



**NYC Department of Health & Mental Hygiene
Universal Reporting Form**

To order more copies of this form call the Provider Access Line: 1-866-NYC-DOH1

Form PD-16 (9/09)

PHA No.		
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Mail completed form to: NYC Dept. of Health & Mental Hygiene; 125 Worth Street, Room 315, CN-6; New York, NY 10013 • Or report online: www.nyc.gov/nycmed

PATIENT INFORMATION	Patient Last Name		First Name		Middle Name		DATE OF REPORT ____ / ____ / ____						
	Patient AKA: Last Name		AKA: First Name		M.I.								
	Date of Birth ____ / ____ / ____		Age		Country of Birth		Soc. Sec. No.						
	If patient is a child, Guardian Last Name			Guardian First Name		M.I.		<input type="checkbox"/> Homeless Borough: <input type="checkbox"/> Manhattan <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island <input type="checkbox"/> NYC, borough unknown <input type="checkbox"/> Not NYC (Specify City/State) _____, _____ <input type="checkbox"/> Unknown					
	Patient Home Address <input type="checkbox"/> Unknown				Apt. No.		Zip Code						
	Home Telephone Number <input type="checkbox"/> Unknown (____) _____ - _____				Medical Record Number								
	Other Telephone Number <input type="checkbox"/> Unknown (____) _____ - _____				Medicaid Number <input type="checkbox"/> Unknown								
	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transsexual <input type="checkbox"/> Unknown		Race (Check all that apply) <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> Other race <input type="checkbox"/> Native Hawaiian/Pacific Islander			Ethnicity (Check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Please report non-NYC residents to the appropriate health jurisdiction <input type="checkbox"/> Unknown					
	Admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Admission Date ____ / ____ / ____ <input type="checkbox"/> Unknown		Is patient alive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If no, date of death ____ / ____ / ____ <input type="checkbox"/> Unknown		Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				
	Discharge Date ____ / ____ / ____ <input type="checkbox"/> Unknown								If yes, due date ____ / ____ / ____ <input type="checkbox"/> Unknown				
DATE OF DIAGNOSIS ____ / ____ / ____		Risk Groups for Disease Exposure and/or Transmission <input type="checkbox"/> Unknown Patient works in: <input type="checkbox"/> Childcare <input type="checkbox"/> Food service <input type="checkbox"/> Health care <input type="checkbox"/> Nursing home <input type="checkbox"/> Other _____ Attends/resides in: <input type="checkbox"/> Nursing home <input type="checkbox"/> Day Care/Group baby-sit <input type="checkbox"/> Homeless shelter <input type="checkbox"/> Correctional facility <input type="checkbox"/> School <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____ Foreign travel: Countries _____ <input type="checkbox"/> Date returned to U.S. ____ / ____ / ____											
DATE OF ILLNESS ONSET <input type="checkbox"/> Unknown ____ / ____ / ____													
REPORTER INFORMATION		Name of Person Reporting Disease				Phone Number (____) _____ - _____							
Facility of Person Reporting Disease				PFI Code				Street Address					
								City		State		Zip Code	
Name of Hospital/Healthcare Facility				PFI Code				Phone <input type="checkbox"/> Unknown (____) _____ - _____					
Street Address								City		State		Zip Code	
Name of Testing Laboratory <input type="checkbox"/> Unknown				PFI Code <input type="checkbox"/> Unknown				Phone <input type="checkbox"/> Unknown (____) _____ - _____					
Street Address <input type="checkbox"/> Unknown								City <input type="checkbox"/> Unknown		State <input type="checkbox"/> Unknown		Zip Code <input type="checkbox"/> Unknown	
Name of Physician <input type="checkbox"/> Unknown								Phone <input type="checkbox"/> Unknown (____) _____ - _____					
Street Address <input type="checkbox"/> Unknown								City <input type="checkbox"/> Unknown		State <input type="checkbox"/> Unknown		Zip Code <input type="checkbox"/> Unknown	

Call DOHMH if there is an outbreak or suspected outbreak of any disease or condition, of known or unknown etiology occurring in three or more persons or any unusual manifestation of a disease in an individual. Call Provider Access Line 1-866-NYC-DOH1; after hours, call Poison Control Center 1-212-Poisons (764-7667)

Comments (Additional space on Page 4)

Patient Last Name	First Name	Medical Record Number
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DISEASE WITH SPECIAL INSTRUCTIONS

- Amebiasis (*Entamoeba histolytica* only or cases in which *E. histolytica* cannot be distinguished from *Entamoeba dispar*.)**
- Anaplasmosis
Formerly human granulocytic ehrlichiosis
- Animal Bites (please fill out animal bite information below)
 - Exposure to rabies*
Including a bite or other exposure (e.g. scratch) to any animal confirmed to have rabies, or from any rabies vector species (raccoon, bat, skunk, fox or coyote), or any mammal exhibiting signs suggestive of rabies.
 - Animal Species: _____
 - Breed: _____
 - Color(s): _____
 - Date of Bite: ____/____/____
 - Area of body bitten _____
 - Activity at time of bite _____
 - Place of occurrence _____
 - Treatment given: _____
 - Rabies prophylaxis Yes No
 - HRIG Yes No
 - Rabies Vaccine Yes No
 - Animal Owned Stray Unknown
 - Animal's owner (last name, first name): _____

Address (Street, Apt.): _____

Boro/City, State, Zip: _____

Telephone Number: _____

(_____) _____ - _____

- Anthrax *
- Arboviral Infections*
Specify which virus: _____
If Dengue, West Nile or Yellow Fever, report as such.
Attach copies of diagnostic laboratory results if available.
- Babesiosis
Babesiosis can be transmitted through blood products. If patient has a history of receiving blood transfusion or donating blood within 3 months of onset of illness, report suspected/confirmed cases immediately.*
- Botulism*
 - Foodborne Wound Infant
- Brucellosis *
- Campylobacteriosis **
- Chancroid: see STD section, page 3
- Chlamydia: see STD section, page 3
- Cholera */**
- Creutzfeld-Jakob Disease: see Transmissible Spongiform Encephalopathy
- Cryptosporidiosis **
- Cyclospora **
- Dengue
Attach copies of diagnostic laboratory results if available.
- Drowning
Respiratory impairment from submersion/immersion in liquid.
Drowning Location: _____
Outcome: Death Morbidity No Morbidity
- Diphtheria *

- Ehrlichiosis, Human monocytic ehrlichiosis
If human granulocytic anaplasmosis report as anaplasmosis.
- Encephalitis
Jul.1–Oct. 31 consider and test for West Nile virus.
If due to another reportable disease (e.g. Lyme, West Nile, arbovirus), report under the other disease.
- Escherichia coli* O157:H7 **
- Escherichia coli* (other) Shiga Toxin Producing **
- Giardiasis **
- Glanders *
- Gonorrhea: see STD section, page 3
- Granuloma Inguinale: see STD section, page 3
- Hantavirus *
- Hemolytic Uremic Syndrome
- Hemophilus influenzae*, invasive only
Specimen Source:
 Blood CSF Unknown
 Other _____
- Specify Serotype:*
 Type B Not typeable
 Not tested Unknown
 Other _____

FOR ALL HEPATITIS REPORTS:

Jaundice Yes No Unknown

ALT (SGPT) value: _____ Unknown

Lab reference range: _____ Unknown

- Hepatitis A */**
Total Ab to Hepatitis A is NOT reportable
IgM anti-HAV: Pos Neg Unknown
- Hepatitis B
Report at least one positive hepatitis B test result:
Total Ab to Hepatitis B is NOT reportable
IgM anti-HBc Pos Neg Unknown
If positive, describe symptoms and risks in comments box on page 1 and indicate sexual partners in the past year (Check only one)
 - Males only Females only
 - Males and Females Unknown
- HBsAg: Pos Neg Unknown
- HBeAg: Pos Neg Unknown
- HBV Nucleic Acid: Pos Neg Unknown
- Cases in pregnant women must be reported on the IMMS or via Reporting Central. For information call 718-520-8245.
- Hepatitis C
Check all that apply:
 - EIA with high s/co value: _____
 - RIBA pos. HCV Nucleic Acid (e.g.PCR) pos
 - Is this an acute/new infection? Yes No Unk
- Hepatitis D
- Hepatitis E
- Hepatitis other/Unspecified
For hepatitis D, E, and other/unspecified, please describe in comments box on Page 1.

