

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		
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)
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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)				

(Obtain additional forms from your local health department.)

Laboratory Name	City	State	ZIP Code
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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	Treatment Began (mm/dd/yyyy)	<input type="checkbox"/> Untreated
	Drug(s), Dosage, Route _____	_____	<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	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: _____	If reporting Pelvic Inflammatory Disease: (check all that apply) <input type="checkbox"/> Yes <input type="checkbox"/> Gonococcal PID <input type="checkbox"/> No <input type="checkbox"/> Chlamydial PID <input type="checkbox"/> Unknown <input type="checkbox"/> Other/Unknown Etiology PID
Neurosyphilis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Partner(s) Treated? <input type="checkbox"/> Yes, treated in this clinic <input type="checkbox"/> No, instructed patient to refer partner(s) for treatment <input type="checkbox"/> Yes, Meds/Prescription given to patient for their partner(s) <input type="checkbox"/> No, referred partner(s) to: _____ <input type="checkbox"/> Yes, other: _____ <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: _____			
			Hep A anti-HAV IgM <input type="checkbox"/> Pos <input type="checkbox"/> Neg	Hep B HBsAg <input type="checkbox"/> Pos <input type="checkbox"/> Neg anti-HBc total <input type="checkbox"/> Pos <input type="checkbox"/> Neg anti-HBc IgM <input type="checkbox"/> Pos <input type="checkbox"/> Neg anti-HBs <input type="checkbox"/> Pos <input type="checkbox"/> Neg HBeAg <input type="checkbox"/> Pos <input type="checkbox"/> Neg anti-HBe <input type="checkbox"/> Pos <input type="checkbox"/> Neg HBV DNA: _____	Hep C anti-HCV <input type="checkbox"/> Pos <input type="checkbox"/> Neg RIBA <input type="checkbox"/> Pos <input type="checkbox"/> Neg HCV RNA (e.g., PCR) <input type="checkbox"/> Pos <input type="checkbox"/> Neg	Hep D anti-HDV <input type="checkbox"/> Pos <input type="checkbox"/> Neg	Hep E anti-HEV <input type="checkbox"/> Pos <input type="checkbox"/> Neg							

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 condition 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 electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
- = All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(i)(1)

<p>Acquired Immune Deficiency Syndrome (AIDS) (HIV infection only: see "Human Immunodeficiency Virus")</p> <p>FAX Ⓢ ☒ Amebiasis</p> <p>Anaplasmosis/Ehrlichiosis</p> <p>Ⓢ ! Anthrax</p> <p>Ⓢ ! Avian Influenza (human)</p> <p>FAX Ⓢ ☒ Babesiosis</p> <p>Ⓢ ! Botulism (Infant, Foodborne, Wound)</p> <p>Ⓢ ! Brucellosis</p> <p>FAX Ⓢ ☒ Campylobacteriosis</p> <p>Chancroid</p> <p>FAX Ⓢ ☒ Chickenpox (only hospitalizations and deaths)</p> <p>Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)</p> <p>Ⓢ ! Cholera</p> <p>Ⓢ ! Ciguatera Fish Poisoning</p> <p>Coccidioidomycosis</p> <p>FAX Ⓢ ☒ Colorado Tick Fever</p> <p>Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</p> <p>FAX Ⓢ ☒ Cryptosporidiosis</p> <p>Cysticercosis or Taeniasis</p> <p>Ⓢ ! Dengue</p> <p>Ⓢ ! Diphtheria</p> <p>Ⓢ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>FAX Ⓢ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>Ⓢ ! <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli</i> O157</p> <p>† FAX Ⓢ ☒ Foodborne Disease</p> <p>Giardiasis</p> <p>Gonococcal Infections</p> <p>FAX Ⓢ ☒ <i>Haemophilus influenzae</i> invasive disease (report an incident less than 15 years of age)</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>Influenza deaths (report an incident of less than 18 years of age)</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 Ⓢ ☒ 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>Ⓢ ! Paralytic Shellfish Poisoning</p> <p>Pelvic Inflammatory Disease (PID)</p> <p>FAX Ⓢ ☒ Pertussis (Whooping Cough)</p> <p>Ⓢ ! Plague, Human or Animal</p>	<p>FAX Ⓢ ☒ Poliovirus Infection</p> <p>FAX Ⓢ ☒ Psittacosis</p> <p>FAX Ⓢ ☒ Q Fever</p> <p>Ⓢ ! Rabies, Human or Animal</p> <p>FAX Ⓢ ☒ Relapsing Fever</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>Ⓢ ! Severe Acute Respiratory Syndrome (SARS)</p> <p>Ⓢ ! Shiga toxin (detected in feces)</p> <p>FAX Ⓢ ☒ Shigellosis</p> <p>Ⓢ ! Smallpox (Variola)</p> <p>FAX Ⓢ ☒ <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)</p> <p>FAX Ⓢ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</p> <p>FAX Ⓢ ☒ Syphilis</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</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>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 (e.g., Swimmer's Itch or Hot Tub Rash)</p> <p>FAX Ⓢ ☒ West Nile Virus (WNV) Infection</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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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