

Attachment 2



**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		
	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 Borough: <input type="checkbox"/> Manhattan <input type="checkbox"/> Bronx <input type="checkbox"/> Brooklyn <input type="checkbox"/> Queens <input type="checkbox"/> Staten Island <input type="checkbox"/> NYC, borough unknown	
	Patient Home Address <input type="checkbox"/> Unknown		Apt. No.		Zip Code		<input type="checkbox"/> Not NYC (Specify City/State) _____ <input type="checkbox"/> Unknown		
	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	Race (Check all that apply) <input type="checkbox"/> Transsexual <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Other race		<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian/Pacific Islander		Ethnicity <input type="checkbox"/> Hispanic (Check one) <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 ____ / ____ / ____ Discharge Date ____ / ____ / ____		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	
	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			
<p>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)</p> <p>Comments (Additional space on Page 4)</p>									

Patient Last Name	First Name	Medical Record Number
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DISEASE (CODE) WITH SPECIAL INSTRUCTIONS

<p><input type="checkbox"/> Amebiasis (AMB) (<i>Entamoeba histolytica</i> only or cases in which <i>E. histolytica</i> cannot be distinguished from <i>Entamoeba dispar</i>.)**</p> <p><input type="checkbox"/> Animal Bites *</p> <p>Animal: _____ Breed: _____ Color(s): _____ Date of Bite: ____ / ____ / 20 ____ Area of body bitten _____ Activity at time of bite _____ Place of occurrence _____ Treatment given: _____</p> <p>Rabies prophylaxis <input type="checkbox"/> Yes <input type="checkbox"/> No HRIG <input type="checkbox"/> Yes <input type="checkbox"/> No Rabies Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Animal <input type="checkbox"/> Owned <input type="checkbox"/> Stray <input type="checkbox"/> Unknown Animal's owner (last name, first name): _____</p> <p>Address (Street, Apt.): _____ Boro/City, State, Zip: _____</p> <p>Telephone Number: (_____) _____ - _____</p> <p><input type="checkbox"/> Anthrax (ANT) *</p> <p><input type="checkbox"/> Arboviral Infections (ARB) *</p> <p>Specify which virus: _____ If West Nile Virus or Yellow Fever, report as such on page 2. Attach copies of diagnostic laboratory results if available.</p> <p><input type="checkbox"/> Babesiosis (BAB)</p> <p>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.*</p> <p><input type="checkbox"/> Botulism (BOT) *</p> <p><input type="checkbox"/> Foodborne <input type="checkbox"/> Wound <input type="checkbox"/> Infant</p> <p><input type="checkbox"/> Brucellosis (BRU) *</p> <p><input type="checkbox"/> Campylobacteriosis (CAM) **</p> <p>Chancroid: see STD section, page 3 Chlamydia: see STD section, page 3</p> <p><input type="checkbox"/> Cholera * (CHO) **</p> <p><input type="checkbox"/> Creutzfeld-Jakob Disease (CJD): see Transmissible Spongiform Encephalopathy</p> <p><input type="checkbox"/> Cryptosporidiosis (CSP) **</p> <p><input type="checkbox"/> Cyclospora (CYC) Foreign Travel:</p> <p>Country: _____ Other Country: _____ Return date: ____ / ____ / 20 ____</p> <p><input type="checkbox"/> Diphtheria (DIP) *</p> <p><input type="checkbox"/> Ehrlichiosis (EHR)</p> <p>Specify: <input type="checkbox"/> HGA (formerly HGE) <input type="checkbox"/> HME <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> Encephalitis (ENP)</p> <p>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/wmv/wmv-serologyform.pdf If due to arboviral disease, report under arbovirus</p> <p><input type="checkbox"/> Escherichia coli O157:H7 (EEO) **</p> <p><input type="checkbox"/> Escherichia coli (other) Shiga Toxin Producing (SHT) **</p>	<p><input type="checkbox"/> Giardiasis (GIA) **</p> <p><input type="checkbox"/> Glanders (GLA) *</p> <p>Gonorrhea: see STD section, page 3 Granuloma Inguinale: see STD section, page 3</p> <p><input type="checkbox"/> Haemophilus Influenzae Invasive Disease (HIM) (HIX) * Including meningitis.</p> <p>Specimen Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____</p> <p>Specify Serotype: <input type="checkbox"/> Type B <input type="checkbox"/> Not typeable <input type="checkbox"/> Not tested <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Hantavirus (HNV) *</p> <p><input type="checkbox"/> Hemolytic Uremic Syndrome (HUS)</p> <p align="center">FOR ALL HEPATITIS REPORTS:</p> <p>Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown ALT (SGPT) value: _____ <input type="checkbox"/> Unk Lab reference range: _____ <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> Hepatitis A (HEA) */**</p> <p>Total Ab to Hepatitis A is NOT reportable IgM anti-HAV: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk</p> <p><input type="checkbox"/> Hepatitis B (HEB)</p> <p>Report at least one positive hepatitis B test result: Total Ab to Hepatitis B is NOT reportable IgM anti-HBc <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk If positive, describe symptoms and risks in comments box on page 1 and indicate sexual partners in the past year (Check only one) <input type="checkbox"/> Males only <input type="checkbox"/> Females only <input type="checkbox"/> Males and Females <input type="checkbox"/> Unknown</p> <p>HBsAg: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk HBeAg: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk HBV Nucleic Acid: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk</p> <p>Cases in pregnant women must be reported by faxing the IHMS form to 718-520-6246. For assistance call 1-866-NYC-DOH1.</p> <p><input type="checkbox"/> Hepatitis C (HEC)</p> <p>Check at least one of the test types below: <input type="checkbox"/> EIA with high s/co value: _____ <input type="checkbox"/> RIBA pos. <input type="checkbox"/> PCR pos. <input type="checkbox"/> Other conf. test _____</p> <p><input type="checkbox"/> Acute (new infection)</p> <p><input type="checkbox"/> Hepatitis D (HDV)</p> <p><input type="checkbox"/> Hepatitis E (HEE)</p> <p><input type="checkbox"/> Hepatitis other/Unspecified (HEU)</p> <p><input type="checkbox"/> Herpes, Neonatal: see STD section, page 3</p> <p>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.</p>	<p><input type="checkbox"/> Influenza Check all that apply: <input type="checkbox"/> Novel viral strain with pandemic potential (e.g. H5) * <input type="checkbox"/> Death in a child younger than 18 years of age <input type="checkbox"/> Kawasaki Syndrome (KAW)</p> <p><input type="checkbox"/> Legionellosis (LEG) Specify positive test: <input type="checkbox"/> Culture <input type="checkbox"/> Urine antigen <input type="checkbox"/> DFA <input type="checkbox"/> Serology</p> <p><input type="checkbox"/> Leprosy (LPY) (Hansen's Disease)</p> <p><input type="checkbox"/> Leptospirosis (LEP)</p> <p><input type="checkbox"/> Listeriosis (LIS)</p> <p><input type="checkbox"/> Lyme Disease (LYM) Erythema migrans present? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Lymphogranuloma Venereum: see STD section on Page 3</p> <p><input type="checkbox"/> Malaria (MAL) ** Select at least one of the following: <input type="checkbox"/> falciparum <input type="checkbox"/> vivax <input type="checkbox"/> malariae <input type="checkbox"/> ovale <input type="checkbox"/> undetermined</p> <p><input type="checkbox"/> Measles (MEA) *</p> <p><input type="checkbox"/> Melioidosis (MEL) *</p> <p><input type="checkbox"/> 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/wmv/wmv-serologyform.pdf If due to arboviral disease, report under arbovirus</p> <p><input type="checkbox"/> Meningitis, other bacterial (MEX) Specify Organism: _____</p> <p><input type="checkbox"/> Meningococcal Disease, Invasive (MEC) * Includes meningococcal meningitis (MEM) Test type/Specimen source: <input type="checkbox"/> Blood culture <input type="checkbox"/> CSF Culture <input type="checkbox"/> Antigen test from CSF <input type="checkbox"/> Gram stain <input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Monkey Pox (MPX) *</p> <p><input type="checkbox"/> Mumps (MUM)</p> <p><input type="checkbox"/> Pertussis (PER) for hospitalized cases*</p> <p><input type="checkbox"/> Plague (PLA) *</p> <p>Poisoning: see Poisoning section, page 3</p> <p><input type="checkbox"/> Polio (POL) *</p> <p><input type="checkbox"/> Psittacosis (PSI)</p> <p><input type="checkbox"/> Q Fever (QFV) *</p> <p><input type="checkbox"/> Rabies (RAH) *</p> <p><input type="checkbox"/> Rickettsialpox (RIP)</p> <p><input type="checkbox"/> Rocky Mountain Spotted Fever (RMS)</p> <p><input type="checkbox"/> Rubella (RUB) for an IgM positive case in pregnant women*</p> <p><input type="checkbox"/> Congenital Rubella Syndrome (CRS)</p> <p><input type="checkbox"/> Salmonellosis (SAL) ** Serogroup: _____ If due to <i>Salmonella typhi</i>, select Typhoid Fever</p> <p><input type="checkbox"/> SARS (Severe Acute Respiratory Syndrome) (SARS) *</p> <p><input type="checkbox"/> Scarlet Fever (SFV)</p> <p><input type="checkbox"/> Shigellosis (SHG) **</p> <p><input type="checkbox"/> Smallpox (SPX) *</p> <p><input type="checkbox"/> Staph Enterotoxin B (SEB) *</p> <p><input type="checkbox"/> <i>Staphylococcus aureus</i> with reduced susceptibility to Vancomycin * Source: _____ MIC (μg/ml): _____</p> <p><input type="checkbox"/> Streptococcus (Group A) Invasive only (GAS) Specify Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____</p> <p><input type="checkbox"/> Streptococcus (Group B) Invasive only (GBS) Specify Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Unknown <input type="checkbox"/> Other, Specify: _____</p> <p><input type="checkbox"/> <i>Streptococcus pneumoniae</i> Invasive only Specify Source: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Unknown (DRP and PNE) <input type="checkbox"/> Other _____ All invasive <i>Streptococcus pneumoniae</i> (including resistance data) should be reported by laboratories, per instructions provided by NYC DOHMH. Individual patient reports are not required to be reported separately.</p> <p>Syphilis: see STD section, page 3</p> <p><input type="checkbox"/> Tetanus (TET)</p> <p><input type="checkbox"/> Toxic shock syndrome (TSS) For staph only. For strep select <i>Streptococcus</i> (Group A).</p> <p><input type="checkbox"/> Trachoma (TRA) *</p> <p><input type="checkbox"/> Transmissible Spongiform Encephalopathy (TSE) Creutzfeld-Jakob Disease (CJD) and variants Testing done: _____ (e.g. 14-3-3 on CSF, brain biopsy, autopsy, EEG/MRI)</p> <p><input type="checkbox"/> Trichinosis (TRI): Caused by bacterium <i>Trichinella spiralis</i>. (Trichomoniasis, caused by <i>Trichomonas vaginalis</i>, need not be reported.)</p> <p>Tuberculosis: see TB section on page 4</p> <p><input type="checkbox"/> Tularemia (TUL) *</p> <p><input type="checkbox"/> Typhoid Fever (TYP) **</p> <p>Urethritis (Non-gonococcal): see STD section, page 3</p> <p><input type="checkbox"/> Vaccinia disease (adverse events associated with smallpox vaccination) *</p> <p><input type="checkbox"/> Vibrio spp. (VIB) ** Specify species: _____</p> <p><input type="checkbox"/> Viral Hemorrhagic Fever (VHF) *</p> <p><input type="checkbox"/> West Nile Virus (WNV) * Attach copies of diagnostic laboratory results if available</p> <p>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</p> <p><input type="checkbox"/> Yellow Fever (YEL) * Attach copies of diagnostic laboratory results if available</p> <p><input type="checkbox"/> Yersiniosis (YER) ** non-plague</p>
