPORTED Tuberculosis

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"/> M to F Transgender <input type="checkbox"/> Male <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Female <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)

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)			
Laboratory Name		City		State	ZIP Code

San Joaquin County Public Health Services
 P.O. Box 2009
 Stockton, CA 95201-2009
 FAX: (209) 468-8222
 Phone: (209) 468-3822
 Email: SJCDiseaseReporting@sjcphs.org
 Use secure transmission for emailed reports

(Obtain additional forms from your local health department.)

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