



# 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 (3/09)

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](http://www.nyc.gov/nycmed)

<b>PATIENT INFORMATION</b>	Patient Last Name		First Name		Middle Name		<b>DATE OF REPORT</b>	
	Patient AKA: Last Name		AKA: First Name		M.I.			___ / ___ / 20___
	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	
	Patient Home Address <input type="checkbox"/> Unknown			Apt. No.	Zip Code		Borough: <input type="checkbox"/> Manhattan <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island	
	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"/> NYC, borough unknown <input type="checkbox"/> Not NYC (Specify City/State) _____, _____ <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 Discharge 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	If yes, due date ___/___/20___ <input type="checkbox"/> Unknown		
	DATE OF DIAGNOSIS ___/___/20___	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 ___/___/20___ <input type="checkbox"/> Unknown								
<b>REPORTER INFORMATION</b>		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)

### 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: \_\_\_\_/\_\_\_\_/20\_\_\_\_
  - 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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**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

<i>Please complete for each medication:</i>	<i>Dose</i>	<i>Start Date</i>
Isoniazid (INH) _____	_____	___/___/20___
Rifampin (RIF) _____	_____	___/___/20___
Pyrazinamide (PZA) _____	_____	___/___/20___
Ethambutol (EMB) _____	_____	___/___/20___
Other 1 _____	_____	___/___/20___
Other 2 _____	_____	___/___/20___
Other 3 _____	_____	___/___/20___

**Isolation:**  Yes  No  Unknown

**Other Medical Problems/Other Pertinent Information:**

Comments (Continued from Page 1)