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* 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
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POISONINGS				
MODE OF EXPOSURE <input type="radio"/> Ingestion <input type="radio"/> Ocular <input type="radio"/> Dermal <input type="radio"/> Inhalation <input type="radio"/> Aural <input type="radio"/> Bite <input type="radio"/> Sting <input type="radio"/> IV	TYPE <input type="radio"/> Lead* <i>For persons aged 16 and older indicate:</i> Employer _____ Employer Phone: (____) _____ <input type="radio"/> Arsenic <input type="radio"/> Cadmium <input type="radio"/> Carbon Monoxide* <input type="radio"/> Mercury <input type="radio"/> Pesticide <input type="radio"/> Other _____ <input type="radio"/> Other _____	QUANTITY <input type="radio"/> milliliter (mL) _____ <input type="radio"/> mouthful _____ <input type="radio"/> sip _____ <input type="radio"/> tablespoon _____ <input type="radio"/> tab/pill/cap _____ <input type="radio"/> taste/tick/drop _____ <input type="radio"/> teaspoon _____ <input type="radio"/> unknown	REASON <i>Unintentional</i> <input type="radio"/> general <input type="radio"/> environmental <input type="radio"/> therapeutic <input type="radio"/> misuse <input type="radio"/> bite/sting <input type="radio"/> food poisoning <input type="radio"/> occupational <input type="radio"/> dietary <input type="radio"/> consumer product <input type="radio"/> unknown <i>Intentional</i> <input type="radio"/> suspected suicide <input type="radio"/> misuse <input type="radio"/> abuse <input type="radio"/> unknown <i>Other</i> <input type="radio"/> contamination/tampering <input type="radio"/> malicious <input type="radio"/> withdrawal <i>Adverse reaction</i> <input type="radio"/> drug <input type="radio"/> food <input type="radio"/> other <input type="radio"/> unknown	SYMPTOM ASSESSMENT (Check all that apply) <input type="radio"/> None <input type="radio"/> Nausea/vomiting/diarrhea <input type="radio"/> Lethargic/stupor/coma <input type="radio"/> Agitated <input type="radio"/> Hypertensive <input type="radio"/> Hypotensive <input type="radio"/> Tachycardia <input type="radio"/> Bradycardia <input type="radio"/> Seizure <input type="radio"/> Electrolyte abnormalities <input type="radio"/> Cough/shortness of breath <input type="radio"/> Ocular irritation <input type="radio"/> Skin irritation <input type="radio"/> Unknown <input type="radio"/> Other _____
SPECIMEN SOURCE <input type="radio"/> Capillary <input type="radio"/> Venous <input type="radio"/> Urine <input type="radio"/> Other _____		TIME OF EXPOSURE _____ : _____ <input type="checkbox"/> AM <input type="checkbox"/> PM		PROVIDER TREATMENT <input type="radio"/> No therapy required <input type="radio"/> Oral fluids <input type="radio"/> Emesis <input type="radio"/> Lavage <input type="radio"/> Activated charcoal <input type="radio"/> Cathartic <input type="radio"/> Chelation <input type="radio"/> Insect sting mgmt. <input type="radio"/> Irrigated eye <input type="radio"/> Oxygen <input type="radio"/> Naloxone <input type="radio"/> 50% Dextrose/Thiamine <input type="radio"/> Alkalinize urine <input type="radio"/> N-acetylcysteine (Mucromyst) <input type="radio"/> Other: _____
Date Collected ____/____/20____		VITAL SIGNS Body Weight _____ <input type="radio"/> pounds <input type="radio"/> kilograms BP: ____/____/____		
Date Analyzed ____/____/20____		RESULTS Results (units) _____ Purpose of test <input type="radio"/> Initial <input type="radio"/> Repeat <input type="radio"/> Follow-up		Pupils: <input type="radio"/> dilated <input type="radio"/> constricted

