County of Santa Clara Public Health Department

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only for Civil Surgeon use.

DISEASE BEING REPORTED: Latent Tuberculosis Infection - Civil Surgeon

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

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

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

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)*

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

REPORT TO:

County of Santa Clara Public Health Department
Tuberculosis Prevention and Control Program
Email: PHTBProgram@phd.sccgov.org
Fax: (408) 885-2331
Phone: (408) 885-2440
976 Lenzen Ave. Suite 1700
San Jose, CA 95126

(Obtain additional forms from your local health department.)

LATENT TUBERCULOSIS INFECTION (LTBI)

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

LTBI TREATMENT INFORMATION

Signs and Symptoms ☐ Yes ☐ No

☐ **Current Treatment** *(check all that apply)*
- ☐ Isoniazid/Rifapentine - Weekly X 12 weeks
- ☐ Rifampin daily - 4 months
- ☐ Isoniazid daily - 9 months
- ☐ Other: _____

Date Treatment Initiated: _____ *(mm/dd/yyyy)*

☐ ***Untreated***
- ☐ Will treat
- ☐ Referred to:
  - Provider Name: _____
  - Facility: _____
  - Phone #: _____
  - Address: _____
- ☐ Need assistance linking to care
- ☐ Patient refused treatment
- ☐ Previously completed treatment for TB or LTBI
- ☐ Treatment medically contraindicated: _____
- ☐ Lost to follow-up
- ☐ Other _____

INSURANCE INFORMATION

If requesting assistance linking to care, please provide patient's insurance information:

☐ Medi-Cal ☐ HMO
☐ Medicare ☐ PPO
☐ Managed Care Plan: _____
☐ Private insurance : _____
☐ No insurance

Member ID: _____

Phone number: _____

Subscriber's name: _____

Subscriber's Date of Birth: _____ *(mm/dd/yyyy)*

Remarks: