



## New York City Department of Health and Mental Hygiene Universal Reporting Form

To report an **Immediately notifiable** disease or condition, an outbreak among three or more persons or an unusual manifestation of any disease or condition, or any newly apparent or emerging disease or syndrome, call the Provider Access Line at **866-692-3641**.

Diseases and conditions in green and marked with \* are **Immediately notifiable**; those marked with † are immediately notifiable *if* case meets the risk group criteria on page 2. Report by calling **866-692-3641**.

For all other diseases and conditions, report using Reporting Central online via NYCMED at [www.nyc.gov/health/nycmed](http://www.nyc.gov/health/nycmed), mail this form to the NYC Department of Health and Mental Hygiene, 42-09 28<sup>th</sup> Street, CN-22, Long Island City, NY 11101, or call **866-692-3641** for the appropriate fax number.

Go to [www.nyc.gov/health/diseasereporting](http://www.nyc.gov/health/diseasereporting) for more information.

PATIENT INFORMATION										
Patient Last Name			First Name			Middle Name			<b>DATE OF REPORT</b>	
Patient AKA: Last Name			AKA: First Name			AKA: Middle Name			____/____/____	
Age	Date of Birth ____/____/____		Country of Birth			Social Security Number			<b>DATE OF DIAGNOSIS</b>	
If patient is a child, Guardian Last Name			Guardian First Name			Guardian Middle Name			____/____/____	
Medical Record Number				Medicaid Number						<b>DATE OF ILLNESS ONSET</b>
Patient Home Address				City		State		Zip Code		____/____/____
Country				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"/> Unknown <input type="checkbox"/> Not NYC						
Email Address				Mobile Phone			Home Phone			<input type="checkbox"/> Homeless
Sex <input type="checkbox"/> Male <input type="checkbox"/> Transgender MTF		Race <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian		Ethnicity <input type="checkbox"/> Hispanic		<input type="checkbox"/> Unknown <input type="checkbox"/> Female <input type="checkbox"/> Transgender FTM		<input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic		
Is patient alive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Is case suspected to be due to healthcare associated transmission?					
If no, date of death: ____/____/____		If yes, due date: ____/____/____			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Was patient admitted to hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Is patient a newborn infant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
Admission date: ____/____/____			If yes, name of hospital where infant was born _____							
Discharge date: ____/____/____			Name of facility where infant's mother obtained prenatal care _____							
<b>Foreign travel</b>										
Countries _____							Date returned to U.S. ____/____/____			

OTHER INFORMATION										
REPORTER	Name of Person Reporting Disease					Email address			Phone	
	Name of Facility of Person Reporting Disease					National Provider Identifier (NPI) Code		Permanent Facility Identifier (PFI) Code		
	Facility Street Address					City		State	Zip Code	
FACILITY	Name of Hospital/Healthcare Facility Providing Care for Patient					National Provider Identifier (NPI) Code		Permanent Facility Identifier (PFI) Code		
	Facility Street Address					City		State	Zip Code	
LAB	Name of Testing Laboratory					Phone			Permanent Facility Identifier (PFI) Code	
	Laboratory Street Address					City		State	Zip Code	
PROVIDER	Name of Provider Caring for Patient					National Provider Identifier (NPI) Code		Fax		
	Email address					Phone			Mobile Phone	
	Provider Street Address					City		State	Zip Code	

Patient Last Name	First Name	Medical Record Number
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Diseases and conditions in green and marked with \* are immediately notifiable; those marked with † are immediately notifiable if case meets the risk group criteria at the bottom of the page. Report by calling **866-692-3641**.

For all other diseases and conditions, report using Reporting Central online via NYCMED at [www.nyc.gov/health/nycmed](http://www.nyc.gov/health/nycmed), mail this form to the NYC Department of Health and Mental Hygiene, 42-09 28<sup>th</sup> Street, CN-22, Long Island City, NY 11101, or call **866-692-3641** for the appropriate fax number.

Go to [www.nyc.gov/health/diseasereporting](http://www.nyc.gov/health/diseasereporting) for more information.

<input type="checkbox"/> <b>Amebiasis</b> † <input type="checkbox"/> <b>Anaplasmosis</b> (Human granulocytic anaplasmosis) <b>Animal bite</b> – see Environmental Conditions section on page 3. See rabies if potential for exposure. <input type="checkbox"/> <b>Anthrax</b> * <input type="checkbox"/> <b>Arboviral infections, acute</b> * Specify which virus: _____ If Dengue, West Nile or Yellow Fever, report as such. Attach copies of diagnostic laboratory results if available. <input type="checkbox"/> <b>Babesiosis</b> <input type="checkbox"/> <b>Botulism</b> * <input type="checkbox"/> Foodborne <input type="checkbox"/> Infant <input type="checkbox"/> Wound <input type="checkbox"/> <b>Brucellosis</b> * <input type="checkbox"/> <b>Campylobacteriosis</b> † <b>Carbon Monoxide poisoning</b> * – see Poisonings section on page 3 <b>Chancroid</b> – see STD section on page 4 <b>Chlamydia</b> – see STD section on page 4 <input type="checkbox"/> <b>Cholera</b> * <b>Creutzfeldt-Jakob disease</b> – see Transmissible spongiform encephalopathy <input type="checkbox"/> <b>Cryptosporidiosis</b> † <input type="checkbox"/> <b>Cyclosporiasis</b> † <input type="checkbox"/> <b>Dengue</b> Attach copies of dengue diagnostic laboratory results if available. <input type="checkbox"/> <b>Diphtheria</b> * <b>Drownings</b> – see Environmental Conditions section on page 3 <input type="checkbox"/> <b>Ehrlichiosis</b> (Human monocytic ehrlichiosis) If human granulocytic anaplasmosis report as anaplasmosis. <input type="checkbox"/> <b>Encephalitis</b> If 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. <input type="checkbox"/> <b>Escherichia coli</b> O157:H7 infection† <b>Falls from windows</b> – see Environmental Conditions section on page 3 <input type="checkbox"/> <b>Food poisoning in a group of 2 or more individuals</b> * <input type="checkbox"/> <b>Giardiasis</b> † <input type="checkbox"/> <b>Glanders</b> * <b>Gonorrhea</b> – see STD section on page 4 <b>Granuloma inguinale</b> – see STD section on page 4	<input type="checkbox"/> <b>Haemophilus influenzae</b> (invasive disease)† Specimen Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ Specify Serotype: <input type="checkbox"/> Type B <input type="checkbox"/> Not typeable <input type="checkbox"/> Not tested <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Hantavirus disease</b> * <input type="checkbox"/> <b>Hemolytic uremic syndrome</b> <div style="border: 1px solid black; padding: 5px; text-align: center; margin: 10px 0;"> <b>FOR ALL HEPATITIS REPORTS</b>          Jaundice            <input type="checkbox"/> Yes    <input type="checkbox"/> No    <input type="checkbox"/> Unknown          ALT (SGPT) value: _____ <input type="checkbox"/> Unknown          Lab reference range: _____ <input type="checkbox"/> Unknown       </div> <input type="checkbox"/> <b>Hepatitis A</b> † Total Ab to Hepatitis A is NOT reportable. IgM anti-HAV: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown <input type="checkbox"/> <b>Hepatitis B</b> † Report at least one positive hepatitis B test result. Total Ab to Hepatitis B is not reportable. IgM anti-HBc: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown HBsAg: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown HBeAg: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown HBV Nucleic Acid: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unknown If IgM is positive, describe symptoms and risk in comments box on last page and indicate sexual partners in the past year: (Check only one) <input type="checkbox"/> Males only <input type="checkbox"/> Females only <input type="checkbox"/> Males and Females <input type="checkbox"/> Unknown <b>Hepatitis B in pregnancy</b> Report cases in Reporting Central or fax IMM-5 form to 347-396-2558. For more information, call 347-396-2403. <input type="checkbox"/> <b>Hepatitis C</b> † Check all that apply: <input type="checkbox"/> EIA with high s/co value: _____ <input type="checkbox"/> HCV Nucleic Acid (e.g.PCR) pos Is this an acute/new infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> <b>Hepatitis D</b> <input type="checkbox"/> <b>Hepatitis E</b> † <input type="checkbox"/> <b>Hepatitis, other/unspecified infectious viral hepatitis</b> For hepatitis D, E, and other/unspecified, please describe case in comments box on page 4. <b>Herpes, neonatal</b> – see STD section on page 4	<b>HIV/AIDS</b> Report using the New York State Provider Report Form (PRF). Call 518-474-4284 for forms or 212-442-3388 for more information. <b>Influenza</b> <input type="checkbox"/> Suspected novel viral