



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 (11/06)

PHA No.		
---------	--	--

Mail completed form to: NYC Dept. of Health & Mental Hygiene; 125 Worth Street, Room 315, CN-6; New York, NY 10013 • Or complete 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.			___ / ___ / 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					<input type="checkbox"/> NYC, borough unknown
	Other Telephone Number <input type="checkbox"/> Unknown (____) _____ - _____		Medicaid Number <input type="checkbox"/> Unknown					<input type="checkbox"/> Not NYC (Specify City/State) _____, _____
	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	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 <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 ___/___/20___								
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"/> Unk (____) _____ - _____			
Street Address			City		State	Zip Code		
Name of Testing Laboratory <input type="checkbox"/> Unknown			PFI Code <input type="checkbox"/> Unknown		Phone <input type="checkbox"/> Unk (____) _____ - _____			
Street Address <input type="checkbox"/> Unknown			City <input type="checkbox"/> Unk		State <input type="checkbox"/> Unk	Zip Code <input type="checkbox"/> Unk		
Name of Physician <input type="checkbox"/> Unknown				Phone <input type="checkbox"/> Unk (____) _____ - _____				
Street Address <input type="checkbox"/> Unknown			City <input type="checkbox"/> Unk		State <input type="checkbox"/> Unk	Zip Code <input type="checkbox"/> Unk		
Call DOHMH if there is an outbreak or suspected outbreak of any disease or condition, of known or unknown etiology, which may be a danger to public health, 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 (CODE) WITH SPECIAL INSTRUCTIONS

- Amebiasis (AMB) (*Entamoeba histolytica* only or cases in which *E. histolytica* cannot be distinguished from *Entamoeba dispar*.) **
- Animal Bites *
Animal: _____
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 (ANT) *
- Arboviral Infections (ARB) *
Specify which virus: _____
If West Nile Virus or Yellow Fever, report as such on page 2.
Attach copies of diagnostic laboratory results if available.
- Babesiosis (BAB)
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 (BOT) *
 Foodborne Wound Infant
- Brucellosis (BRU) *
- Campylobacteriosis (CAM) **
Chancroid: see STD section, page 3
Chlamydia: see STD section, page 3
- Cholera * (CHO) **
- Creutzfeld-Jakob Disease (CJD): see Transmissible Spongiform Encephalopathy
- Cryptosporidiosis (CSP) **
- Cyclospora (CYC) Foreign Travel:
Country: _____
Other Country: _____
Return date: ____ / ____ / 20 ____
- Diphtheria (DIP) *
- Ehrlichiosis (EHR)
Specify: HGA (formerly HGE) HME Unk
- Encephalitis (ENP)
July 1–October 31, consider and test for West Nile virus. To submit serological specimens to DOHMH, use form available at: <http://www.nyc.gov/html/doh/downloads/pdf/wnv/wnv-serologyform.pdf>
If due to arboviral disease, report under arbovirus
- Escherichia coli O157:H7 (ECO) **
- Escherichia coli (other) Shiga Toxin Producing (SHT) **

- Giardiasis (GIA) **
 - Glanders (GLA) *
Gonorrhea: see STD section, page 3
Granuloma Inguinale: see STD section, page 3
 - Haemophilus Influenzae Invasive Disease (HIM) (HIX) * Including meningitis.
Specimen Source:
 Blood CSF Unknown
 Other _____
Specify Serotype:
 Type B Not typeable
 Not tested Unknown
 Other _____
 - Hantavirus (HNV) *
 - Hemolytic Uremic Syndrome (HUS)
- FOR ALL HEPATITIS REPORTS:

Jaundice Yes No Unknown
ALT (SGPT) value: _____ Unk
Lab reference range: _____ Unk
- Hepatitis A (HEA) */**
Total Ab to Hepatitis A is NOT reportable
IgM anti-HAV: Pos Neg Unk
 - Hepatitis B (HEB)
Report at least one positive hepatitis B test result:
Total Ab to Hepatitis B is NOT reportable
IgM anti-HBc Pos Neg Unk
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 Unk
HBeAg: Pos Neg Unk
HBV Nucleic Acid: Pos Neg Unk
Cases in pregnant women must be reported by faxing the IMM5 form to 718-520-6246. For assistance call 1-866-NYC-DOH1.
 - Hepatitis C (HEC)
Check at least one of the test types below:
 EIA with high s/co value: _____
 RIBA pos. PCR pos.
 Other conf. test _____
 Acute (new infection)
 - Hepatitis D (HDV)
 - Hepatitis E (HEE)
 - Hepatitis other/Unspecified (HEU)
 - 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:
 Novel viral strain with pandemic potential (e.g. H5) *
 Death in a child younger than 18 years of age
- Kawasaki Syndrome (KAW)
- Legionellosis (LEG) Specify positive test:
 Culture Urine antigen
 DFA Serology
- Leprosy (LPY) (Hansen's Disease)
- Leptospirosis (LEP)
- Listeriosis (LIS)
- Lyme Disease (LYM)
Erythema migrans present?
 Yes No Unknown
Lymphogranuloma Venereum: see STD section on Page 3
- Malaria (MAL) ** Select at least one of the following:
 falciparum vivax malariae
 ovale undetermined
- Measles (MEA) *
- Melioidosis (MEL) *
- Meningitis, Aseptic/ Viral (MAS)
July 1–October 31, consider and test for West Nile virus. To submit serological specimens to DOHMH, use form available at: <http://www.nyc.gov/html/doh/downloads/pdf/wnv/wnv-serologyform.pdf>
If due to arboviral disease, report under arbovirus
- Meningitis, other bacterial (MEX)
Specify Organism: _____
- Meningococcal Disease, Invasive (MEC) * Includes meningococcal meningitis (MEM)
Test type/Specimen source:
 Blood culture CSF Culture
 Antigen test from CSF Gram stain
 Other _____
- Monkey Pox (MPX) *
- Mumps (MUM)
- Pertussis (PER) for hospitalized cases*
- Plague (PLA) *
Poisoning: see Poisoning section, page 3
- Polio (POL) *
- Psittacosis (PSI)
- Q Fever (QFV) *
- Rabies (RAH) *
- Rickettsialpox (RIP)
- Rocky Mountain Spotted Fever (RMS)
- Rubella (RUB) for an IgM positive case in pregnant women*
- Congenital Rubella Syndrome (CRS)
- Salmonellosis (SAL) ** Serogroup: _____
If due to Salmonella typhi, select Typhoid Fever
- SARS (Severe Acute Respiratory Syndrome) (SARS) *
- Scarlet Fever (SFV)
- Shigellosis (SHG) **

- Smallpox (SPX) *
 - Staph Enterotoxin B (SEB) *
 - Staphylococcus aureus with reduced susceptibility to Vancomycin *
Source: _____
MIC (µg/ml): _____
 - Streptococcus (Group A) Invasive only (GAS)
Specify Source: Blood CSF Unknown
 Other, Specify: _____
 - Streptococcus (Group B) Invasive only (GBS)
Specify Source: Blood CSF Unknown
 Other, Specify: _____
 - Streptococcus pneumoniae Invasive only (DRP and PNE)
Specify Source: Blood CSF Unknown
 Other
All invasive Streptococcus pneumoniae (including resistance data) should be reported by laboratories, per instructions provided by NYC DOHMH. Individual patient reports are not required to be reported separately.
 - Syphilis: see STD section, page 3
 - Tetanus (TET)
 - Toxic shock syndrome (TSS) For staph only. For strep select Streptococcus (Group A).
 - Trachoma (TRA) *
 - Transmissible Spongiform Encephalopathy (TSE) Creutzfeldt-Jakob Disease (CJD) and variants
Testing done: _____
(e.g. 14-3-3 on CSF, brain biopsy, autopsy, EEG/MRI)
 - Trichinosis (TRI): Caused by bacterium Trichinella spiralis. (Trichomoniasis, caused by Trichomonas vaginalis, need not be reported.)
 - Tuberculosis: see TB section on page 4
 - Tularemia (TUL) *
 - Typhoid Fever (TYP) **
 - Urethritis (Non-gonococcal): see STD section, page 3
 - Vaccinia disease (adverse events associated with smallpox vaccination) *
 - Vibrio spp. (VIB) **
Specify species: _____
 - Viral Hemorrhagic Fever (VHF) *
 - West Nile Virus (WNV) * Attach copies of diagnostic laboratory results if available
- Window Falls.
Fall from windows of multiple dwellings, buildings with three or more apartments, by children aged ten years and younger, report Immediately on "Child Window Fall Report Card" or blue notification card.
For assistance call 1-866-NYC-DOH1
- Yellow Fever (YEL) * Attach copies of diagnostic laboratory results if available
 - Yersiniosis (YER) ** non-plague