- Herpes, Neonatal: see STD section, page 3
- HIV/AIDS. For assistance in reporting a case of HIV/AIDS, to receive the required New York State Provider Report Forms (PRF), or to obtain more information, call (212) 442-3388.
- Influenza Check all that apply:
 - Suspected novel viral strain with pandemic potential (e.g. H5) *
 - Death in a child younger than 18 years of age
- Kawasaki Syndrome
- Legionellosis, *Specify positive test:*
 - Culture Urine antigen
 - DFA Serology
- Leprosy (Hansen's Disease)
- Leptospirosis
- Listeriosis
- Lyme Disease
Erythema migrans present?
 Yes No Unknown
- Lymphocytic Choriomeningitis Virus
- Lymphogranuloma Venereum: see STD section on Page 3
- Malaria ** *Select at least one of the following:*
 - falciparum vivax malariae
 - ovale undetermined
- Measles *
- Melioidosis *
- Meningitis, Aseptic/Viral
Jul.1–Oct. 31 consider and test for West Nile virus.
If due to another reportable disease (e.g. Lyme, West Nile, arbovirus), report under the other disease.
- Meningitis, other bacterial
Specify Organism: _____
- Meningococcal Disease, Invasive*
Test type/Specimen source:
 - Blood culture CSF Culture
 - Antigen test from CSF Gram stain
 - Other _____
- Monkeypox *
- Mumps
- Pertussis for hospitalized cases*
- Plague *
- Poisoning: see Poisoning section, page 3
- Polio *
- Psittacosis
- Q Fever *
- Rabies *
- Ricin *
- Rickettsialpox
- Rocky Mountain Spotted Fever
- Rubella
for an IgM positive case in pregnant women*
- Rubella, Congenital Syndrome

- Salmonellosis ** Serogroup: _____
If due to *Salmonella typhi* or *paratyphi*, select Typhoid/Paratyphoid Fever
- SARS (Severe Acute Respiratory Syndrome) *
- Shigellosis **
- Smallpox *
- Staph Enterotoxin B *
- Staphylococcus aureus*, vancomycin intermediate and resistant*
Source: _____
MIC (µg/ml): _____
- Streptococcus (Group A) Invasive only
Specify Source: Blood CSF Unknown
 Other, *Specify:* _____
- Streptococcus (Group B) Invasive only
Specify Source: Blood CSF Unknown
 Other, *Specify:* _____
- Syphilis: see STD section, page 3
- Tetanus
- Toxic shock syndrome, For staph only.
For strep select *Streptococcus (Group A)*.
- Trachoma
- Transmissible Spongiform Encephalopathy
Creutzfeld-Jakob Disease and variants
Testing done: _____
(e.g. 14-3-3 on CSF, brain biopsy, autopsy, EEG/MRI)
- Trichinosis: Caused by bacterium *Trichinella spiralis*. (Trichomoniasis, caused by *Trichomonas vaginalis*, need not be reported.)
- Tuberculosis: see TB section on page 4
- Tularemia *
- Typhoid/Paratyphoid Fever **
- Vaccinia disease (adverse events associated with smallpox vaccination) *
- Vibrio spp. *
Specify species: _____
- Viral Hemorrhagic Fever *
- West Nile Virus * Attach copies of diagnostic laboratory results if available
- Window Falls.
Falls from windows of buildings with three or more apartments, by children aged ten years and younger, report on yellow **Child Window Fall Notification Report**. For assistance call 1-866-NYC-DOH1
- Yellow Fever * Attach copies of diagnostic laboratory results if available
- Yersiniosis ** non-plague

Patient Last Name	First Name	Medical Record Number
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POISONINGS

MODE OF EXPOSURE <input type="radio"/> Ingestion <input type="radio"/> Ocular <input type="radio"/> Dermal <input type="radio"/> Inhalation <input type="radio"/> Aural <input type="radio"/> Bite <input type="radio"/> Sting <input type="radio"/> IV	TYPE <input type="radio"/> Lead For persons aged 16 and older indicate: Employer _____ Employer Phone: (____) ____-_____ <input type="radio"/> Arsenic <input type="radio"/> Cadmium <input type="radio"/> Carbon Monoxide* <input type="radio"/> Mercury <input type="radio"/> Pesticide <input type="radio"/> Other _____ <input type="radio"/> Other _____	QUANTITY <input type="radio"/> Milliliter (mL) _____ <input type="radio"/> Mouthful _____ <input type="radio"/> Sip _____ <input type="radio"/> Tablespoon _____ <input type="radio"/> Tab/pill/cap _____ <input type="radio"/> Taste/lick/drop _____ <input type="radio"/> Teaspoon _____ <input type="radio"/> Unknown	REASON <i>Intentional</i> <input type="radio"/> Suspected suicide <input type="radio"/> Misuse <input type="radio"/> Abuse <input type="radio"/> Unknown <i>Other</i> <input type="radio"/> Contamination/tampering <input type="radio"/> Malicious <input type="radio"/> Withdrawal <i>Adverse reaction</i> <input type="radio"/> Drug <input type="radio"/> Food <input type="radio"/> Other <input type="radio"/> Unknown	SYMPTOM ASSESSMENT (Check all that apply) <input type="radio"/> None <input type="radio"/> Nausea/vomiting/diarrhea <input type="radio"/> Lethargic/stupor/coma <input type="radio"/> Agitated <input type="radio"/> Hypertensive <input type="radio"/> Hypotensive <input type="radio"/> Tachycardia <input type="radio"/> Bradycardia <input type="radio"/> Seizure <input type="radio"/> Electrolyte abnormalities <input type="radio"/> Cough/shortness of breath <input type="radio"/> Ocular irritation <input type="radio"/> Skin irritation <input type="radio"/> Unknown <input type="radio"/> Other _____	
SPECIMEN SOURCE <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Urine <input type="radio"/> Other _____ Laboratory Accession Number _____ Date Collected ____/____/____ Date Analyzed ____/____/____ Results (units) _____ Purpose of test <input type="radio"/> Initial <input type="radio"/> Repeat <input type="radio"/> Follow-up	TIME OF EXPOSURE _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM	VITAL SIGNS Body Weight _____ Resp: _____ Pupils: _____ <input type="radio"/> Pounds <input type="radio"/> Kilograms Temp: _____ ° F / ° C <input type="radio"/> Dilated <input type="radio"/> Constricted BP: _____/_____/_____ Pulse: _____			PROVIDER TREATMENT <input type="radio"/> No therapy required <input type="radio"/> Oral fluids <input type="radio"/> Emesis <input type="radio"/> Lavage <input type="radio"/> Activated charcoal <input type="radio"/> Cathartic <input type="radio"/> Chelation <input type="radio"/> Insect sting mgmt. <input type="radio"/> Irrigated eye <input type="radio"/> Oxygen <input type="radio"/> Naloxone <input type="radio"/> 50% Dextrose/Thiamine <input type="radio"/> Alkalinize urine <input type="radio"/> N-acetylcysteine (Mucromyst) <input type="radio"/> Other: _____

