CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

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

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

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:

San Benito County Health & Human Services Agency--Public Health Services
439 Fourth Street, Hollister, CA 95023
Phone: 831-637-5367
Confidential fax: 831-637-9073
After 5 p.m., weekends & holidays:
Phone: 831-471-1170

(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:

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)(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.)
✆ = Report by telephone within one working day of identification (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)

FAX ✆ ✉	Amebiasis
	Anaplasmosis
✆ !	Anthrax, human or animal
FAX ✆ ✉	Babesiosis
✆ !	Botulism (Infant, Foodborne, Wound, Other)
	Brucellosis, animal (except infections due to *Brucella canis*)
✆ !	Brucellosis, human
FAX ✆ ✉	Campylobacteriosis
	Chancroid
FAX ✆ ✉	Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
FAX ✆ ✉	Chikungunya Virus Infection
	Chlamydia trachomatis infections, including lymphogranuloma venereum (LGV)
✆ !	Cholera
✆ !	Ciguatera Fish Poisoning
	Coccidioidomycosis
	Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉	Cryptosporidiosis
	Cyclosporiasis
	Cysticercosis or taeniasis
✆ !	Dengue Virus Infection
✆ !	Diphtheria
✆ !	Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
	Ehrlichiosis
FAX ✆ ✉	Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ !	*Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
✆ !	Flavivirus infection of undetermined species
† FAX ✆ ✉	Foodborne Disease
	Giardiasis
	Gonococcal Infections
FAX ✆ ✉	*Haemophilus influenzae,* invasive disease, all serotypes (report an incident of less than five years of age)
FAX ✆ ✉	Hantavirus Infections
✆ !	Hemolytic Uremic Syndrome
FAX ✆ ✉	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
✆ !	Influenza, novel strains (human)
	Legionellosis
	Leprosy (Hansen Disease)
	Leptospirosis
FAX ✆ ✉	Listeriosis
	Lyme Disease
FAX ✆ ✉	Malaria
✆ !	Measles (Rubeola)
FAX ✆ ✉	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ !	Meningococcal Infections
	Mumps
✆ !	Novel Virus Infection with Pandemic Potential
✆ !	Paralytic Shellfish Poisoning
FAX ✆ ✉	Pertussis (Whooping Cough)
✆ !	Plague, human or animal
FAX ✆ ✉	Poliovirus Infection
FAX ✆ ✉	Psittacosis
FAX ✆ ✉	Q Fever
✆ !	Rabies, human or animal
FAX ✆ ✉	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 ✆ ✉	Salmonellosis (Other than Typhoid Fever)
✆ !	Scombroid Fish Poisoning
✆ !	Shiga toxin (detected in feces)
FAX ✆ ✉	Shigellosis
✆ !	Smallpox (Variola)
FAX ✆ ✉	Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉	Syphilis
	Tetanus
FAX ✆ ✉	Trichinosis
FAX ✆ ✉	Tuberculosis
	Tularemia, animal
✆ !	Tularemia, human
FAX ✆ ✉	Typhoid Fever, Cases and Carriers
FAX ✆ ✉	*Vibrio* Infections
✆ !	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉	West Nile Virus (WNV) Infection
✆ !	Yellow Fever
FAX ✆ ✉	Yersiniosis
✆ !	Zika Virus Infection
✆ !	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 §2641.30-2643.20

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/tOAHIVRptgSP.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 (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.ccrcal.org.