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

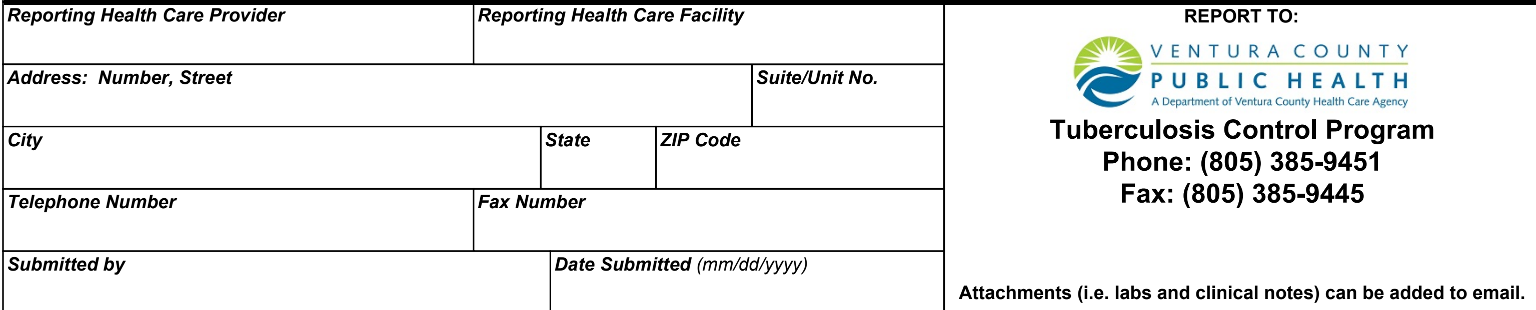
Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

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:

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

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

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

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 should 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 ☐ Neg ☐ Indeterminate ☐ 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: