|  |  |  |
| --- | --- | --- |
| Nazwa i adres laboratorium1)  | **ZLB-1****Zgłoszenie dodatniego wyniku badania w  kierunku biologicznych czynników chorobotwórczych**2) | Adresaci:**Państwowy Powiatowy Inspektor Sanitarny** **w** ......................................................... |
| **Resortowy kod identyfikacyjny podmiotu leczniczego**3)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) Nie dotyczy dodatnich wyników badań w kierunku gruźlicy i ludzkiego wirusa niedoboru odporności (HIV) – zgłaszanych na innych formularzach.3) 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).4) 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. Rozpoznany biologiczny czynnik chorobotwórczy: ………………………………………………………………………………………………………... 3. Rodzaj badanej próbki / pobranego materiału diagnostycznego: ………………………………………………………………………………………….4. Metoda diagnostyczna:

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  preparat bezpośredni  |  |  izolacja  |  |  badanie molekularne |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | badanie stwierdzające obecność antygenu............................................................................................................................................................ |  |  |  |
|  |  |  |  |  |
|  |  badanie stwierdzające obecność/dynamikę swoistych przeciwciał |  |   |  |   |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
|  | inne (wpisać jakie) ………………………………………………………….. ……............................................................................................................................................................................................................................................................... |  |  |  |
|  |  |  |  |  |

 |
| **II. Dane osoby, u której stwierdzono dodatni wynik badania w kierunku biologicznych czynników****chorobotwórczych** 1. Nazwisko

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

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

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | / |  |  | / |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

5. Nazwa i numer identyfikacyjny dokumentu4) 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 nanieśćnadrukiem albo pieczątką)1. Imię i nazwisko ............................................................... 2. Numer prawa wykonywania zawodu: ...........................………. 3. Podpis ............................4. Telefon kontaktowy: ....................................................... 5. E-mail: ....................................................... |