Form PD-16 (9/09)

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

PHA No.

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. | ☐ Homeless

Patient Home Address ☐ Unknown | Apt. No. | Zip Code | Borough: ☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island ☐ NYC, borough unknown

Home Telephone Number ☐ Unknown ( ) – | Medical Record Number

Other Telephone Number ☐ Unknown ( ) – | Medicaid Number ☐ Unknown

Sex ☐ Male ☐ Female ☐ Transexual ☐ Unknown

Race *(Check all that apply)* ☐ Asian ☐ White ☐ American Indian/Alaska Native ☐ Unknown ☐ Black ☐ Other race ☐ Native Hawaiian/Pacific Islander

Ethnicity *(Check one)* ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Please report non-NYC residents to the appropriate health jurisdiction

☐ Not NYC (*Specify City/State*) _____, _____ ☐ Unknown

Admitted to hospital? ☐ Yes ☐ No ☐ Unknown

Admission Date ____/____/_____ ☐ Unknown

Discharge Date ____/____/_____ ☐ Unknown

Is patient alive? ☐ Yes ☐ No ☐ Unknown

If no, date of death ☐ Unknown ____/____/_____

Is patient pregnant? ☐ Yes ☐ No ☐ Unknown

If yes, due date ☐ Unknown ____/____/_____

DATE OF DIAGNOSIS ____/____/_____

DATE OF ILLNESS ONSET ☐ Unknown ____/____/_____

Risk Groups for Disease Exposure and/or Transmission ☐ Unknown

Patient works in: ☐ Childcare ☐ Food service ☐ Health care ☐ Nursing home ☐ Other _____

Attends/resides in: ☐ Nursing home ☐ Day Care/Group baby-sit ☐ Homeless shelter ☐ Correctional facility ☐ School ☐ Hospital ☐ Other _____

Foreign travel: Countries _____ ☐ Date returned to U.S. __ __/__ __/__ __

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 ☐ Unknown ( ) –

Street Address | City | State | Zip Code

Name of Testing Laboratory ☐ Unknown | PFI Code ☐ Unknown | Phone ☐ Unknown ( ) –

Street Address ☐ Unknown | City ☐ Unknown | State ☐ Unknown | Zip Code ☐ Unknown

Name of Physician ☐ Unknown | Phone ☐ Unknown ( ) –

Street Address ☐ Unknown | City ☐ Unknown | State ☐ Unknown | Zip Code ☐ 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	

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* 0157: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 IMM5 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 Syndome

☐ 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

* 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	

POISONINGS

MODE OF EXPOSURE
- ○ Ingestion
- ○ Ocular
- ○ Dermal
- ○ Inhalation
- ○ Aural
- ○ Bite
- ○ Sting
- ○ IV

TYPE
- ○ Lead *For persons aged 16 and older indicate:*
  - Employer _____
  - Employer Phone: (_____) _____ – _____
- ○ Arsenic ○ Cadmium ○ Carbon Monoxide*
- ○ Mercury ○ Pesticide
- ○ Other _____
- ○ Other _____

QUANTITY
- ○ Milliliter (mL) _____
- ○ Mouthful _____
- ○ Sip _____
- ○ Tablespoon _____
- ○ Tab/pill/cap _____
- ○ Taste/lick/drop_____
- ○ Teaspoon _____
- ○ Unknown

REASON

Unintentional
- ○ General
- ○ Environmental
- ○ Therapeutic
- ○ Misuse
- ○ Bite/sting
- ○ Food poisoning
- ○ Occupational
- ○ Dietary
- ○ Consumer product
- ○ Unknown

Intentional
- ○ Suspected suicide
- ○ Misuse
- ○ Abuse
- ○ Unknown

Other
- ○ Contamination/ tampering
- ○ Malicious
- ○ Withdrawal

Adverse reaction
- ○ Drug
- ○ Food
- ○ Other
- ○ Unknown

SYMPTOM ASSESSMENT *(Check all that apply)*
- ○ None
- ○ Nausea/vomiting/diarrhea
- ○ Lethargic/stupor/coma
- ○ Agitated
- ○ Hypertensive
- ○ Hypotensive
- ○ Tachycardia
- ○ Brachycardia
- ○ Seizure
- ○ Electrolyte abnormalities
- ○ Cough/shortness of breath
- ○ Ocular irritation
- ○ Skin irritation
- ○ Unknown
- ○ Other _____

SPECIMEN SOURCE
- ○ Capillary ○ Venous ○ Urine
- ○ Other _____

Laboratory Accession Number _____

Date Collected ____/ ____ / _____

Date Analyzed ____/ ____ / _____

Results (units) _____

Purpose of test
- ○ Initial ○ Repeat
- ○ Follow-up

TIME OF EXPOSURE

____ ____ : ____ ____
- ☐ AM ☐ PM

VITAL SIGNS

Body Weight _____
- ○ Pounds ○ Kilograms

BP: __ __ __/ __ __ __

Resp: _____

Temp: _____ ○ F ○ C

Pulse: _____

Pupils:
- ○ Dilated
- ○ Constricted

PROVIDER TREATMENT
- ○ No therapy required
- ○ Oral fluids
- ○ Emesis
- ○ Lavage
- ○ Activated charcoal
- ○ Cathartic
- ○ Chelation
- ○ Insect sting mgmt.
- ○ Irrigated eye
- ○ Oxygen
- ○ Naxolone
- ○ 50% Dextrose/Thiamine
- ○ Alkalinize urine
- ○ N-acetylcysteine (Mucromyst)
- ○ Other: _____

