Form PD-16 (11/06)

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 complete online:* www.nyc.gov/nycmed

PATIENT INFORMATION

Patient Last Name	First Name	Middle Name	DATE OF REPORT
			____ / ____ / 20____
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
			Borough: ☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island ☐ NYC, borough unknown

Patient Home Address ☐ Unknown	Apt. No.	Zip Code	☐ Not NYC (*Specify City/State*) _____, _____ ☐ Unknown
Home Telephone Number ☐ Unknown (_____) _____ – _____	Medical Record Number		
Other Telephone Number ☐ Unknown (_____) _____ – _____	Medicaid Number ☐ Unknown		

Sex	Race *(Check all that apply)*	Ethnicity *(Check one)*	*Please report non-NYC residents to the appropriate health jurisdiction*
☐ Male ☐ Transexual ☐ Female ☐ Unknown	☐ Asian ☐ White ☐ American Indian/Alaska Native ☐ Unknown ☐ Black ☐ Other race ☐ Native Hawaiian/Pacific Islander	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	

Admitted to hospital?	Admission Date / Discharge Date	Is patient alive?	If no, date of death	Is patient pregnant?	If yes, due date
☐ Yes ☐ No ☐ Unknown	____ / ____ / _____ ☐ Unknown ____ / ____ / _____ ☐ Unknown	☐ Yes ☐ No ☐ Unknown	_____ / _____ / _____ ☐ Unknown	☐ Yes ☐ No ☐ Unknown	☐ Unknown ____ / ____ / 20_____

DATE OF DIAGNOSIS ____ / ____ / 20_____

DATE OF ILLNESS ONSET ☐ Unknown ____ / ____ / 20_____

Risk Groups for Disease Exposure ☐ 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 ☐ Unk (_____) _____ – _____	
Street Address	City	State	Zip Code
Name of Testing Laboratory ☐ Unknown	PFI Code ☐ Unknown	Phone ☐ Unk (_____) _____ – _____	
Street Address ☐ Unknown	City ☐ Unk	State ☐ Unk	Zip Code ☐ Unk
Name of Physician ☐ Unknown		Phone ☐ Unk (_____) _____ – _____	
Street Address ☐ Unknown	City ☐ Unk	State ☐ Unk	Zip Code ☐ 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)*

Patient Last Name	First Name	Medical Record Number	

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 susceptiblity 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*
Specify Source: ○ Blood ○ CSF ○ Unknown
(DRP and PNE)
○ 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) Creutzfeld-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

* Report suspected/confirmed cases immediately 1-866-NYC-DOH1, after hours 1-800-222-1222

** For enteric pathogens, 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 ____ / ____ / 20_____

Date Analyzed ____ / ____ / 20_____

Results (units) _____

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

TIME OF EXPOSURE

____ ____ : ____ ____
☐ AM ☐ PM

VITAL SIGNS

Body Weight _____
○ pounds ○ kilograms

Resp: _____

Temp: _____ ○ F ○ C

Pulse: _____

BP: __ __ __/ __ __ __

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)
- ○ 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 ○ Endocervical ○ Oropharyngeal
- ○ Anorectal ○ Unknown
- ○ Other _____

Specimen collection date ___ / ___ / 20___

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Chlamydia (CT) *Specify specimen source:*
- ○ Endocervical ○ Urethral ○ Anorectal
- ○ Oropharyngeal ○ Unknown
- ○ Other _____
- ○ Add'l specimen source: _____

Specify test type:
- ○ Culture ○ Nucleic acid amplification
- ○ Nucleic acid hybridization
- ○ EIA ○ DFA ○ Unknown
- ○ Other: _____
- ○ Add'l test: _____

Specimen collection date ___ / ___ / 20___

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ Gonorrhea (GC) *Specify specimen source:*
- ○ Endocervical ○ Urethral ○ Anorectal
- ○ Oropharyngeal ○ Unknown
- ○ Other _____
- ○ Add'l specimen source: _____

Specify test type:
- ○ Culture ○ Nucleic acid amplification
- ○ Nucleic acid hybridization ○ Unknown
- ○ Other: _____
- ○ Add'l test: _____

Specimen collection date ___ / ___ / 20___

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

Fluoroquinolone resistant isolate
- ○ Antibiotic susceptibility not done
- ○ Intermediate resistant ○ Resistant