SEXUALLY TRANSMITTED DISEASES			
<p style="text-align: center;">FOR ALL STD REPORTS</p> <p><i>As of the date of this report,</i></p> <p>Were any of this patient's sex partners notified of possible exposure to a sexually transmitted disease? <input type="radio"/> Yes, our office notified the partner(s) <input type="radio"/> Yes, the patient was asked to notify partner(s) <input type="radio"/> No <input type="radio"/> Unknown</p> <p>Did you provide treatment for any of this patient's sex partners? <input type="radio"/> Yes, I gave extra medication/prescription for the sex partner(s) <input type="radio"/> Yes, I saw the sex partner(s) in my office <input type="radio"/> No <input type="radio"/> Unknown</p> <p>For all sexually transmitted diseases, indicate sexual partners in past year (Check only one) <input type="radio"/> Males only <input type="radio"/> Females only <input type="radio"/> Males and Females <input type="radio"/> Unknown</p> <p><input type="checkbox"/> Chancroid <i>Specify specimen source:</i> <input type="radio"/> Penile <input type="radio"/> Endocervical <input type="radio"/> Oropharyngeal <input type="radio"/> Anorectal <input type="radio"/> Unknown <input type="radio"/> Other _____</p> <p>Specimen collection date ____/____/20____ Treatment _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p> <p><input type="checkbox"/> Chlamydia (CT) <i>Specify specimen source:</i> <input type="radio"/> Endocervical <input type="radio"/> Urethral <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Unknown <input type="radio"/> Other _____ <input type="radio"/> Add'l specimen source: _____</p> <p><i>Specify test type:</i> <input type="radio"/> Culture <input type="radio"/> Nucleic acid amplification <input type="radio"/> Nucleic acid hybridization <input type="radio"/> EIA <input type="radio"/> DFA <input type="radio"/> Unknown <input type="radio"/> Other: _____ <input type="radio"/> Add'l test: _____</p>	<p>Specimen collection date ____/____/20____ Treatment _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p> <p><input type="checkbox"/> Gonorrhea (GC) <i>Specify specimen source:</i> <input type="radio"/> Endocervical <input type="radio"/> Urethral <input type="radio"/> Anorectal <input type="radio"/> Oropharyngeal <input type="radio"/> Unknown <input type="radio"/> Other _____ <input type="radio"/> Add'l specimen source: _____</p> <p><i>Specify test type:</i> <input type="radio"/> Culture <input type="radio"/> Nucleic acid amplification <input type="radio"/> Nucleic acid hybridization <input type="radio"/> Unknown <input type="radio"/> Other: _____ <input type="radio"/> Add'l test: _____</p> <p>Specimen collection date ____/____/20____ Treatment _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p> <p>Fluoroquinolone resistant isolate <input type="radio"/> Antibiotic susceptibility not done <input type="radio"/> Intermediate resistant <input type="radio"/> Resistant</p> <p><input type="checkbox"/> Granuloma Inguinale <i>Specify specimen source:</i> <input type="radio"/> Penile <input type="radio"/> Endocervical <input type="radio"/> Oropharyngeal <input type="radio"/> Anorectal <input type="radio"/> Unknown <input type="radio"/> Other _____</p> <p>Specimen collection date ____/____/20____ Treatment _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p> <p><input type="checkbox"/> Herpes, Neonatal Herpes simplex virus infection in infants aged 60 days or less. <input type="radio"/> Clinical dx <input type="radio"/> Lab confirmed dx: <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> Antigen detection <input type="checkbox"/> Serologic <input type="checkbox"/> Tzanck