

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name <input style="width: 95%;" type="text"/>		Social Security Number <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/>		Ethnicity (✓ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
First Name/Middle Name (or initial) <input style="width: 95%;" type="text"/>		Birth Date Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/>		Age <input style="width: 15%;" type="text"/>	
Address: Number, Street <input style="width: 95%;" type="text"/>				Apt./Unit Number <input style="width: 95%;" type="text"/>	
City/Town <input style="width: 95%;" type="text"/>		State <input style="width: 15%;" type="text"/>	ZIP Code <input style="width: 30%;" type="text"/>		
Area Code <input style="width: 15%;" type="text"/>	Home Telephone <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	Estimated Delivery Date Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/>	
Area Code <input style="width: 15%;" type="text"/>	Work Telephone <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/> - <input style="width: 15%;" type="text"/>	Patient's Occupation/Setting <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other _____		<input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White: _____ <input type="checkbox"/> Other: _____	

DATE OF ONSET Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/>	Reporting Health Care Provider <input style="width: 95%;" type="text"/> Reporting Health Care Facility <input style="width: 95%;" type="text"/> Address <input style="width: 95%;" type="text"/> City <input style="width: 20%;" type="text"/> State <input style="width: 10%;" type="text"/> ZIP Code <input style="width: 20%;" type="text"/> Telephone Number (<input style="width: 10%;" type="text"/>) Fax (<input style="width: 10%;" type="text"/>) Submitted by <input style="width: 30%;" type="text"/> Date Submitted <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/> <input style="width: 10%;" type="text"/>		REPORT TO			
DATE DIAGNOSED Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/>						
DATE OF DEATH Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/>						
(Obtain additional forms from your local health department.)						

SEXUALLY TRANSMITTED DISEASES (STD)			VIRAL HEPATITIS						
Syphilis <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Secondary <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Congenital <input type="checkbox"/> Latent (unknown duration)			Syphilis Test Results <input type="checkbox"/> RPR Titer: _____ <input type="checkbox"/> VDRL Titer: _____ <input type="checkbox"/> FTA/MHA: <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: _____			Pos Neg Pend Not Done			
<input type="checkbox"/> Neurosyphilis			<input type="checkbox"/> Hep A anti-HAV IgM <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			<input type="checkbox"/> Hep B HBsAg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____			<input type="checkbox"/> Chlamydia <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____			<input type="checkbox"/> Hep C anti-HCV <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____			<input type="checkbox"/> PID (Unknown Etiology) <input type="checkbox"/> Chancroid <input type="checkbox"/> Non-Gonococcal Urethritis			<input type="checkbox"/> Hep D (Delta) anti-Delta <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>			
STD TREATMENT INFORMATION <input type="checkbox"/> Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/>			<input type="checkbox"/> Other: _____			<input type="checkbox"/> Other: _____			
<input type="checkbox"/> Suspected Exposure Type <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Other needle exposure <input type="checkbox"/> Sexual contact <input type="checkbox"/> Household contact <input type="checkbox"/> Child care <input type="checkbox"/> Other: _____									

TUBERCULOSIS (TB) Status <input type="checkbox"/> Active Disease <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspected <input type="checkbox"/> Infected, No Disease <input type="checkbox"/> Convertor <input type="checkbox"/> Reactor	Mantoux TB Skin Test Date Performed Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/> Results: _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done	Bacteriology Date Specimen Collected Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/> Source _____ Smear: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Culture: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pending <input type="checkbox"/> Not done Other test(s) _____	TB TREATMENT INFORMATION <input type="checkbox"/> Current Treatment <input type="checkbox"/> INH <input type="checkbox"/> RIF <input type="checkbox"/> PZA <input type="checkbox"/> EMB <input type="checkbox"/> Other: _____ Date Treatment Initiated Month <input style="width: 15%;" type="text"/> Day <input style="width: 15%;" type="text"/> Year <input style="width: 15%;" type="text"/> <input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Refused treatment <input type="checkbox"/> Referred to: _____
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REMARKS

**Title 17, California Code of Regulations (CCR), §2500, §2593, §2641–2643, and §2800–2812
Reportable Diseases and Conditions***

§2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.
- **§2500(c)** The administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local health officer.
- **§2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500 (h) (i)]

- ☎ = Report **immediately by telephone** (designated by a ♦ in regulations).
- † = Report **immediately by telephone** when **two or more cases** or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations).
- FAX ☎ ☒ = Report by **FAX, telephone, or mail within one working day of identification** (designated by a + in regulations).
- = All other diseases/conditions should be reported by FAX, telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1), §2641–2643

<p>Acquired Immune Deficiency Syndrome (AIDS) (HIV infection only: see "Human Immunodeficiency Virus")</p> <p>FAX ☎ ☒ Amebiasis</p> <p>FAX ☎ ☒ Anisakiasis</p> <p>☎ Anthrax</p> <p>FAX ☎ ☒ Babesiosis</p> <p>☎ Botulism (Infant, Foodborne, Wound)</p> <p>☎ Brucellosis</p> <p>FAX ☎ ☒ Campylobacteriosis</p> <p>Chancroid</p> <p>Chlamydial Infections</p> <p>☎ Cholera</p> <p>☎ Ciguatera Fish Poisoning</p> <p>Coccidioidomycosis</p> <p>FAX ☎ ☒ Colorado Tick Fever</p> <p>FAX ☎ ☒ Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology</p> <p>FAX ☎ ☒ Cryptosporidiosis</p> <p>Cysticercosis</p> <p>☎ Dengue</p> <p>☎ Diarrhea of the Newborn, Outbreaks</p> <p>☎ Diphtheria</p> <p>☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>Echinococcosis (Hydatid Disease)</p> <p>Ehrlichiosis</p> <p>FAX ☎ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☎ <i>Escherichia coli</i> O157:H7 Infection</p> <p>† FAX ☎ ☒ Foodborne Disease</p> <p>Giardiasis</p> <p>Gonococcal Infections</p> <p>FAX ☎ ☒ <i>Haemophilus influenzae</i> Invasive Disease</p> <p>☎ Hantavirus Infections</p> <p>☎ Hemolytic Uremic Syndrome</p> <p>Hepatitis, Viral</p> <p>FAX ☎ ☒ Hepatitis A</p> <p>Hepatitis B (specify acute case or chronic)</p> <p>Hepatitis C (specify acute case or chronic)</p> <p>Hepatitis D (Delta)</p> <p>Hepatitis, other, acute</p> <p>Human Immunodeficiency Virus (HIV) (§2641–2643): reporting is NON-NAME (see www.dhs.ca.gov/aids)</p> <p>Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)</p> <p>Legionellosis</p> <p>Leprosy (Hansen Disease)</p> <p>Leptospirosis</p> <p>FAX ☎ ☒ Listeriosis</p> <p>Lyme Disease</p> <p>FAX ☎ ☒ Lymphocytic Choriomeningitis</p> <p>FAX ☎ ☒ Malaria</p> <p>FAX ☎ ☒ Measles (Rubeola)</p> <p>FAX ☎ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>☎ Meningococcal Infections</p> <p>Mumps</p> <p>Non-Gonococcal Urethritis (Excluding Laboratory Confirmed Chlamydial Infections)</p>	<p>☎ Paralytic Shellfish Poisoning</p> <p>Pelvic Inflammatory Disease (PID)</p> <p>FAX ☎ ☒ Pertussis (Whooping Cough)</p> <p>☎ Plague, Human or Animal</p> <p>FAX ☎ ☒ Poliomyelitis, Paralytic</p> <p>FAX ☎ ☒ Psittacosis</p> <p>FAX ☎ ☒ Q Fever</p> <p>☎ Rabies, Human or Animal</p> <p>FAX ☎ ☒ Relapsing Fever</p> <p>Reye Syndrome</p> <p>Rheumatic Fever, Acute</p> <p>Rocky Mountain Spotted Fever</p> <p>Rubella (German Measles)</p> <p>Rubella Syndrome, Congenital</p> <p>FAX ☎ ☒ Salmonellosis (Other than Typhoid Fever)</p> <p>☎ Scombroid Fish Poisoning</p> <p>FAX ☎ ☒ Shigellosis</p> <p>☎ Smallpox (Variola)</p> <p>FAX ☎ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</p> <p>FAX ☎ ☒ Swimmer's Itch (Schistosomal Dermatitis)</p> <p>FAX ☎ ☒ Syphilis</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>Toxoplasmosis</p> <p>FAX ☎ ☒ Trichinosis</p> <p>FAX ☎ ☒ Tuberculosis</p> <p>☎ Tularemia</p> <p>FAX ☎ ☒ Typhoid Fever, Cases and Carriers</p> <p>Typhus Fever</p> <p>☎ Varicella (deaths only)</p> <p>FAX ☎ ☒ <i>Vibrio</i> Infections</p> <p>☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)</p> <p>FAX ☎ ☒ Water-associated Disease</p> <p>☎ Yellow Fever</p> <p>FAX ☎ ☒ Yersiniosis</p> <p>☎ OCCURRENCE of ANY UNUSUAL DISEASE</p> <p>☎ OUTBREAKS of ANY DISEASE (Including diseases not listed in §2500). Specify if institutional and/or open community.</p>
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REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Alzheimer's Disease and Related Conditions, and Disorders Characterized by Lapses of Consciousness
Cancer (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix)

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California's Citation and Fine Program (Title 16, CCR, §1364).