SEXUALLY TRANSMITTED DISEASES

FOR ALL STD REPORTS <i>As of the date of this report,</i> <input checked="" type="checkbox"/> Were any of this patient's sex partners notified of possible exposure to a sexually transmitted disease? <input type="radio"/> Yes, our office notified the partner(s) <input type="radio"/> Yes, the patient was asked to notify partner(s) <input type="radio"/> No <input type="radio"/> Unknown <input checked="" type="checkbox"/> Did you provide treatment for any of this patient's sex partners? <input type="radio"/> Yes, I gave extra medication/prescription for the sex partner(s) <i>If yes, for how many sex partners was medication/prescription provided? _____</i> <input type="radio"/> Yes, I saw the sex partner(s) in my office <input type="radio"/> No <input type="radio"/> Unknown <input checked="" type="checkbox"/> For all sexually transmitted diseases, indicate sexual partners in past year (Check only one) <input type="radio"/> Males only <input type="radio"/> Females only <input type="radio"/> Males and Females <input type="radio"/> Unknown <input type="checkbox"/> Chancroid <i>Specify specimen source:</i> <input type="radio"/> Penile <input type="radio"/> Vaginal <input type="radio"/> Endocervical <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Other _____ Specimen collection date ____/____/____ Treatment _____ Treatment date ____/____/____ ° Unknown <input type="checkbox"/> Chlamydia (CT) <i>Specify specimen source:</i> <input type="radio"/> Endocervical <input type="radio"/> Urethral <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Urine <input type="radio"/> Other _____ <i>Specify test type:</i> <input type="radio"/> Culture <input type="radio"/> Nucleic acid amplification <input type="radio"/> Nucleic acid hybridization <input type="radio"/> EIA <input type="radio"/> DFA <input type="radio"/> Other: _____	Specimen collection date ____/____/____ Treatment _____ Treatment date ____/____/____ ° Unknown <input type="checkbox"/> Gonorrhea (GC) <i>Specify specimen source:</i> <input type="radio"/> Endocervical <input type="radio"/> Urethral <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Urine <input type="radio"/> Other _____ <i>Specify test type:</i> <input type="radio"/> Culture <input type="radio"/> Nucleic acid amplification <input type="radio"/> Nucleic acid hybridization <input type="radio"/> Other: _____ Specimen collection date ____/____/____ Treatment _____ Treatment date ____/____/____ ° Unknown <input type="checkbox"/> Granuloma Inguinale <i>Specify specimen source:</i> <input type="radio"/> Penile <input type="radio"/> Vaginal <input type="radio"/> Endocervical <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Other _____ Specimen collection date ____/____/____ Treatment _____ Treatment date ____/____/____ ° Unknown <input type="checkbox"/> Herpes, Neonatal Herpes simplex virus infection in infants aged 60 days or less. <input type="radio"/> Clinical dx <input type="radio"/> Lab confirmed dx: <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Antigen detection <input type="checkbox"/> Serologic <input type="checkbox"/> Tzanck <i>Herpes type:</i> <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Not typed <i>Clinical Syndrome (check all that apply):</i> <input type="radio"/> Skin, eye, mucous membrane infection <input type="radio"/> CNS involvement <input type="radio"/> Disseminated disease Herpes lesions present? <input type="radio"/> Yes, anatomic site _____ <input type="radio"/> No <input type="radio"/> Unknown Specimen collection date ____/____/____	Treatment for infant _____ Treatment date ____/____/____ ° Unknown Mother's Name: _____ Mother's DOB: ____/____/____ <input type="checkbox"/> Lymphogranuloma Venereum <i>Clinical Presentation (Check all that apply):</i> <input type="radio"/> Proctitis <input type="radio"/> Lymphadenopathy <input type="radio"/> Skin lesion <input type="radio"/> Buboe <input type="radio"/> Other _____ Specimen collection date ____/____/____ Treatment _____ Treatment date ____/____/____ ° Unknown <input type="checkbox"/> Syphilis Stage: <input type="radio"/> Congenital <input type="radio"/> Primary (chancere present) <i>check all that apply</i> <input type="checkbox"/> Penile <input type="checkbox"/> Vaginal <input type="checkbox"/> Endocervical <input type="checkbox"/> Anorectal <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Other _____ <input type="radio"/> Secondary <input type="checkbox"/> Alopecia <input type="checkbox"/> Condylomata <input type="checkbox"/> Mucous patches <input type="checkbox"/> Rash <input type="radio"/> Early Latent (no symptoms, infection ≤ 1 year duration) <input type="radio"/> Late Latent (no symptoms, infection of > 1 year duration) <input type="radio"/> Tertiary (gumma or cardiovascular) Neurologic symptoms present? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Treatment : _____ List Medication and Dosage: _____ Treatment date ____/____/____ ° Unknown	Syphilis Test Types. <i>Check all that apply</i> 1. Serologic tests for syphilis <input type="checkbox"/> A. Non-treponemal Test <input type="radio"/> RPR <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive Titer _____ <input type="radio"/> VDRL <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive Titer _____ Specimen collection date ____/____/____ <input type="checkbox"/> B. Treponemal Test <input type="radio"/> TP-PA/MHA-TP <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> FTA <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> Treponemal IgG <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive Specimen collection date ____/____/____ 2. Cerebrospinal fluid tests <input type="radio"/> CSF VDRL <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> CSF FTA <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> Other Test: _____ Result: _____ Specimen collection date ____/____/____ <input type="radio"/> Elevated CSF protein <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="radio"/> Elevated CSF leukocytes <input type="checkbox"/> Yes <input type="checkbox"/> No Specimen collection date ____/____/____ 3. Organism visualization <input type="radio"/> Darkfield <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="radio"/> Other test: _____ Result: _____ Specimen collection date ____/____/____
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* Report suspected/confirmed cases immediately 1-866-NYC-DOH1, after hours 1-212-764-7667; Report all other results within 24 hours.

