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)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Home Address: Number, Street

Apt./Unit No.

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*

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

☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese

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

☐ Chinese ☐ Korean ☐ Other *(specify)*:
☐ Filipino ☐ Laotian

Email Address

Primary Language ☐ English ☐ Spanish ☐ Other: _____

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

Birth Date *(mm/dd/yyyy)*

Age ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

☐ White
☐ Other *(specify)*: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown

Est. Delivery Date *(mm/dd/yyyy)*

Country of Birth

☐ 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**

REPORT TO:

VENTURA COUNTY
PUBLIC HEALTH
A Department of Ventura County Health Care Agency

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

Tuberculosis Control Program
Phone: (805) 385-9451
Fax: (805) 385-9445

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

Telephone Number **Fax Number**

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

Attachments (i.e. labs and clinical notes) can be added to email.

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

TUBERCULOSIS (TB)

TB TREATMENT INFORMATION

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): _____

☐ **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: