CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

DISEASE BEING REPORTED ☐ Tuberculosis Inpatient ☐

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:
County of Riverside Department of Public Health
Disease Control Branch
Tuberculosis Program
P.O. Box 7600, Riverside, CA 92513-7600
Phone: (951) 358-5107 Fax: (951) 358-7922

AFTER HOURS, HOLIDAY & WEEKEND
Emergency: (951) 782-2974

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 ☐ 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): _____

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: