

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: 25%;" type="text"/> - <input style="width: 25%;" type="text"/> - <input style="width: 25%;" 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: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>		Age <input style="width: 40%;" type="text"/>	
Address: Number, Street <input style="width: 95%;" type="text"/>				Apt./Unit Number <input style="width: 40%;" type="text"/>	
City/Town <input style="width: 95%;" type="text"/>		State <input style="width: 20%;" type="text"/>	ZIP Code <input style="width: 40%;" type="text"/>		
Area Code <input style="width: 20%;" type="text"/>	Home Telephone <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" 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: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>	
Area Code <input style="width: 20%;" type="text"/>	Work Telephone <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" 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 _____		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 <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>		Reporting Health Care Provider <input style="width: 95%;" type="text"/>			REPORT TO				
DATE DIAGNOSED Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>		Reporting Health Care Facility <input style="width: 95%;" type="text"/>							
DATE OF DEATH Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>		Address <input style="width: 95%;" type="text"/>							
		City <input style="width: 40%;" type="text"/> State <input style="width: 20%;" type="text"/> ZIP Code <input style="width: 40%;" type="text"/>							
		Telephone Number (<input style="width: 20%;" type="text"/>) <input style="width: 40%;" type="text"/>	Fax (<input style="width: 20%;" type="text"/>) <input style="width: 40%;" type="text"/>						
		Submitted by <input style="width: 40%;" type="text"/>	Date Submitted (Month/Day/Year) <input style="width: 20%;" type="text"/> / <input style="width: 20%;" type="text"/> / <input style="width: 20%;" 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: _____		<input type="checkbox"/> Hep A anti-HAV IgM <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done	<input type="checkbox"/> Hep B HBsAg <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done	<input type="checkbox"/> Hep C anti-HCV <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done	<input type="checkbox"/> Hep D (Delta) anti-Delta <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Pend <input type="checkbox"/> Not Done	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Neurosyphilis	<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"/> PID (Unknown Etiology) <input type="checkbox"/> Chancroid <input type="checkbox"/> Non-Gonococcal Urethritis	<input type="checkbox"/> Acute anti-HBc <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Chronic anti-HBc IgM <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Acute PCR-HCV <input type="checkbox"/> Pos <input type="checkbox"/> Neg	<input type="checkbox"/> Chronic anti-HBs <input type="checkbox"/> Pos <input type="checkbox"/> Neg	
STD TREATMENT INFORMATION <input type="checkbox"/> Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated: Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" 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: _____	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"/> Converter <input type="checkbox"/> Reactor		Mantoux TB Skin Test Date Performed: Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/> Results: _____ mm <input type="checkbox"/> Pending <input type="checkbox"/> Not Done		Bacteriology Date Specimen Collected: Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" 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: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" 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: _____	
Site(s) <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both		Chest X-Ray Date Performed: Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/> <input type="checkbox"/> Normal <input type="checkbox"/> Pending <input type="checkbox"/> Not done <input type="checkbox"/> Cavitory <input type="checkbox"/> Abnormal/Noncavitory					

REMARKS

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, 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 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)

	Acquired Immune Deficiency Syndrome (AIDS) (Human Immunodeficiency Virus infection only - see lower right)	FAX ☎ ☒	Poliomyelitis, Paralytic
		FAX ☎ ☒	Psittacosis
FAX ☎ ☒	Amebiasis	FAX ☎ ☒	Q Fever
	☎ Anthrax	☎	Rabies, Human or Animal
	☎ Avian Influenza (human)	FAX ☎ ☒	Relapsing Fever
FAX ☎ ☒	Babesiosis		Rheumatic Fever, Acute
	☎ Botulism (Infant, Foodborne, Wound)		Rocky Mountain Spotted Fever
	☎ Brucellosis		Rubella (German Measles)
FAX ☎ ☒	Campylobacteriosis		Rubella Syndrome, Congenital
	Chancroid	FAX ☎ ☒	Salmonellosis (Other than Typhoid Fever)
FAX ☎ ☒	Chickenpox (only hospitalizations and deaths)	☎	Scombroid Fish Poisoning
	Chlamydial Infections, including Lymphogranulom Venereum (LGV)	☎	Severe Acute Respiratory Syndrome (SARS)
	☎ Cholera	☎	Shiga toxin (detected in feces)
	☎ Ciguatera Fish Poisoning	FAX ☎ ☒	Shigellosis
	Coccidioidomycosis	☎	Smallpox (Variola)
FAX ☎ ☒	Colorado Tick Fever	☎	<i>Staphylococcus aureus</i> infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ☎ ☒	Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology	FAX ☎ ☒	Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
	Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	FAX ☎ ☒	Syphilis
FAX ☎ ☒	Cryptosporidiosis		Tetanus
	Cysticercosis or Taeniasis	FAX ☎ ☒	Toxic Shock Syndrome
	☎ Dengue		Toxoplasmosis
	☎ Diarrhea of the Newborn, Outbreak	FAX ☎ ☒	Trichinosis
	☎ Diphtheria	FAX ☎ ☒	Tuberculosis
	☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	☎	Tularemia
	Ehrlichiosis	FAX ☎ ☒	Typhoid Fever, Cases and Carriers
FAX ☎ ☒	Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic		Typhus Fever
	☎ <i>Escherichia coli</i> : shiga toxin producing (STEC) including <i>E. coli</i> O157	FAX ☎ ☒	<i>Vibrio</i> Infections
† FAX ☎ ☒	Foodborne Disease	☎	Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
	Giardiasis	FAX ☎ ☒	Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)
	Gonococcal Infections	FAX ☎ ☒	West Nile Virus (WNV) Infection
FAX ☎ ☒	<i>Haemophilus influenzae</i> invasive disease (report an incident less than 15 years of age)	☎	Yellow Fever
	☎ Hantavirus Infections	FAX ☎ ☒	Yersiniosis
	☎ Hemolytic Uremic Syndrome	☎	OCCURRENCE of ANY UNUSUAL DISEASE
	Hepatitis, Viral	☎	OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.
FAX ☎ ☒	Hepatitis A		
	Hepatitis B (specify acute case or chronic)		
	Hepatitis C (specify acute case or chronic)		
	Hepatitis D (Delta)		
	Hepatitis, other, acute		
	Influenza deaths (report an incident of less than 18 years of age)		
	Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)		
	Legionellosis		
	Leprosy (Hansen Disease)		
	Leptospirosis		
FAX ☎ ☒	Listeriosis		
	Lyme Disease		
FAX ☎ ☒	Malaria		
FAX ☎ ☒	Measles (Rubeola)		
FAX ☎ ☒	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic		
	☎ Meningococcal Infections		
	Mumps		
	☎ Paralytic Shellfish Poisoning		
	Pelvic Inflammatory Disease (PID)		
FAX ☎ ☒	Pertussis (Whooping Cough)		
	☎ Plague, Human or Animal		

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, §2641.5-2643.20 and <http://www.cdph.ca.gov/programs/AIDS/Pages/OAHIVReporting.aspx>.

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS § 2800-2812 AND § 2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (§ 2593)**

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 Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty (\$250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrca.org.