

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 _____		Social Security Number ____-____-____		Ethnicity (✓ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
First Name/Middle Name (or initial) _____		Birth Date Month Day Year		Age _____	
Address: Number, Street _____				Apt./Unit Number _____	
City/Town _____		State _____	Zip Code _____		
Area Code ____-____	Home Telephone ____-____	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 Day Year	
Area Code ____-____	Work Telephone ____-____	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 _____		Race (✓ one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (✓ one) <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other _____	
<input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White _____ <input type="checkbox"/> Other _____					

DATE OF ONSET Month Day Year ____/____/____		Reporting Health Care Provider _____		REPORT TO	
DATE DIAGNOSED Month Day Year ____/____/____		Reporting Health Care Facility _____			
DATE OF DEATH Month Day Year ____/____/____		Address _____			
		City _____ State _____ Zip Code _____			
		Telephone Number (____) _____ Fax (____) _____			
		Submitted By _____ Date Submitted (Month/Day/Year) ____/____/____		(Obtain additional forms from your local health department.)	

SEXUALLY TRANSMITTED DISEASES (STD)		Syphilis Test Results	
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) <input type="checkbox"/> Neurosyphilis		<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 _____	
Gonorrhea <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> PID <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____		<input type="checkbox"/> PID (Unknown Etiology) <input type="checkbox"/> Chancroid <input type="checkbox"/> Non-Gonococcal Urethritis	
STD TREATMENT INFORMATION <input type="checkbox"/> Treated (Drugs, Dosage, Route) Date Treatment Initiated _____ Month Day Year		<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 _____	

VIRAL HEPATITIS		Pos		Neg		Pend		Not Done	
<input type="checkbox"/> Hep A	anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute	anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic	anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hep C	anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute	PCR-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic									
<input type="checkbox"/> Hep D (Delta)	anti-Delta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<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 Month Day Year Date Performed _____ Results _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done	Bacteriology Month Day Year Date Specimen Collected _____ 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) _____
Chest X-Ray Month Day Year Date Performed _____ <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory	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 _____
<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 _____	

REMARKS _____ _____	
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Title 17, California Code of Regulations (CCR), §2500 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 (2) 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 (1) working day of identification** (designated by a + in regulations).
- ☒ = All other diseases/conditions should be reported by FAX, telephone, or mail within seven (7) calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

- Acquired Immune Deficiency Syndrome (AIDS)
- FAX ☎ ☒ Amebiasis
- FAX ☎ ☒ Anisakiasis
- ☎ Anthrax
- FAX ☎ ☒ Babesiosis
- ☎ Botulism (Infant, Foodborne, Wound)
- ☎ Brucellosis
- FAX ☎ ☒ Campylobacteriosis
- Chancroid
- Chlamydial Infections
- ☎ Cholera
- ☎ Ciguatera Fish Poisoning
- Coccidioidomycosis
- FAX ☎ ☒ Colorado Tick Fever
- FAX ☎ ☒ Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology
- FAX ☎ ☒ Cryptosporidiosis
- Cysticercosis
- ☎ Dengue
- ☎ Diarrhea of the Newborn, Outbreaks
- ☎ Diphtheria
- ☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- Echinococcosis (Hydatid Disease)
- Ehrlichiosis
- FAX ☎ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ☎ *Escherichia coli* O157:H7 Infection
- † FAX ☎ ☒ Foodborne Disease
- Giardiasis
- Gonococcal Infections
- FAX ☎ ☒ *Haemophilus influenzae* Invasive Disease
- ☎ Hantavirus Infections
- ☎ Hemolytic Uremic Syndrome
- Hepatitis, Viral
- FAX ☎ ☒ Hepatitis A
 - Hepatitis B (specify acute case or chronic)
 - Hepatitis C (specify acute case or chronic)
 - Hepatitis D (Delta)
 - Hepatitis, other, acute
- Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- FAX ☎ ☒ Listeriosis
- Lyme Disease
- FAX ☎ ☒ Lymphocytic Choriomeningitis
- FAX ☎ ☒ Malaria
- FAX ☎ ☒ Measles (Rubeola)
- FAX ☎ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ☎ Meningococcal Infections
- Mumps
- Non-Gonococcal Urethritis (Excluding Laboratory Confirmed Chlamydial Infections)
- ☎ Paralytic Shellfish Poisoning
- Pelvic Inflammatory Disease (PID)

- FAX ☎ ☒ Pertussis (Whooping Cough)
- ☎ Plague, Human or Animal
- FAX ☎ ☒ Poliomyelitis, Paralytic
- FAX ☎ ☒ Psittacosis
- FAX ☎ ☒ Q Fever
- ☎ Rabies, Human or Animal
- FAX ☎ ☒ Relapsing Fever
- Reye Syndrome
- Rheumatic Fever, Acute
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- FAX ☎ ☒ Salmonellosis (Other than Typhoid Fever)
- ☎ Scombroid Fish Poisoning
- FAX ☎ ☒ Shigellosis
- ☎ Smallpox (Variola)
- FAX ☎ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
- FAX ☎ ☒ Swimmer's Itch (Schistosomal Dermatitis)
- FAX ☎ ☒ Syphilis
- Tetanus
- Toxic Shock Syndrome
- Toxoplasmosis
- FAX ☎ ☒ Trichinosis
- FAX ☎ ☒ Tuberculosis
- ☎ Tularemia
- FAX ☎ ☒ Typhoid Fever, Cases and Carriers
- Typhus Fever
- ☎ Varicella (deaths only)
- FAX ☎ ☒ *Vibrio* Infections
- ☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
- FAX ☎ ☒ Water-associated Disease
- ☎ Yellow Fever
- FAX ☎ ☒ Yersiniosis
- ☎ **OCURRENCE of ANY UNUSUAL DISEASE**
- ☎ **OUTBREAKS of ANY DISEASE** (Including diseases not listed in §2500). Specify if institutional and/or open community.

REPORTABLE NONCOMMUNICABLE DISEASES/CONDITIONS §2500(j)(2):

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

LOCALLY REPORTABLE DISEASES (If Applicable):

* Use of this form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations, §2500 (rev. 1996). (Cancer reporting is mandated by §2593.) Failure to report is a misdemeanor (Health and Safety Code §120295, formerly §3354), punishable by a fine of not less than \$50 nor more than \$1,000, or by imprisonment for a term of not more than 90 days, or by both. Each day the violation is continued is a separate offense.