

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name		First Name		MI	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		
Home Address: Number, Street				Apt./Unit No.			
City		State	ZIP Code		Race (check all that apply) <input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (check all that apply) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown		
Home Telephone Number		Cell Telephone Number		Work Telephone Number			
Email Address			Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____				
Birth Date (mm/dd/yyyy)		Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		Gender <input type="checkbox"/> M to F Transgender <input type="checkbox"/> Male <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Female <input type="checkbox"/> Other: _____		
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Est. Delivery Date (mm/dd/yyyy)		Country of Birth			
Occupation or Job Title				Occupational or Exposure Setting (check all that apply): <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> School <input type="checkbox"/> Other (specify): _____			

Date of Onset (mm/dd/yyyy)		Date of First Specimen Collection (mm/dd/yyyy)		Date of Diagnosis (mm/dd/yyyy)		Date of Death (mm/dd/yyyy)	
Reporting Health Care Provider			Reporting Health Care Facility			REPORT TO:	
Address: Number, Street				Suite/Unit No.			
City		State	ZIP Code				
Telephone Number		Fax Number					
Submitted by			Date Submitted (mm/dd/yyyy)				
Laboratory Name				City		State	ZIP Code

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)			
Gender of Sex Partners (check all that apply) <input type="checkbox"/> Male <input type="checkbox"/> M to F Transgender <input type="checkbox"/> Female <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		STD TREATMENT <input type="checkbox"/> Treated in office <input type="checkbox"/> Given prescription Drug(s), Dosage, Route _____	
		Treatment Began (mm/dd/yyyy) _____ <input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Patient refused treatment <input type="checkbox"/> Referred to: _____	

If reporting Syphilis, Stage: <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Secondary <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Latent (unknown duration) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Congenital Neurosyphilis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Syphilis Test Results <input type="checkbox"/> RPR <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> VDRL <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> FTA-ABS <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> TP-PA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> EIA/CLIA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other: _____		Titer _____		If reporting Chlamydia and/or Gonorrhea: Specimen Source(s) (check all that apply) <input type="checkbox"/> Cervical <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> Urethral <input type="checkbox"/> Urine <input type="checkbox"/> Vaginal <input type="checkbox"/> Other: _____		Symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If reporting Pelvic Inflammatory Disease: (check all that apply) <input type="checkbox"/> Gonococcal PID <input type="checkbox"/> Chlamydial PID <input type="checkbox"/> Other/Unknown Etiology PID	
		Partner(s) Treated? <input type="checkbox"/> Yes, treated in this clinic <input type="checkbox"/> Yes, Meds/Prescription given to patient for their partner(s) <input type="checkbox"/> Yes, other: _____		<input type="checkbox"/> No, instructed patient to refer partner(s) for treatment <input type="checkbox"/> No, referred partner(s) to: _____ <input type="checkbox"/> Unknown							

VIRAL HEPATITIS																																																																													
Diagnosis (check all that apply) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B (acute) <input type="checkbox"/> Hepatitis B (chronic) <input type="checkbox"/> Hepatitis B (perinatal) <input type="checkbox"/> Hepatitis C (acute) <input type="checkbox"/> Hepatitis C (chronic) <input type="checkbox"/> Hepatitis D <input type="checkbox"/> Hepatitis E		Is patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Suspected Exposure Type(s) <input type="checkbox"/> Blood transfusion, dental or medical procedure <input type="checkbox"/> IV drug use <input type="checkbox"/> Other needle exposure <input type="checkbox"/> Sexual contact <input type="checkbox"/> Household contact <input type="checkbox"/> Perinatal <input type="checkbox"/> Child care <input type="checkbox"/> Other: _____		ALT (SGPT) Result: _____ Upper Limit: _____ AST (SGOT) Result: _____ Upper Limit: _____ Bilirubin result: _____		<table border="1"> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th></th> <th>Pos</th> <th>Neg</th> </tr> <tr> <td>Hep A</td> <td>anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep C</td> <td>anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep B</td> <td>HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBc total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>HCV RNA (e.g., PCR)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep D</td> <td>anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep E</td> <td>anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>HBeAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>HBV DNA:</td> <td colspan="2">_____</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>			Pos	Neg		Pos	Neg	Hep A	anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep C	anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	Hep B	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>		RIBA	<input type="checkbox"/>	<input type="checkbox"/>		anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>		HCV RNA (e.g., PCR)	<input type="checkbox"/>	<input type="checkbox"/>		anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep D	anti-HDV	<input type="checkbox"/>	<input type="checkbox"/>		anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	Hep E	anti-HEV	<input type="checkbox"/>	<input type="checkbox"/>		HBeAg	<input type="checkbox"/>	<input type="checkbox"/>						anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>						HBV DNA:	_____					
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Remarks: Patient tab Clinical Info tab Syphilis Lab tab Case Investigation tab