** Please complete Risk Groups section on front of form.

Patient Last Name	First Name	Medical Record Number
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TUBERCULOSIS *Please complete Risk Groups section on front of form.*

Tuberculosis *Check all that apply*

Primary disease site:

- Pulmonary
- Lymphatic
- Bone/Joint
- Soft tissue/Muscles
- Peritoneal
- Meningeal
- Genitourinary
- Gastrointestinal
- Other: _____

Other sites:

- Pulmonary
- Lymphatic
- Bone/Joint
- Soft tissue/Muscles
- Peritoneal
- Meningeal
- Genitourinary
- Gastrointestinal
- Other: _____

Laboratory Results:

Specimen Number _____

- Unknown

Specimen Source:

- Sputum
- Tracheal aspirate
- Bronchial fluid/Broncho-alveolar lavage
- Lymph node
- Lung tissue
- Pleural fluid
- Pleura
- Blood
- Urine
- Other: _____

Collection date ___/___/___ Unknown

Testing Laboratory: _____

- Unknown

AFB Smear

- Positive

Smear Grade:

- suspicious
- 1+ rare
- 2+ few
- 3+ moderate
- 4+ numerous
- Negative
- Pending
- Not Done
- Unknown

M. tb Culture

- Positive
- Negative
- Pending
- Contaminated
- Not Done
- Unknown

Nucleic Acid Amplification (NAA)

Test Type:

- MTD
- Amplicor
- Not Done
- Unknown
- Other: _____

Test Result:

- Positive
- Negative
- Pending
- Not Done
- Unknown

Pathology consistent with TB

- Positive
- Negative
- Not Done
- Unknown

Pathology findings: _____

Chest X-Ray ___/___/___

- Normal
- Abnormal
- Miliary
- Non-Cavitary
- Cavitary
 - Consistent with TB
 - Not consistent with TB

CT Scan / **MRI** ___/___/___

- Normal
- Abnormal
- Miliary
- Non-Cavitary
- Cavitary
 - Consistent with TB
 - Not consistent with TB

TB Screening Test

Test Type:

- History of Positive TST
- TST, Size _____ mm
 - Positive
 - Negative

Date Implanted

___/___/___

- QuantiFERON® TB-Gold (QFT-G)
 - Positive
 - Negative
 - Indeterminate or Invalid
- QuantiFERON® TB-Gold in tube (QFT-GIT)
 - Positive
 - Negative
 - Indeterminate or Invalid
- T-Spot.TB
 - Positive
 - Negative
 - Borderline (equivocal)
 - Indeterminate or Invalid

Date blood drawn

___/___/___

Other: _____

- Not done
- Unknown

Treatment

On Anti-TB Medications Yes No Unknown

Please complete for each medication:

<i>Medication</i>	<i>Dose</i>	<i>Start Date</i>
Isoniazid (INH)	_____	___/___/___
Rifampin (RIF)	_____	___/___/___
Pyrazinamide (PZA)	_____	___/___/___
Ethambutol (EMB)	_____	___/___/___
Other 1	_____	___/___/___
Other 2	_____	___/___/___
Other 3	_____	___/___/___

Isolation: Yes No Unknown

Other Medical Problems/Other Pertinent Information:

Comments (Continued from Page 1)