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

Specimen collection date ___ / ___ / 20___

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

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

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

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

Specimen collection date ___ / ___ / 20___

Treatment for infant _____

Trtmt. Start Date: ___ / ___ / _____ ○ Unknown

Mother's Name: _____

Mother's DOB: ____ / ____ / _____

☐ Lymphogranuloma Venereum

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

Specimen collection date ___ / ___ / 20___

Treatment _____

Treatment date ___ / ___ / _____ ○ Unknown

☐ SYPHILIS *(Stages, check all that apply)*
- ○ Primary (chancre present) *check all that apply*
  - ☐ Penile ☐ Endocervical ☐ Oropharyngeal
  - ☐ Anorectal ☐ Unknown
  - ☐ Other _____
- ○ Secondary
  - ☐ Alopecia ☐ Condylomata
  - ☐ Mucous patches ☐ Rash
- ○ Congenital *—*Call 1-866-NYC-DOH1*
- ○ Early Latent (no symptoms, infection ≤ 1 year duration)
- ○ Late Latent (no symptoms, infection of > 1 year duration)
- ○ Tertiary (gumma or cardiovascular)
- ○ Neurological symptoms ☐ Yes ☐ No ☐ Unknown

List Medication and Dosage:

_____

Treatment date ___ / ___ / ___ ○ Unknown

SYPHILIS TEST TYPES *Check all that apply*

1. Serologic tests for syphilis

☐ A. Non-treponemal Test ○ Not done

Test date ___ / ___ / 20___

Titer _____

○ Serum RPR
☐ Reactive ☐ Non-reactive

○ Serum VDRL ☐ Not done
☐ Reactive ☐ Non-reactive

☐ B. Treponemal Test ○ Not done

Test date ___ / ___ / 20___

○ TP-PA/MHA-TP ☐ Reactive ☐ Non-reactive

○ FTA ☐ Reactive ☐ Non-reactive

○ Treponemal IgG ☐ Reactive ☐ Non-reactive

2. Cerebrospinal fluid tests

Test date ___ / ___ / 20___

○ CSF VDRL ☐ Not done
☐ Reactive ☐ Non-reactive

○ CSF FTA ☐ Not done
☐ Reactive ☐ Non-reactive

○ Other Test: _____

Test date ___ / ___ / 20___

○ Elevated CSF protein ☐ Not done
☐ Yes ☐ No

○ Elevated CSF leukocytes ☐ Not done
☐ Yes ☐ No

3. Organism visualization ○ Not done

Test date ___ / ___ / 20___

○ Darkfield
☐ Positive ☐ Negative

○ Other test: _____

☐ Urethritis (Non-gonococcal)

Treatment _____

Treatment date _____ ○ Unknown

* Report suspected/confirmed cases immediately 1-866-NYC-DOH1, after hours 1-800-222-1222

** For enteric pathogens, 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:	*Other sites:*
○ Pulmonary	○ Pulmonary
○ Lymphatic	○ Lymphatic
○ Bone/Joint	○ Bone/Joint
○ Soft tissue/Muscles	○ Soft tissue/Muscles
○ Peritoneal	○ Peritoneal
○ Meningeal	○ Meningeal
○ Genitourinary	○ Genitourinary
○ Gastronintestinal	○ Gastronintestinal
○ Other: _____	○ 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
Test Type:
○ MTD ○ Amplicor ○ Not Done ○ Unknown
○ Other: _____
Test Result:
○ Positive ○ Negative ○ Pending
○ Not Done ○ Unknown

Pathology consistent with TB
○ Positive
Pathology findings: _____
_____
_____
○ Negative ○ Not Done ○ Unknown

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
Date Implanted____ / ____ / _____
○ Quantiferon TB-Gold
○ Other: _____
○ Not done ○ Unknown

Test Result:
○ Positive ○ Negative
○ Indeterminate ○ Pending
○ Unknown

Treatment
On Anti-TB Medications ○ Yes ○ No ○ Unknown

Please complete for each medication:	*Dose*	*Start Date*
INH (Isoniazid)	_____	____ / ____ / 20_____
Rifampin	_____	____ / ____ / 20_____
Pyrazinamide	_____	____ / ____ / 20_____
Ethambutol	_____	____ / ____ / 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)*

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/health/nycmed