CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

DISEASE BEING REPORTED

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***

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 ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian
☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____
☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

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:

(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 ☐ Not done ☐ Indeterminate ☐ Unknown ☐ Negative

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:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax
✆ ! Avian Influenza (human)
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound)
✆ ! Brucellosis
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (only hospitalizations and deaths)
Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
FAX ✆ ✉ Colorado Tick Fever
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cysticercosis or Taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae* invasive disease (report an incident less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
Hepatitis, Viral
FAX ✆ ✉ Hepatitis A
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta)
Hepatitis, other, acute
Influenza deaths (report an incident of less than 18 years of age)
Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
FAX ✆ ✉ Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, Human or Animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, Human or Animal
FAX ✆ ✉ Relapsing Fever
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
✆ ! Tularemia
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
Typhus Fever
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)
FAX ✆ ✉ West Nile Virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! **OCCURRENCE of ANY UNUSUAL DISEASE**
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) § 2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Heatlh and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org