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***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)* | ***Country of Birth***

Occupation or Job Title

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other *(specify)*: _____

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ 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***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

Shasta County Health and Human Services Agency
- Public Health Branch
2650 Breslauer Way
Redding, CA 96001

Phone during business hours: (530) 225-5591
*After hours and weekends:
(530) 339-9941 Fax: (530) 225-5074

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

TUBERCULOSIS (TB)

Status
☐ Active Disease
- ☐ Confirmed
- ☐ Suspected

☐ Infected, No Disease
- ☐ Converter*

* For TST, an increase of ≥10 mm in induration size during ≤2 years.

Sites(s)
☐ Pulmonary
☐ Extra-Pulmonary
☐ Both

Mantoux TB Skin Test

_____ Date Placed *(mm/dd/yyyy)* _____ Date Read *(mm/dd/yyyy)*

Results: _____ mm ☐ Not done ☐ Pending ☐ Not read

Interferon Gamma Release Assay (IGRA)

Date Collected: _____ *(mm/dd/yyyy)*

Specify test name: _____

Results: ☐ Positive ☐ Indeterminate ☐ Negative ☐ Not done ☐ Unknown

Imaging: ☐ *Chest X-Ray* ☐ *Chest CT Scan or Other Chest Imaging Study*

Date Performed: _____ *(mm/dd/yyyy)*

Results: ☐ Normal ☐ Pending ☐ Cavitary ☐ Abnormal/Noncavitary ☐ 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: ☐ Pos ☐ Neg ☐ Pending ☐ Not done

Culture for *M. tuberculosis* complex: ☐ Pos ☐ Neg ☐ Pending ☐ Not done

Pathology suggests TB ☐

Rapid Drug Resistance Assay
☐ INH resistance ☐ Not done
☐ RIF resistance
☐ No INH or RIF resistance detected

Nucleic Acid Amplification/PCR Test for M. tuberculosis complex

Specify test type: _____

Results: ☐ Pos ☐ Indeterminate ☐ Neg ☐ Not done

Other test(s): _____

TB TREATMENT INFORMATION

☐ **Current Treatment** *(check all that apply)*
- ☐ INH ☐ RIF ☐ PZA ☐ EMB ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Date Treatment Initiated: _____ *(mm/dd/yyyy)*

☐ ***Drug resistance suspected***

☐ ***Untreated***
- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Patient refused treatment
- ☐ Other: _____
- ☐ Referred to: _____

Remarks: