

▶ **Report suspected/confirmed cases immediately by calling 1-866-NYC-DOH1 during business hours or 212-764-7667 after hours.**

## HIV/AIDS

- Diagnosis of HIV infection
- Diagnosis of HIV illness in a previously unreported individual (i.e.; HIV illness not meeting AIDS case definition)
- Diagnosis of AIDS-defining conditions

For assistance in reporting a case of HIV/AIDS, to receive the required NYS Provider Report Forms (PRF), or to obtain more information, please call 212-442-3388.

NYS law also requires that PRFs contain names of sexual or needle-sharing partners of the infected person known to medical providers or those whom the infected person wishes to have notified of their possible exposures. Providers can utilize and/or refer HIV-infected persons to the NYC DOHMH Contact Notification Assistance Program (CNAP) at 212-693-1419 for assistance in carrying out partner notification.

For more information about reporting a case of HIV or AIDS to the NYC DOHMH, visit:

<http://www.nyc.gov/html/doh/html/dires/hcpreporting.shtml>

## Sexually Transmitted Diseases

FAX 212-788-4452

- Chancroid
- Chlamydia
- Gonorrhea
- Granuloma Inguinale (Donovanosis)
- Herpes, Neonatal
  - (herpes simplex virus infection in infants age 60 days or less) with or without lab confirmation
- Lymphogranuloma Venereum
- Syphilis, including congenital syphilis

## Tuberculosis

FAX 212-788-4179

- Positive AFB smears
- Positive nucleic acid amplification test for *M. tb* complex
- Positive cultures for *M. tb* complex
- Continuation, discontinuation, completion, or other outcomes of treatment for active TB
- Susceptibility tests on *M. tb* cultures (5)
- Pathology findings consistent with TB
- Patients suspected of having TB
- Patients started on 2 or more anti TB drugs for the treatment of TB
- Any culture or NAA result associated with an AFB-positive smear (even if negative for *M. tb* complex (5))
- Child less than 5 yrs with a positive TST or blood-based test for TB infection

## Vaccine – Preventable Diseases

FAX 212-676-2300

- ▶ Diphtheria
- ▶ Measles
- Mumps (1)
- Pertussis (1)
- ▶ Poliomyelitis
- Rubella, including congenital rubella syndrome (1)
- Tetanus
- ▶ Vaccinia disease (adverse events associated with Smallpox vaccination)
- Varicella Zoster virus (chickenpox) (5)

## Other Reportable Communicable Diseases and Conditions

FAX 212-788-4268

- Amebiasis (1,2)
- Anaplasmosis, formerly human granulocytic ehrlichiosis
  - ▶ Anthrax
  - ▶ Arboviral infections, acute
  - Babesiosis

- ▶ Botulism
- ▶ Brucellosis
- Campylobacteriosis (1,2)
- ▶ Cholera
- Creutzfeldt-Jacob disease
- Cryptosporidiosis (1,2)
- Cyclosporiasis (1,2)
- Dengue
- Ehrlichiosis
- Encephalitis (3)
- Escherichia coli* O157:H7 and other Shiga toxin producing *E coli* (1,2)
- Giardiasis (1,2)
- ▶ Glanders
- ▶ Hantavirus disease
- Hemolytic uremic syndrome
- Hemophilus influenzae* (invasive disease) (1)
- ▶ Hepatitis A (1,2)
- Hepatitis B, C, D, E
- Hepatitis B cases in pregnant women must be reported on the IMM5 form or via Reporting Central. For more information, call 718-520-8245.
- Hepatitis, other suspected infectious
- Hospital-associated infections
- Influenza, lab confirmed (5)
- ▶ Influenza, novel strain with pandemic potential
- Influenza-related pediatric deaths (<18 years)
- Kawasaki syndrome
- Legionellosis
- Leprosy (Hansen's disease)
- Leptospirosis
- Listeriosis
- Lyme disease
- Lymphocytic choriomeningitis virus
- Malaria
- ▶ Melioidosis
- Meningitis, viral (3)
- Meningitis, bacterial
- ▶ Meningococcal disease, invasive (1)
- ▶ Monkeypox
- Norovirus (5)
- ▶ Plague
- Psittacosis
- ▶ Q fever
- ▶ Rabies
- Respiratory Syncytial Virus (RSV) (5)
- ▶ Ricin
- Rickettsialpox
- Rocky Mountain spotted fever
- Rotavirus (5)
- Salmonellosis (1,2)
- ▶ SARS (Severe Acute Respiratory Syndrome)
- Shigellosis (1,2)
- ▶ Smallpox
- Staphylococcus aureus* (methicillin resistant) (5)
- Staphylococcus aureus*, vancomycin intermediate (VISA)
- ▶ *Staphylococcus aureus*, vancomycin resistant (VRSA)
- ▶ Staphylococcal enterotoxin B
- Streptococcal infection group A (invasive disease)
- Streptococcal infection group B (invasive disease)
- Streptococcus pneumoniae* (invasive disease) (5)
- Toxic shock syndrome
- Trachoma
- Transmissible spongiform encephalopathies
- Trichinosis
- ▶ Tularemia
- Typhoid/Paratyphoid fever (1,2)
- Vibrio* species, non-cholera
- ▶ Viral hemorrhagic fever
- ▶ West Nile virus
- ▶ Yellow fever
- Yersiniosis (1,2)

## Immunizations

Immunizations administered to children aged 18 years and younger must be reported to the Department. For information on how to report, please consult the website of the City Immunization Registry at [www.nyc.gov/health/cir](http://www.nyc.gov/health/cir)

## Injuries

**Animal Bites**, FAX 212-676-0463

- Reports are accepted via fax of Animal Report form VPHS-55, phone or Reporting Central.
- ▶ Exposure to rabid or rabid-acting animal, or any rabies vector species (4)

**Drownings**, FAX 212-676-1517

- Respiratory impairment from submersion/immersion in liquid. Drowning outcomes are classified as death, morbidity, and no morbidity.

**Falls**, FAX 212 442-2629

- Falls from windows of buildings with 3 or more apartments, by children aged 10 years and younger

## Poisonings

PHONE 212-764-7667, FAX 212-447-8223

- Poisonings by drugs or other toxic agents including but not limited to pesticides and
- ▶ Carbon monoxide

**Lead Poisoning**

- FAX 212-676-6326, children 17 years and under
- FAX 212-788-4299, adults
- Blood lead levels of 10 mcg/dl or greater

**Other Heavy Metal Poisoning**

- (Arsenic, Cadmium, Mercury)
- FAX 212-788-4299

**Food Poisoning** (1,2)

- FAX 212-442-3378
- ▶ In a group of 2 or more persons

## Sterilizations

- Permanent sterilization procedures performed on both male and female patients must be reported to the Department. For information on how to report, call 212-442-1740.

## Vital Events Certificates

- All births, deaths, and spontaneous and induced terminations of pregnancy must be reported to the Department using appropriate NYC certificates. To obtain blank certificate forms call 212-788-4520. To enroll in the Electronic Death Registration System, email: [EDRS@health.nyc.gov](mailto:EDRS@health.nyc.gov)

## Notes

- (1) Report immediately by telephone a suspected case in a childcare, day care/group babysit, healthcare, nursing home, correctional, or homeless facility.
- (2) Report immediately by telephone a suspected case in a food handler, child care worker, or health care worker.
- (3) July 1-Oct 31: consider and test for West Nile virus.
- (4) A bite or other (e.g, scratch) exposure 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 should be reported immediately. All other animal bites can be reported routinely via mail, telephone, fax or Reporting Central. If needed, consultation on management of animal bites and use of rabies post exposure prophylaxis is available on a 24/7 basis by calling the DOHMH contact numbers below.
- (5) Reporting is only required through the Department's Electronic Clinical Laboratory Reporting System and not by individual providers.

## Outbreaks

Section 11.03(c) of the NYC Health Code requires the immediate reporting by telephone of a suspected outbreak among 3 or more persons of any disease or condition (whether it is listed here or not), and of any unusual manifestation of disease in an individual.

**During business hours call: 1-866-NYC-DOH1 (1-866-692-3641) for questions or forms. After business hours call: 212-POISONS (212-764-7667). To report online, visit Reporting Central at: [www.nyc.gov/nycmed](http://www.nyc.gov/nycmed)**

**All results must be reported within 24 hours except where noted that immediate reporting is required. (▶)**



# 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.		
---------	--	--

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				<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 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
-------------------	------------	-----------------------

**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)