Spec. Herpes type: <input type="radio"/> Type 1 <input type="radio"/> Type 2 <input type="radio"/> Not typed Clinical Syndrome (check all that apply): <input type="radio"/> Eye, mucous membrane, skin infection <input type="radio"/> CNS involvement <input type="radio"/> Disseminated disease</p>	<p>Herpes lesions present? <input type="radio"/> Yes, anatomic site _____ <input type="radio"/> No <input type="radio"/> Unknown</p> <p>Specimen collection date ____/____/20____ Treatment for infant _____ Trtmt. Start Date: ____/____/____ <input type="radio"/> Unknown Mother's Name: _____ Mother's DOB: ____/____/____</p> <p><input type="checkbox"/> Lymphogranuloma Venereum <i>Clinical Presentation (Check all that apply):</i> <input type="radio"/> Proctitis <input type="radio"/> Lymphadenopathy <input type="radio"/> Skin lesion <input type="radio"/> Buboe <input type="radio"/> Unknown <input type="radio"/> Other _____</p> <p>Specimen collection date ____/____/20____ Treatment _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p> <p><input type="checkbox"/> SYPHILIS (Stages, check all that apply) <input type="radio"/> Primary (chancere present) <i>check all that apply</i> <input type="checkbox"/> Penile <input type="checkbox"/> Endocervical <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Anorectal <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="radio"/> Secondary <input type="checkbox"/> Alopecia <input type="checkbox"/> Condylomata <input type="checkbox"/> Mucous patches <input type="checkbox"/> Rash <input type="radio"/> Congenital *—Call 1-866-NYC-DOH1 <input type="radio"/> Early Latent (no symptoms, infection ≤ 1 year duration) <input type="radio"/> Late Latent (no symptoms, infection of > 1 year duration) <input type="radio"/> Tertiary (gumma or cardiovascular) <input type="radio"/> Neurological symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown List Medication and Dosage: _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p>	<p>SYPHILIS TEST TYPES Check all that apply</p> <p>1. Serologic tests for syphilis <input type="checkbox"/> A. Non-treponemal Test <input type="radio"/> Not done Test date ____/____/20____ Titer _____ <input type="radio"/> Serum RPR <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> Serum VDRL <input type="checkbox"/> Not done <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive</p> <p><input type="checkbox"/> B. Treponemal Test <input type="radio"/> Not done Test date ____/____/20____ <input type="radio"/> TP-PA/MHA-TP <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> FTA <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> Treponemal IgG <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive</p> <p>2. Cerebrospinal fluid tests Test date ____/____/20____ <input type="radio"/> CSF VDRL <input type="checkbox"/> Not done <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> CSF FTA <input type="checkbox"/> Not done <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="radio"/> Other Test: _____ Test date ____/____/20____ <input type="radio"/> Elevated CSF protein <input type="checkbox"/> Not done <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="radio"/> Elevated CSF leukocytes <input type="checkbox"/> Not done <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Organism visualization <input type="radio"/> Not done Test date ____/____/20____ <input type="radio"/> Darkfield <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="radio"/> Other test: _____</p> <p><input type="checkbox"/> Urethritis (Non-gonococcal) Treatment _____ Treatment date ____/____/____ <input type="radio"/> Unknown</p>