strain with pandemic potential (e.g., avian H5N1 or H7N9)* <input type="checkbox"/> Death in a child aged 18 or younger <b>Lead poisoning</b> – see Poisonings section on page 3 <input type="checkbox"/> <b>Legionellosis</b> † Specify positive test: <input type="checkbox"/> Culture <input type="checkbox"/> Urine antigen <input type="checkbox"/> DFA <input type="checkbox"/> Serology <input type="checkbox"/> <b>Leprosy</b> (Hansen's disease) <input type="checkbox"/> <b>Leptospirosis</b> <input type="checkbox"/> <b>Listeriosis</b> † <input type="checkbox"/> <b>Lyme disease</b> Erythema migrans present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> <b>Lymphocytic choriomeningitis virus</b> <b>Lymphogranuloma venereum</b> – see STD section on page 4 <input type="checkbox"/> <b>Malaria</b> † Select at least one of the following: <input type="checkbox"/> falciparum <input type="checkbox"/> vivax <input type="checkbox"/> malariae <input type="checkbox"/> ovale <input type="checkbox"/> undetermined Complete Foreign Travel section on page 1. <input type="checkbox"/> <b>Measles (rubeola)</b> * <input type="checkbox"/> <b>Melioidosis</b> * <input type="checkbox"/> <b>Meningitis, bacterial</b> <input type="checkbox"/> <b>Meningococcal disease, invasive (including meningitis)</b> * Test type/Specimen source: <input type="checkbox"/> Blood culture <input type="checkbox"/> CSF culture <input type="checkbox"/> Antigen test from CSF <input type="checkbox"/> Gram stain <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>Monkeypox</b> * <input type="checkbox"/> <b>Mumps</b> † <input type="checkbox"/> <b>Paratyphoid fever</b> † <input type="checkbox"/> <b>Pertussis</b> (whooping cough)† <input type="checkbox"/> <b>Pesticide poisoning</b> – see Poisonings section on page 3 <input type="checkbox"/> <b>Plague</b> * <b>Poisoning</b> – see Poisonings section on page 3 <input type="checkbox"/> <b>Poliomyelitis</b> * <input type="checkbox"/> <b>Psittacosis</b> <input type="checkbox"/> <b>Q Fever</b> * <input type="checkbox"/> <b>Rabies and exposure to rabies</b> * – see animal bites in Environmental Conditions section on page 3	<input type="checkbox"/> <b>Ricin poisoning</b> * <input type="checkbox"/> <b>Rickettsialpox</b> <input type="checkbox"/> <b>Rocky Mountain spotted fever</b> <input type="checkbox"/> <b>Rubella</b> (German measles)* <input type="checkbox"/> <b>Rubella syndrome, congenital</b> <input type="checkbox"/> <b>Salmonellosis</b> † Serogroup: _____ If due to Salmonella typhi or paratyphi, select Typhoid or Paratyphoid Fever. <input type="checkbox"/> <b>Severe or novel coronavirus</b> (e.g., SARS or MERS-CoV)* <input type="checkbox"/> <b>Shiga-toxin producing Escherichia coli</b> (STEC) infection† <input type="checkbox"/> <b>Shigellosis</b> † <input type="checkbox"/> <b>Smallpox (variola)</b> * <input type="checkbox"/> <b>Staphylococcal enterotoxin B poisoning</b> * <input type="checkbox"/> <b>Staphylococcus aureus</b> , vancomycin intermediate (VISA) and resistant (VRSA)* Source: _____ MIC (µg/ml): _____ <input type="checkbox"/> <b>Streptococcus</b> (Group A and B) invasive† Specify Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____ <b>Syphilis</b> , including congenital – see STD section on page 4 <input type="checkbox"/> <b>Tetanus</b> <input type="checkbox"/> <b>Toxic shock syndrome</b> <input type="checkbox"/> <b>Trachoma</b> <input type="checkbox"/> <b>Transmissible spongiform encephalopathy</b> (Creutzfeldt-Jakob disease and variants) Testing done: _____ (e.g. 14-3-3 on CSF, brain biopsy, autopsy, EEG/MRI) <input type="checkbox"/> <b>Trichinosis</b> <b>Tuberculosis</b> – see Tuberculosis section on page 3 <input type="checkbox"/> <b>Tularemia</b> * <input type="checkbox"/> <b>Typhoid fever</b> † <input type="checkbox"/> <b>Vaccinia disease</b> (adverse events associated with smallpox vaccination)* <input type="checkbox"/> <b>Vibrio species</b> , non-cholera Specify species: _____ <input type="checkbox"/> <b>Viral hemorrhagic fever</b> * <input type="checkbox"/> <b>West Nile fever and viral neuroinvasive disease</b> (e.g., meningitis and encephalitis)* Attach copies of diagnostic laboratory results if available. <input type="checkbox"/> <b>Yellow fever</b> * Attach copies of diagnostic laboratory results if available. <input type="checkbox"/> <b>Yersiniosis</b> , non-plague†
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\* Report suspected and confirmed cases immediately to 1-866-692-3641. † If case meets any of the risk group criteria below, report immediately to 1-866-692-3641.

RISK GROUPS FOR DISEASE EXPOSURE/TRANSMISSION Complete this section for diseases marked with † and if case meets any criteria, report it immediately to 1-866-692-3641.				
Patient works in:	<input type="checkbox"/> Childcare	<input type="checkbox"/> Health care facility	<input type="checkbox"/> Long-term care facility/Nursing home	<input type="checkbox"/> Clinical/Research laboratory
<input type="checkbox"/> Unknown	<input type="checkbox"/> Food service	<input type="checkbox"/> Correctional facility	<input type="checkbox"/> Position with routine animal contact	<input type="checkbox"/> Other _____
Patient attends/resides in:	<input type="checkbox"/> Assisted living facility	<input type="checkbox"/> School <input type="checkbox"/> Dormitory	<input type="checkbox"/> Day Care/Group baby-sit	<input type="checkbox"/> Long-term care facility/Nursing home
<input type="checkbox"/> Unknown	<input type="checkbox"/> Correctional facility	<input type="checkbox"/> Shelter	<input type="checkbox"/> Other congregate living facility _____	

Patient Last Name	First Name	Medical Record Number
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**ENVIRONMENTAL CONDITIONS**

<input type="checkbox"/> <b>Animal bites</b> <input type="checkbox"/> <b>Exposure to rabies*</b> Including a bite or other exposure 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: _____ Date of Bite: ___/___/___ Area of body bitten: _____ Breed: _____ Color(s): _____ Activity at time of bite: _____ <input type="radio"/> Owned <input type="radio"/> Stray <input type="radio"/> Unknown Place of occurrence: _____ Owner's Name: _____ Treatment given: _____ Address: _____ Rabies prophylaxis <input type="radio"/> Yes <input type="radio"/> No City, State, Zip: _____ HRIG <input type="radio"/> Yes <input type="radio"/> No Phone: _____ Rabies Vaccine <input type="radio"/> Yes <input type="radio"/> No	<input type="checkbox"/> <b>Drownings</b> Respiratory impairment from submersion/immersion in liquid.  Drowning Location: _____ Outcome: <input type="radio"/> Death <input type="radio"/> Morbidity <input type="radio"/> No Morbidity
<input type="checkbox"/> <b>Window Falls</b> Falls from windows of buildings with 3 or more dwellings, by children aged 16 years and younger, report by calling 646-632-6204 or on Child Window Fall Notification Report paper form.	