SEXUALLY TRANSMITTED DISEASES

FOR ALL STD REPORTS

As of the date of this report,

☛ Were any of this patient's sex partners notified of possible exposure to a sexually transmitted disease?
- ○ Yes, our office notified the partner(s)
- ○ Yes, the patient was asked to notify partner(s)
- ○ No ○ Unknown

☛ Did you provide treatment for any of this patient's sex partners?
- ○ Yes, I gave extra medication/prescription for the sex partner(s)

  If yes, for how many sex partners was medication/ prescription provided? _____
- ○ Yes, I saw the sex partner(s) in my office
- ○ No ○ Unknown

☛ For all sexually transmitted diseases, indicate sexual partners in past year *(Check only one)*
- ○ Males only ○ Females only
- ○ Males and Females ○ Unknown

☐ Chancroid *Specify specimen source:*
- ○ Penile ○ Vaginal ○ Endocervical
- ○ Anorectal ○ Oropharyngeal
- ○ Other _____

Specimen collection date ___ / ___ / ____

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Chlamydia (CT) *Specify specimen source:*
- ○ Endocervical ○ Urethral ○ Anorectal
- ○ Oropharyngeal ○ Urine
- ○ Other _____

Specify test type:
- ○ Culture ○ Nucleic acid amplification
- ○ Nucleic acid hybridization
- ○ EIA ○ DFA
- ○ Other: _____

Specimen collection date ___ / ___ / ____

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Gonorrhea (GC) *Specify specimen source:*
- ○ Endocervical ○ Urethral ○ Anorectal
- ○ Oropharyngeal ○ Urine
- ○ Other _____

Specify test type:
- ○ Culture ○ Nucleic acid amplification
- ○ Nucleic acid hybridization
- ○ Other: _____

Specimen collection date ___ / ___ / ____

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Granuloma Inguinale *Specify specimen source:*
- ○ Penile ○ Vaginal ○ Endocervical
- ○ Anorectal ○ Oropharyngeal
- ○ Other _____

Specimen collection date ___ / ___ / ____

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Herpes, Neonatal
Herpes simplex virus infection in infants aged 60 days or less.
- ○ Clinical dx
- ○ Lab confirmed dx: ☐ Culture ☐ PCR ☐ Antigen detection ☐ Serologic ☐ Tzanck

Herpes type: ○ Type 1 ○ Type 2 ○ Not typed

Clinical Syndrome *(check all that apply):*
- ○ Skin, eye, mucous membrane infection
- ○ CNS involvement ○ Disseminated disease

Herpes lesions present?
- ○ Yes, anatomic site _____
- ○ No ○ Unknown

Specimen collection date ___ / ___ / ____

Treatment for infant _____

Treatment date ___ / ___ / ____ ○ Unknown

Mother's Name: _____

Mother's DOB: ____/ ____/ _____

☐ Lymphogranuloma Venereum

Clinical Presentation *(Check all that apply):*
- ○ Proctitis ○ Lymphadenopathy ○ Skin lesion
- ○ Buboe
- ○ Other _____

Specimen collection date ___ / ___ / ____

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Syphilis

Stage:
- ○ Congenital
- ○ Primary (chancre present) *check all that apply*
  - ☐ Penile ☐ Vaginal ☐ Endocervical
  - ☐ Anorectal ☐ Oropharyngeal
  - ☐ Other _____
- ○ Secondary
  - ☐ Alopecia ☐ Condylomata
  - ☐ Mucous patches ☐ Rash
- ○ Early Latent (no symptoms, infection ≤ 1 year duration)
- ○ Late Latent (no symptoms, infection of > 1 year duration)
- ○ Tertiary (gumma or cardiovascular)

Neurologic symptoms present?
- ○ Yes ○ No ○ Unknown

Treatment :

List Medication and Dosage:

_____

Treatment date ___ / ___ / ___ ○ Unknown

Syphilis Test Types. *Check all that apply*

1. Serologic tests for syphilis

☐ A. Non-treponemal Test
- ○ RPR
  - ☐ Reactive ☐ Non-reactive
  - Titer _____
- ○ VDRL
  - ☐ Reactive ☐ Non-reactive
  - Titer _____

Specimen collection date ___ / ___ / ____

☐ B. Treponemal Test
- ○ TP-PA/MHA-TP ☐ Reactive ☐ Non-reactive
- ○ FTA ☐ Reactive ☐ Non-reactive
- ○ Treponemal IgG ☐ Reactive ☐ Non-reactive

Specimen collection date ___ / ___ / ____

2. Cerebrospinal fluid tests
- ○ CSF VDRL
  - ☐ Reactive ☐ Non-reactive
- ○ CSF FTA
  - ☐ Reactive ☐ Non-reactive
- ○ Other Test: _____

  Result: _____

Specimen collection date ___ / ___ / ____
- ○ Elevated CSF protein
  - ☐ Yes ☐ No
- ○ Elevated CSF leukocytes
  - ☐ Yes ☐ No

Specimen collection date ___ / ___ / ____

3. Organism visualization
- ○ Darkfield
  - ☐ Positive ☐ Negative
- ○ Other test: _____

  Result: _____

Specimen collection date ___ / ___ / ____

* 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	

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
- ○ Gastronintestinal
- ○ Other: _____

Other sites:
- ○ Pulmonary
- ○ Lymphatic
- ○ Bone/Joint
- ○ Soft tissue/Muscles
- ○ Peritoneal
- ○ Meningeal
- ○ Genitourinary
- ○ Gastronintestinal
- ○ 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:	*Dose*	*Start Date*
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)*

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/health/nycmed