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| Nazwa i adres komórki organizacyjnej zakładu leczniczego/praktyki lekarskiej1) | **ZLK-2****Zgłoszenie rozpoznania gruźlicy** | Adresat:**Państwowy Powiatowy** **Inspektor Sanitarny** **w** ........................................................ |
| **Resortowy kod identyfikacyjny podmiotu leczniczego**2)Część I. Numer księgi rejestrowej

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Część II. TERYT

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Część VII. Komórka organizacyjna

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 | **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, numer identyfikacyjny innego dokumentu, na podstawie którego jest możliwe ustalenie danych osobowych.(\*)  Niepotrzebne skreślić. |
| **I . ROZPOZNANIE****1. Kod ICD-10 2. Określenie słowne 3. Data rozpoznania** (dd/mm/rrrr)

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 |
| **II. Dane PACJENTA** **1. Nazwisko**

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**2. Imię 3. Data urodzenia** (dd/mm/rrrr) **4. Nr PESEL**

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**5. Nazwa i numer identyfikacyjny dokumentu**3) **6. Płeć (M, K) 7. Obywatelstwo**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**8. Kraj urodzenia**

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**9. Osoba bezdomna**

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| --- | --- | --- |
|  | Tak (w pkt 10–13 podać województwo, powiat, gminę i miejscowość) |  |

**Adres miejsca zamieszkania:****10. Województwo 11. Powiat 12. Gmina**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**13. Miejscowość 14. Kod pocztowy**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**15. Ulica 16. Nr domu 17. Nr lokalu**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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**18. Dane kontaktowe** (wypełnić w przypadku gdy pacjent lub jego przedstawiciel ustawowy wyraża na to zgodę):Telefon kontaktowy:……………………………………………………………………..E-mail:………………………………………………………………………………………**III. DANE UZUPEŁNIAJĄCE****1. Lokalizacja i stan bakteriologiczny choroby:** **a) płucna****nowe zachorowanie wznowa**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | bakteriologia (+) |  | bakteriologia (-)  |  | bakteriologia (+) |  | bakteriologia (-) |

**b) pozapłucna****nowe zachorowanie wznowa**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | bakteriologia (+) |  | bakteriologia (-)  |  | bakteriologia (+) |  | bakteriologia (-) |

**2. Poprzednie rozpoznanie gruźlicy (rok)**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  |  |

**3. Poprzednie leczenie przeciwprątkowe**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | nieleczony |  | leczony prawidłowo  |  | leczony nieprawidłowo |  | brak danych |

**4. Szczepienia BCG**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | wykonano |  | nie wykonano |  |  |  |  |

**5. Odczyn tuberkulinowy (OT)**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | wykonano |  | nie wykonano  |  | wynik testu IGRA (+) |  | wynik testu IGRA (-) |

**6. Liczba osób współzamieszkujących**:………**7. Styczność z gruźlicą czynną**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | aktualna |  | zakończona, rok:……..  |  | nie stwierdzono styczności |  | brak danych |

**8. Badania bakteriologiczne plwociny****a) bakterioskopia/rozmaz**(\*)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | wynik (+) |  | wynik (-)  |  | wykonano, brak wyników |  | nie wykonano |

**b) posiew/hodowla**(\*)

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | wynik (+) |  | wynik (-)  |  | wykonano, brak wyników |  | nie wykonano |

**9. Badanie histopatologiczne**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | wykonano |  | potwierdzono gruźlicę  |  | nie potwierdzono gruźlicy |  | nie wykonano |

**10. Inne badania bakteriologiczne** (podać jakie)………………………………………………………………………………………………………………..**11. Okoliczności wykrycia chorego na gruźlicę:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | z objawów klinicznych |  | ze styczności z chorym  |  | przy hospitalizacji |  | w badaniu sekcyjnym  |

|  |  |
| --- | --- |
|  | w badaniu grup ryzyka (z wyłączeniem styczności z chorym)  |

|  |  |
| --- | --- |
|  | w innych badaniach profilaktycznych (np. badania wstępne, okresowe)  |

|  |  |
| --- | --- |
|  | w innych badaniach  |

**12. Kontakt ze zwierzętami**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Tak |  | Nie |  |  |  |  |

 |
|  **IV. DANE ZGŁASZAJĄCEGO LEKARZA/FELCZERA**(wpisać albo nanieśćnadrukiem albo pieczątką) 1. Imię i nazwisko............................................................... ……………. 2. Numer prawa wykonywania zawodu: .................................... 3. Podpis ........................................4. Telefon kontaktowy: ......................................................................... 5. E-mail: ....................................................................... |