**POISONINGS**

<b>ROUTE OF EXPOSURE</b> <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	<b>CHEMICAL</b> <input type="checkbox"/> <b>Lead</b> For persons aged 16 and older indicate: Employer _____ Employer phone _____ <input type="checkbox"/> <b>Carbon Monoxide*</b> Source: <input type="radio"/> Furnace/Boiler <input type="radio"/> Generator <input type="radio"/> Vehicle <input type="radio"/> Other _____ <input type="checkbox"/> <b>Arsenic</b> <input type="checkbox"/> <b>Cadmium</b> <input type="checkbox"/> <b>Mercury</b> <input type="checkbox"/> <b>Pesticide</b> <input type="checkbox"/> <b>Other</b> _____	<b>QUANTITY</b> <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 _____	<b>REASON AND SETTING</b> Intentional: <input type="radio"/> Suspected suicide <input type="radio"/> Misuse <input type="radio"/> Abuse <input type="radio"/> Unknown Other: <input type="radio"/> Bite/sting <input type="radio"/> Contamination/tampering <input type="radio"/> Malicious <input type="radio"/> Withdrawal Adverse reaction: <input type="radio"/> Drug <input type="radio"/> Food <input type="radio"/> Other <input type="radio"/> Unknown	<b>SYMPTOM ASSESSMENT (Check all that apply)</b> <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"/> Brachycardia <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 _____
<b>SPECIMEN SOURCE</b> <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Urine <input type="radio"/> Other _____ Date Collected: ___/___/___ Date Analyzed: ___/___/___	Laboratory Accession Number: _____ Results (units): _____ Purpose of test: <input type="radio"/> Initial <input type="radio"/> Repeat <input type="radio"/> Follow-up	<b>DATE AND TIME OF EXPOSURE</b> ___/___/___ :___:___ <input type="radio"/> AM <input type="radio"/> PM	<b>VITAL SIGNS</b> Body Weight: _____ <input type="radio"/> Pounds <input type="radio"/> Kilograms BP: ___/___/___ Resp: _____ Temp: _____ °F <input type="radio"/> °C Pulse: _____ Pupils: <input type="radio"/> Dilated <input type="radio"/> Constricted	<b>PROVIDER TREATMENT</b> <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"/> Naxolone <input type="radio"/> 50% Dextrose/Thiamine <input type="radio"/> Alkalinize urine <input type="radio"/> N-acetylcysteine (Mucromyst) <input type="radio"/> Other _____

**TUBERCULOSIS†**

<b>Tuberculosis† (Check all that apply)</b> Primary disease site: <input type="radio"/> Pulmonary <input type="radio"/> Lymphatic <input type="radio"/> Bone/Joint <input type="radio"/> Soft tissue/Muscles <input type="radio"/> Peritoneal <input type="radio"/> Meningeal <input type="radio"/> Genitourinary <input type="radio"/> Gastrointestinal <input type="radio"/> Other: _____  Other sites: <input type="radio"/> Pulmonary <input type="radio"/> Lymphatic <input type="radio"/> Bone/Joint <input type="radio"/> Soft tissue/Muscles <input type="radio"/> Peritoneal <input type="radio"/> Meningeal <input type="radio"/> Genitourinary <input type="radio"/> Gastrointestinal <input type="radio"/> Other: _____	<b>AFB Smear:</b> <input type="radio"/> Positive Smear Grade: <input type="radio"/> 1+ rare <input type="radio"/> 2+ few <input type="radio"/> 3+ moderate <input type="radio"/> 4+ numerous <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> Not Done <input type="radio"/> Unknown <b>Nucleic Acid Amplification (NAA):</b> Test type: <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> Not Done <input type="radio"/> Unknown <b>M. tb Complex Culture:</b> <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Pending <input type="radio"/> Contaminated <input type="radio"/> Not Done <input type="radio"/> Unknown	<b>CT Scan / MRI</b> ___/___/___ <b>Body Site:</b> <input type="radio"/> Chest <input type="radio"/> Muscle <input type="radio"/> Brain <input type="radio"/> Neck <input type="radio"/> Abdomen <input type="radio"/> Pelvis <input type="radio"/> Head <input type="radio"/> Sinuses <input type="radio"/> Joints <input type="radio"/> Spine <input type="radio"/> Unknown <input type="radio"/> Other: _____ <input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Consistent with TB <input type="radio"/> Not consistent with TB <input type="radio"/> Evidence of Cavity <input type="radio"/> Evidence of Miliary TB	<b>TB Screening Test:</b> <input type="radio"/> History of positive test result Year (yyyy): _____ Date of most recent test: ___/___/___ <b>Type of Test:</b> <input type="radio"/> Tuberculin Skin Test (TST) <input type="radio"/> QuantiFERON® TB-Gold in tube (QFT-GIT) <input type="radio"/> T-Spot TB <b>Result:</b> <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Unknown <input type="radio"/> Indeterminate <input type="radio"/> Borderline Induration _____ mm																								
<b>Laboratory Results:</b> Specimen Number: _____ <input type="radio"/> Unknown  <b>Specimen Source:</b> <input type="radio"/> Sputum <input type="radio"/> Tracheal aspirate <input type="radio"/> Bronchial fluid/Broncho-alveolar lavage <input type="radio"/> Lymph node <input type="radio"/> Lung tissue <input type="radio"/> Pleural fluid <input type="radio"/> Pleura <input type="radio"/> Blood <input type="radio"/> Urine <input type="radio"/> Other: _____  Collection date: ___/___/___ <input type="radio"/> Unknown Testing Laboratory: _____ <input type="radio"/> Unknown	<b>Pathology consistent with TB:</b> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Not Done <input type="radio"/> Unknown Date: ___/___/___ <b>Pathology Specimen Number:</b> _____ <b>Pathology Findings:</b> _____ <b>Chest X-Ray:</b> ___/___/___ <input type="radio"/> Normal <input type="radio"/> Abnormal <input type="radio"/> Consistent with TB <input type="radio"/> Not consistent with TB <input type="radio"/> Evidence of Cavity <input type="radio"/> Evidence of Miliary TB	<b>Treatment:</b> On Anti-TB Medications <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown Please complete for each medication: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:60%;"></th> <th style="width:20%;">Dose (mg)</th> <th style="width:20%;">Start Date</th> </tr> </thead> <tbody> <tr> <td>Isoniazid (INH)</td> <td>_____</td> <td>___/___/___</td> </tr> <tr> <td>Rifampin (RIF)</td> <td>_____</td> <td>___/___/___</td> </tr> <tr> <td>Pyrazinamide (PZA)</td> <td>_____</td> <td>___/___/___</td> </tr> <tr> <td>Ethambutol (EMB)</td> <td>_____</td> <td>___/___/___</td> </tr> <tr> <td>Other 1</td> <td>_____</td> <td>___/___/___</td> </tr> <tr> <td>Other 2</td> <td>_____</td> <td>___/___/___</td> </tr> <tr> <td>Other 3</td> <td>_____</td> <td>___/___/___</td> </tr> </tbody> </table> Airborne Isolation: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown If yes, date initiated: ___/___/___ Date discontinued: ___/___/___ Describe other medical problems or other pertinent information in the comments box on the last page.			Dose (mg)	Start Date	Isoniazid (INH)	_____	___/___/___	Rifampin (RIF)	_____	___/___/___	Pyrazinamide (PZA)	_____	___/___/___	Ethambutol (EMB)	_____	___/___/___	Other 1	_____	___/___/___	Other 2	_____	___/___/___	Other 3	_____	___/___/___
	Dose (mg)	Start Date																									
Isoniazid (INH)	_____	___/___/___																									
Rifampin (RIF)	_____	___/___/___																									
Pyrazinamide (PZA)	_____	___/___/___																									
Ethambutol (EMB)	_____	___/___/___																									
Other 1	_____	___/___/___																									
Other 2	_____	___/___/___																									
Other 3	_____	___/___/___																									

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Patient Last Name	First Name	Medical Record Number
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**SEXUALLY TRANSMITTED DISEASES**

FOR ALL STD REPORTS

<p><b>As of the date of this report,</b>  <b>Were any of this patient's sex partners notified of possible exposure to an STD?</b> (Check all that apply)</p> <p><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</p>	<p><b>Did you provide treatment for any of this patient's partners?</b>          (Check all that apply)</p> <p><input type="radio"/> Yes, I saw the sex partner(s) in my office  <input type="radio"/> Yes, I gave extra medication for _____ (#) partner(s)  <input type="radio"/> Yes, I wrote a prescription for _____ (#) partner(s)  <input type="radio"/> Yes, some other way (specify): _____  <input type="radio"/> No    <input type="radio"/> Unknown</p>	<p><b>Please indicate gender of sexual partners in past year:</b>          (Check only one)</p> <p><input type="radio"/> Males only  <input type="radio"/> Females only  <input type="radio"/> Males and Females  <input type="radio"/> Unknown</p>
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<input type="checkbox"/> <b>Chancroid</b> Specify type of specimen: <input type="radio"/> Penile <input type="radio"/> Vaginal <input type="radio"/> Endocervical <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal Other: _____ Specimen collection date: ___/___/___ Treatment: _____ Treatment date: ___/___/___ <input type="radio"/> Unknown	<input type="checkbox"/> <b>Granuloma inguinale</b> Specify type of specimen: <input type="radio"/> Penile <input type="radio"/> Vaginal <input type="radio"/> Endocervical <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal Other: _____ Specimen collection date: ___/___/___ Treatment: _____ Treatment date: ___/___/___ <input type="radio"/> Unknown	<input type="checkbox"/> <b>Lymphogranuloma venereum</b> Clinical Presentation (Check all that apply) <input type="radio"/> Proctitis <input type="radio"/> Lymphadenopathy <input type="radio"/> Skin lesion <input type="radio"/> Buboe Other: _____ Specimen collection date: ___/___/___ Treatment: _____ Treatment date: ___/___/___ <input type="radio"/> Unknown	Syphilis Test Types: (Check all that apply) 1. Serologic tests for syphilis <input type="radio"/> A. Non-treponemal Test <input type="radio"/> RPR <input type="radio"/> Reactive <input type="radio"/> Non-reactive Titer: _____ <input type="radio"/> VDRL <input type="radio"/> Reactive <input type="radio"/> Non-reactive Titer: _____ Specimen collection date: ___/___/___ <input type="radio"/> B. Treponemal Test <input type="radio"/> TP-PA/MHA-TP <input type="radio"/> Reactive <input type="radio"/> Non-reactive <input type="radio"/> FTA <input type="radio"/> Reactive <input type="radio"/> Non-reactive <input type="radio"/> Treponemal IgG <input type="radio"/> Reactive <input type="radio"/> Non-reactive Specimen collection date: ___/___/___ 2. Cerebrospinal fluid tests <input type="radio"/> CSF VDRL <input type="radio"/> Reactive <input type="radio"/> Non-reactive <input type="radio"/> CSF FTA <input type="radio"/> Reactive <input type="radio"/> Non-reactive Other Test: _____ Result: _____ Specimen collection date: ___/___/___ <input type="radio"/> Elevated CSF protein <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Elevated CSF leukocytes <input type="radio"/> Yes <input type="radio"/> No Specimen collection date: ___/___/___ 3. Organism visualization <input type="radio"/> Darkfield <input type="radio"/> Positive <input type="radio"/> Negative <input type="radio"/> Other test: _____ Result: _____ Specimen collection date: ___/___/___
<input type="checkbox"/> <b>Chlamydia (CT)</b> Specify type of specimen: <input type="radio"/> Endocervical <input type="radio"/> Urethral <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Urine Other: _____ Specify test type: <input type="radio"/> Culture <input type="radio"/> Nucleic acid amplification <input type="radio"/> Nucleic acid hybridization <input type="radio"/> EIA <input type="radio"/> DFA Other: _____ Specimen collection date: ___/___/___ Treatment: _____ Treatment date: ___/___/___ <input type="radio"/> Unknown	<input type="checkbox"/> <b>Herpes, neonatal</b> Herpes simplex virus infection in infants aged 60 days and younger. <input type="radio"/> Clinical diagnosis <input type="radio"/> Lab confirmed diagnosis <input type="radio"/> Culture <input type="radio"/> PCR <input type="radio"/> Antigen detection <input type="radio"/> Serologic <input type="radio"/> Tzanck Herpes type: <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Not typed Clinical Syndrome (Check all that apply) <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: ___/___/___ <input type="radio"/> Unknown Mother's Name: _____ Mother's DOB: ___/___/___ Mother's Labor and Delivery Medical Record No: _____ _____ _____	<input type="checkbox"/> <b>Syphilis</b> Stage: <input type="radio"/> Congenital <input type="radio"/> Primary, chancre present (Check all that apply) <input type="radio"/> Penile <input type="radio"/> Vaginal <input type="radio"/> Endocervical <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal Other: _____ <input type="radio"/> Secondary <input type="radio"/> Alopecia <input type="radio"/> Condylomata <input type="radio"/> Mucous patches <input type="radio"/> 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 below: _____ _____ _____ Treatment date: ___/___/___ <input type="radio"/> Unknown <p style="text-align: right; font-size: small;">Continue to next column</p>	
<input type="checkbox"/> <b>Gonorrhea (GC)</b> Specify type of specimen: <input type="radio"/> Endocervical <input type="radio"/> Urethral <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Urine Other: _____ Specify test type: <input type="radio"/> Culture <input type="radio"/> Nucleic acid amplification <input type="radio"/> Nucleic acid hybridization Other: _____ Specimen collection date: ___/___/___ Treatment 1*: _____ mg/gram Treatment 2*: _____ mg/gram Treatment date: ___/___/___ <input type="radio"/> Unknown			

\*For uncomplicated gonococcal infections of the cervix, urethra, anorectum or pharynx, CDC recommends dual therapy (irrespective of concurrent chlamydial infection) using BOTH Ceftriaxone 250mg IM AND Azithromycin 1g PO. (Doxycycline 100mg PO bid x 7 d may be substituted for the Azithromycin.)

**Comments:**