

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

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		Gender		<input type="checkbox"/> M to F Transgender <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____	
<input type="checkbox"/> Months <input type="checkbox"/> Days		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		<input type="checkbox"/> Asian (check all that apply) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown			
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: Mendocino County Public Health Communicable Disease Control 1120 South Dora Street Ukiah, CA 95482 Phone: (707) 472-2713 Fax: (707) 472-2714 (Obtain additional forms from your local health department.)	
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

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

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 jurisdiction 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)(1)]

- ⓪ ! = 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.)
- ⓪ = Report by telephone within one working day of identification (designated by a + in regulations).
- FAX ⓪ = 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(ii)(1)

<p>FAX ⓪ = Amebiasis Anaplasmosis ⓪ † Anthrax, human or animal FAX ⓪ = Babesiosis ⓪ † Botulism (Infant, Foodborne, Wound, Other) Brucellosis, animal (except infections due to <i>Brucella canis</i>) ⓪ † Brucellosis, human FAX ⓪ = Campylobacteriosis Chancroid FAX ⓪ = Chickenpox (Varicella) (outbreaks, hospitalizations and deaths) FAX ⓪ = Chikungunya Virus Infection <i>Chlamydia trachomatis</i> infections, including lymphogranuloma venereum (LGV) ⓪ † Cholera ⓪ † Ciguatera Fish Poisoning Coccidioidomycosis Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE) FAX ⓪ = Cryptosporidiosis Cyclosporiasis Cysticercosis or taeniasis ⓪ † Dengue Virus Infection ⓪ † Diphtheria ⓪ † Domoic Acid Poisoning (Amnesic Shellfish Poisoning) Ehrlichiosis FAX ⓪ = Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic ⓪ † <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli</i> O157 ⓪ † Flavivirus infection of undetermined species † FAX ⓪ = Foodborne Disease Giardiasis Gonococcal Infections FAX ⓪ = <i>Haemophilus influenzae</i>, invasive disease, all serotypes (report an incident of less than five years of age) FAX ⓪ = Hantavirus Infections ⓪ † Hemolytic Uremic Syndrome FAX ⓪ = Hepatitis A, acute infection Hepatitis B (specify acute case or chronic) Hepatitis C (specify acute case or chronic) Hepatitis D (Delta) (specify acute case or chronic) Hepatitis E, acute infection Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS) Human Immunodeficiency Virus (HIV), acute infection Influenza, deaths in laboratory-confirmed cases for age 0-64 years ⓪ † Influenza, novel strains (human) Legionellosis Leptosy (Hansen Disease) Leptospirosis</p>	<p>FAX ⓪ = Listeriosis Lyme Disease FAX ⓪ = Malaria ⓪ † Measles (Rubeola) FAX ⓪ = Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic ⓪ † Meningococcal Infections Mumps ⓪ † Novel Virus Infection with Pandemic Potential ⓪ † Paralytic Shellfish Poisoning FAX ⓪ = Pertussis (Whooping Cough) ⓪ † Plague, human or animal FAX ⓪ = Poliovirus Infection FAX ⓪ = Psittacosis FAX ⓪ = Q Fever ⓪ † Rabies, human or animal FAX ⓪ = Relapsing Fever Respiratory Syncytial Virus (only report a death in a patient less than less than five years of age) Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses Rocky Mountain Spotted Fever Rubella (German Measles) Rubella Syndrome, Congenital FAX ⓪ = Salmonellosis (Other than Typhoid Fever) ⓪ † Scombroid Fish Poisoning ⓪ † Shiga toxin (detected in feces) FAX ⓪ = Shigellosis ⓪ † Smallpox (Variola) FAX ⓪ = Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only) FAX ⓪ = Syphilis Tetanus FAX ⓪ = Trichinosis FAX ⓪ = Tuberculosis Tularemia, animal ⓪ † Tularemia, human FAX ⓪ = Typhoid Fever, Cases and Carriers FAX ⓪ = <i>Vibrio</i> Infections ⓪ † Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) FAX ⓪ = West Nile Virus (WNV) Infection ⓪ † Yellow Fever FAX ⓪ = Yersiniosis ⓪ † Zika Virus Infection ⓪ † OCCURRENCE of ANY UNUSUAL DISEASE ⓪ † OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500) Specify if institutional and/or open community.</p>
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HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and <http://www.cdph.ca.gov/programs/aids/Pages/IOAHIVRptgSP.aspx>

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800-2812 and §2693(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 (Health & 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.ccrca.org.