

# CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

## DISEASE BEING REPORTED

<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Ethnicity (check one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown	
<b>Home Address: Number, Street</b>				<b>Apt./Unit No.</b>		
<b>City</b>		<b>State</b>	<b>ZIP Code</b>			
<b>Home Telephone Number</b>		<b>Cell Telephone Number</b>		<b>Work Telephone Number</b>		
<b>Email Address</b>				<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
<b>Birth Date (mm/dd/yyyy)</b>		<b>Age</b> <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	<b>Gender</b> <input type="checkbox"/> M to F Transgender <input type="checkbox"/> Male <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Female <input type="checkbox"/> Other: _____			
<b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Est. Delivery Date (mm/dd/yyyy)</b>		<b>Country of Birth</b>		
<b>Occupation or Job Title</b>				<b>Occupational or Exposure Setting (check all that apply):</b> <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): _____		
<b>Date of Onset (mm/dd/yyyy)</b>		<b>Date of First Specimen Collection (mm/dd/yyyy)</b>		<b>Date of Diagnosis (mm/dd/yyyy)</b>		<b>Date of Death (mm/dd/yyyy)</b>
<b>Reporting Health Care Provider</b>			<b>Reporting Health Care Facility</b>			
<b>Address: Number, Street</b>				<b>Suite/Unit No.</b>		
<b>City</b>		<b>State</b>	<b>ZIP Code</b>			
<b>Telephone Number</b>		<b>Fax Number</b>				
<b>Submitted by</b>			<b>Date Submitted (mm/dd/yyyy)</b>			
<b>Laboratory Name</b>			<b>City</b>	<b>State</b>	<b>ZIP Code</b>	



**REPORT TO:**  
**Ventura County Public Health**  
**Tuberculosis Control Program**  
**Phone (805) 385-9451**  
**FAX (805) 385-9445**  
<http://www.vchca.org/public-health/for-health-care-providers>

Attachments (i.e. labs and clinical notes) can be added to E-mail.

TUBERCULOSIS (TB)	TB TREATMENT INFORMATION
<p><b>Status</b></p> <input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected  <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Converter*  <p>* For TST, an increase of ≥10 mm in induration size during ≤2 years.</p> <p><b>Sites(s)</b></p> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both	<p><b>Mantoux TB Skin Test</b></p> <p>Date Placed (mm/dd/yyyy) _____ Date Read (mm/dd/yyyy) _____</p> <p>Results: _____ mm    <input type="checkbox"/> Not done  <input type="checkbox"/> Pending  <input type="checkbox"/> Not read</p> <p><b>Interferon Gamma Release Assay (IGRA)</b></p> <p>Date Collected: _____ (mm/dd/yyyy)</p> <p>Specify test name: _____</p> <p>Results: <input type="checkbox"/> Positive    <input type="checkbox"/> Not done  <input type="checkbox"/> Indeterminate    <input type="checkbox"/> Unknown  <input type="checkbox"/> Negative</p> <p><b>Imaging:</b>    <input type="checkbox"/> Chest X-Ray  <input type="checkbox"/> Chest CT Scan or Other Chest Imaging Study</p> <p>Date Performed: _____ (mm/dd/yyyy)</p> <p>Results: <input type="checkbox"/> Normal  <input type="checkbox"/> Pending  <input type="checkbox"/> Cavitory  <input type="checkbox"/> Abnormal/Noncavitory  <input type="checkbox"/> Not done</p>
<p><b>Bacteriology/Pathology</b></p> <p>Please mark positive on smear or culture if any of initial specimens obtained was positive</p> <p>Date Specimen Collected: _____ (mm/dd/yyyy)</p> <p>Source: _____</p> <p>Smear for acid-fast bacilli:  <input type="checkbox"/> Pos    <input type="checkbox"/> Neg    <input type="checkbox"/> Pending    <input type="checkbox"/> Not done</p> <p>Culture for <i>M. tuberculosis</i> complex:  <input type="checkbox"/> Pos    <input type="checkbox"/> Neg    <input type="checkbox"/> Pending    <input type="checkbox"/> Not done</p> <p>Pathology suggests TB    <input type="checkbox"/></p> <p>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</p> <p><b>Nucleic Acid Amplification/PCR Test for <i>M. tuberculosis</i> complex</b></p> <p>Specify test type: _____</p> <p>Results: <input type="checkbox"/> Pos    <input type="checkbox"/> Indeterminate  <input type="checkbox"/> Neg    <input type="checkbox"/> Not done</p> <p><b>Other test(s):</b> _____</p>	<p><input type="checkbox"/> <b>Current Treatment (check all that apply)</b></p> <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: _____ <p><b>Date Treatment Initiated:</b> _____ (mm/dd/yyyy)</p> <p><input type="checkbox"/> <b>Drug resistance suspected</b></p> <p><input type="checkbox"/> <b>Untreated</b></p> <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)(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(i)(1)**

- Acquired Immune Deficiency Syndrome (AIDS)  
(HIV infection only: see "Human Immunodeficiency Virus")
- FAX Ⓢ Ⓢ Amebiasis
- Ⓢ ! Anaplasmosis/Ehrlichiosis
- Ⓢ ! 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) (only hospitalizations and deaths)
- 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
- Ⓢ ! 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 of less than 15 years of age)
- Ⓢ ! 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
- 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
- Ⓢ ! 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
- 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
- Ⓢ ! 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, 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
- Ⓢ ! 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 (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](http://www.ccrca.org).