|  |  |  |
| --- | --- | --- |
| Nazwa i adres laboratorium1) | **ZLB-2**  **Zgłoszenie dodatniego wyniku badania w kierunku gruźlicy** | Adresaci:  **Państwowy Powiatowy Inspektor Sanitarny**  **w** ......................................................... |
| **Resortowy kod identyfikacyjny podmiotu leczniczego**2)  Część I. Numer księgi rejestrowej   |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |   Część II. TERYT siedziby   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |   Część VII. Komórka organizacyjna   |  |  |  | | --- | --- | --- | |  |  |  | | **Uwagi:**  1) W przypadku dokumentu sporządzonego w postaci papierowej dane mogą być naniesione na dokument w formie pieczątki albo nadruku.  2) Wypełnić zgodnie z rozporządzeniem Ministra Zdrowia z dnia 17 maja 2012 r. w sprawie systemu resortowych kodów identyfikacyjnych oraz szczegółowego sposobu ich nadawania (Dz. U. z 2019 r. poz. 173).  3) Wypełnić w przypadku, gdy osobie nie nadano numeru PESEL, wpisując serię i numer paszportu albo nazwę i numer identyfikacyjny innego dokumentu, na podstawie którego jest możliwe ustalenie danych osobowych. | |
| **I. WYNIK BADANIA**  1. Data uzyskania wyniku (dd/mm/rrrr)   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | / |  |  | / |  |  |  |  |     2. Rozpoznane prątki chorobotwórcze: ………………………………………………………………………………………………………………….    3. Rodzaj badanej próbki / pobranego materiału diagnostycznego: …………………………………………………………………………………..    4. Metoda diagnostyczna:   |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  | preparat bezpośredni |  | hodowla |  | badanie molekularne |  |  |  |  | | |  |  |  |  |  |  |  |  |  |  | | |  | inne (wpisać jakie) ………………………………………………………….. ……...................................................................................................  ............................................................................................................................................................ | | |  |  | | |  | | | |  |  |  |  | | | | | | |  | | | |
| **II. Dane osoby, u której stwierdzono dodatni wynik badania w kierunku gruźlicy**  1. Nazwisko   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   2. Imię 3. Data urodzenia (dd/mm/rrrr) 4. Numer PESEL   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   5. Nazwa i numer identyfikacyjny dokumentu3)  6. Płeć (M, K) 7. Obywatelstwo   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   Adres miejsca zamieszkania:  8. Kod pocztowy 9. Miejscowość   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | – |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   10. Województwo 11. Powiat 12. Gmina   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   13. Ulica 14. Numer domu 15. Numer lokalu   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   16.   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | Brak danych w zakresie pkt 1–15 |  |  |  |  |  |  |   **III. DANE PODMIOTU LECZNICZEGO LUB OSOBY ZLECAJĄCEJ BADANIE:**  1. Nazwisko (lub nazwa podmiotu leczniczego)   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   2. Imię (lub nazwa podmiotu leczniczego) 3. Numer prawa wykonywania zawodu   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |   4. Nazwa komórki organizacyjnej zakładu leczniczego albo praktyki lekarskiej, w których wystawiono zlecenie lekarskie:    ……………………………………………………………………………………………………………………………………………………………………………………..  5. Numer telefonu   |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |     6. Kod pocztowy 7. Miejscowość   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | – |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |     8. Ulica 9. Numer domu 10. Numer lokalu   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | | |
| **IV. Inne informacje**  1. Data pobrania próbki (dd/mm/rrrr)   |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | |  |  | / |  |  | / |  |  |  |  |   2. Badana próbka pochodziła:   |  |  | | --- | --- | |  | od pacjenta leczonego ambulatoryjnie |  |  |  | | --- | --- | |  | od pacjenta hospitalizowanego, jeżeli tak, podać nazwę i adres szpitala: |   …………………………………………………………………………………………………………………………………………………………………   |  |  | | --- | --- | |  | od pacjenta na jego zlecenie |  |  |  | | --- | --- | |  | inne jakie: ………………………………………………………………… |   3. Powód wykonania badania   |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | |  | diagnostyka kliniczna |  | badanie pracownicze |  | ciąża |  | przyjęcie do szpitala | |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | inne badanie przesiewowe |  | z własnej inicjatywy, bez zlecenia lekarskiego |  | inny powód, jaki…………………....... | | | |
| **V. UWAGI** (w tym dodatkowe informacje istotne z punktu widzenia interpretacji uzyskanego dodatniego wyniku badania w kierunku biologicznych czynników chorobotwórczych): | | |
| **VI. Dane OSOBY zgłaszającej** (wpisać albo nanieść nadrukiem albo pieczątką)  1. Imię i nazwisko ............................................................... 2. Numer prawa wykonywania zawodu: ...........................………. 3. Podpis ............................  4. Telefon kontaktowy: ....................................................... 5. E-mail: ....................................................... | | |