* 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.

Universal Reporting Form (URF)

The URF should be used to report all diseases and conditions previously reported on the 395V/VDH341 (Report of Communicable/Sexually Transmitted Diseases) and TB76 (for reporting Tuberculosis). These include:

- Communicable diseases as listed in the section entitled ‘Disease (code) with special instructions’ (Pages 1 and 2 of the URF)
- Poisoning cases as listed in the section ‘Poisoning’ (Page 2 of the URF)
- Sexually transmitted diseases as listed in the section ‘Sexually Transmitted Diseases’ (Page 2 of the URF)
- Tuberculosis in section ‘Tuberculosis’ (Page 2 of the URF)

* **Note:** this form does not replace any other DOHMH forms (such as the IMM5 form for reporting hepatitis B in pregnant women or the CDC Malaria Case Surveillance Report)

To order more URFs, call the Provider Access Line at 1-866-NYC-DOH1 (allow 2 – 3 weeks for delivery).

Or you can download the URF at www.nyc.gov/html/doh/pdf/hcp/urf-0803.pdf

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 the Provider Access Line 1-866-NYC-DOH1 during business hours; after 5PM call the Poison Control Center at 1-800-222-1222.

Did you know that you can now complete and submit URFs online?

Follow the steps listed below to get started!

- You will need to create an account on NYC-MED, the portal where the web-URF is posted. Follow these instructions:
 1. Enter the NYC-MED web address into browser: www.nyc.gov/health/nycmed
 2. To create a new user ID, Select the link “Not yet a user? Click here.”
 3. After the new user page loads, enter the required information (including first name, last name, professional degree, email address, secret question/answer, work affiliation, and work address.) You will be asked to create a password. Record the password in a secure location.
 4. Check the email account you provided to NYC-MED; an email containing your new user ID should be generated within 1 hour. Your password will NOT be contained within the email.
Note: Only one user ID may be generated per unique email address.
 5. Return to the NYC-MED web page to confirm your user ID and password are functional: www.nyc.gov/health/nycmed. Once you successfully log in, the link to the URF will be located on the upper-left side of the web page.
- Now you’re ready to enter URFs online. Follow these instructions:
 1. Enter the NYC-MED web address into your browser: www.nyc.gov/health/nycmed
 2. Enter your username and password.
 3. Choose ‘Universal Reporting Form’ from the menu on the left of the screen.

Instructions for Completing the Paper Universal Reporting Form (URF)

Page 1

Patient Information

Complete all requested information

In addition to the other demographic information, please complete the ‘Date of Report’ (upper right hand corner), ‘Zip Code,’ ‘Borough,’ ‘Race,’ ‘Ethnicity,’ the section labeled ‘Risk Groups for Disease Exposure,’ ‘Date of Diagnosis,’ and ‘Date of Illness Onset’

Reporter Information

- Complete all requested information

Disease (Code) with Special Instructions (continues on page 2)

- Clearly mark the box to the left of the disease you are reporting
- Specify organisms, sites, specific test results, species, and serogroups where indicated
- Complete any additional requested information
- Note: Disease names printed in green with one asterisk denote diseases that must be reported immediately. Call the Provider Access Line at 1-866-NYC-DOH1 during business hours; after 5PM call the Poison Control Center at 1-800-222-1222.
- Note: For enteric pathogens (marked with two asterisks), please complete the section labeled 'Risk Groups for Disease Exposure' located in the 'Patient Information' section
- Note: For sexually transmitted diseases (marked with a green †), indicate the gender of sexual partners in the past year (footnoted section, page 2)
- Information on how to report animal bites, HIV/AIDS, and window falls is available within the 'Disease (Code)' section

Page 2

Patient Name & Medical Record Number

- Complete the 'Patient Last Name,' 'First Name,' and 'Medical Record Number' at the top of *Page 2*

Disease (Code) with Special Instructions (continued from page one)

- Follow instructions as listed for *Page 1*

Poisoning

- Clearly mark the circle to the left of the appropriate poison and specimen types as well as the 'Purpose of Test'
- Complete the additional requested information

Sexually Transmitted Diseases

- Clearly mark the box to the left of the disease you are reporting
- Complete any additional requested information including sites, test types, treatments, test dates, and stage of disease (for syphilis)
- Indicate the gender of sexual partners in the past year (footnoted section).

Tuberculosis

- Complete all requested information
- Complete the section 'Risk Groups for Disease Exposure' on page one in the 'Patient Information' section

Where to send completed URFs

Mail all completed reports to:

NYC Department of Health and Mental Hygiene
125 Worth St, Room 315, CN6
New York, NY 10013

To order more URFs

Call the Provider Access Line 1-866-NYC-DOH1 (allow 2-3 weeks for delivery)

The URF can also be downloaded at www.nyc.gov/html/doh/pdf/hcp/urf-0803.pdf

Questions? Please call the Provider Access Line at 1-866-NYC-DOH1