

# CONFIDENTIAL MORBIDITY REPORT

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

**DISEASE BEING REPORTED:** \_\_\_\_\_

<b>Patient's Last Name</b> <input style="width: 95%;" type="text"/>		<b>Social Security Number</b> <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/> - <input style="width: 25%;" type="text"/>		<b>Ethnicity (✓ one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
<b>First Name/Middle Name (or initial)</b> <input style="width: 95%;" type="text"/>		<b>Birth Date</b> Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>		<b>Age</b> <input style="width: 40%;" type="text"/>	
<b>Address: Number, Street</b> <input style="width: 95%;" type="text"/>				<b>Apt./Unit Number</b> <input style="width: 40%;" type="text"/>	
<b>City/Town</b> <input style="width: 95%;" type="text"/>		<b>State</b> <input style="width: 20%;" type="text"/>	<b>ZIP Code</b> <input style="width: 40%;" type="text"/>		
<b>Area Code</b> <input style="width: 20%;" type="text"/>	<b>Home Telephone</b> <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>	<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F	<b>Pregnant?</b> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	<b>Estimated Delivery Date</b> Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>	
<b>Area Code</b> <input style="width: 20%;" type="text"/>	<b>Work Telephone</b> <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/> - <input style="width: 20%;" type="text"/>	<b>Patient's Occupation/Setting</b> <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 _____		<b>Race (✓ one)</b> <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: _____	

<b>DATE OF ONSET</b> Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>	<b>Reporting Health Care Provider</b> <input style="width: 95%;" type="text"/>	<b>REPORT TO</b>
<b>DATE DIAGNOSED</b> Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>	<b>Reporting Health Care Facility</b> <input style="width: 95%;" type="text"/>	
<b>DATE OF DEATH</b> Month <input style="width: 20%;" type="text"/> Day <input style="width: 20%;" type="text"/> Year <input style="width: 20%;" type="text"/>	<b>Address</b> <input style="width: 95%;" type="text"/>	
	<b>City</b> <input style="width: 40%;" type="text"/> <b>State</b> <input style="width: 20%;" type="text"/> <b>ZIP Code</b> <input style="width: 40%;" type="text"/>	
	<b>Telephone Number</b> ( <input style="width: 20%;" type="text"/> ) <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <b>Fax</b> ( <input style="width: 20%;" type="text"/> ) <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>	
	<b>Submitted by</b> <input style="width: 40%;" type="text"/> <b>Date Submitted</b> (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.)

<b>SEXUALLY TRANSMITTED DISEASES (STD)</b>	<b>VIRAL HEPATITIS</b>																																																							
<b>Syphilis</b> <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	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th>Pend</th> <th>Not Done</th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> Hep A anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep B anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Acute anti-HBc</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chronic anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep C anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Acute PCR-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chronic</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Hep D (Delta) anti-Delta</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </tbody> </table>		Pos	Neg	Pend	Not Done	<input type="checkbox"/> Hep A anti-HAV IgM	<input type="checkbox"/> Hep B anti-HBc	<input type="checkbox"/> Acute anti-HBc	<input type="checkbox"/> Chronic anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/> Hep C anti-HCV	<input type="checkbox"/> Acute PCR-HCV	<input type="checkbox"/> Chronic	<input type="checkbox"/> Hep D (Delta) anti-Delta	<input type="checkbox"/> Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																																
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<b>Syphilis Test Results</b> <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: _____																																																								
<b>Gonorrhea</b> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____	<b>Chlamydia</b> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID <input type="checkbox"/> Other: _____																																																							
<b>STD TREATMENT INFORMATION</b> <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: _____																																																							
<b>Suspected Exposure Type</b> <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: _____																																																								

<b>TUBERCULOSIS (TB) Status</b>	<b>Mantoux TB Skin Test</b>	<b>Bacteriology</b>	<b>TB TREATMENT INFORMATION</b>
<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	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	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 BCG Vaccine Given? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, at what age/year? _____ Other test(s) _____	<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: _____
<b>Site(s)</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Extra-Pulmonary <input type="checkbox"/> Both	<b>Chest X-Ray</b> 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, §2641-2643, 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 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**

	Acquired Immune Deficiency Syndrome (AIDS) (HIV infection only: see "Human Immunodeficiency Virus")				
FAX ☎ ☒	Amebiasis			FAX ☎ ☒	Pelvic Inflammatory Disease (PID)
☎ ☎ ☎	Anthrax			☎	Pertussis (Whooping Cough)
	Avian Influenza (human)			FAX ☎ ☒	Plague, Human or Animal
FAX ☎ ☒	Babesiosis			FAX ☎ ☒	Poliomyelitis, Paralytic
☎ ☎ ☎	Botulism (Infant, Foodborne, Wound)			FAX ☎ ☒	Psittacosis
	Brucellosis			FAX ☎ ☒	Q Fever
FAX ☎ ☒	Campylobacteriosis			☎	Rabies, Human or Animal
	Chancroid			FAX ☎ ☒	Relapsing Fever
FAX ☎ ☒	Chickenpox (only hospitalizations and deaths)				Rheumatic Fever, Acute
	Chlamydial Infections, including Lymphogranulom Venereum (LGV)				Rocky Mountain Spotted Fever
☎ ☎	Cholera			FAX ☎ ☒	Rubella (German Measles)
	Ciguatera Fish Poisoning				Rubella Syndrome, Congenital
	Coccidioidomycosis				Salmonellosis (Other than Typhoid Fever)
FAX ☎ ☒	Colorado Tick Fever			☎	Scombroid Fish Poisoning
FAX ☎ ☒	Conjunctivitis, Acute Infectious of the Newborn, Specify Etiology			☎	Severe Acute Respiratory Syndrome (SARS)
	Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform			FAX ☎ ☒	Shiga toxin (detected in feces)
	Encephalopathies (TSE)			FAX ☎ ☒	Shigellosis
FAX ☎ ☒	Cryptosporidiosis				Smallpox (Variola)
	Cysticercosis or Taeniasis			FAX ☎ ☒	Streptococcal Infections (Outbreaks of Any Type and Individual
☎ ☎ ☎	Dengue				Cases in Food Handlers and Dairy Workers Only)
	Diarrhea of the Newborn, Outbreak			FAX ☎ ☒	Syphilis
☎ ☎ ☎	Diphtheria				Tetanus
	Domoic Acid Poisoning (Amnesic Shellfish Poisoning)				Toxic Shock Syndrome
	Ehrlichiosis				Toxoplasmosis
FAX ☎ ☒	Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic			FAX ☎ ☒	Trichinosis
	<i>Escherichia coli</i> : shiga toxin producing (STEC) including <i>E. coli</i> O157			FAX ☎ ☒	Tuberculosis
† FAX ☎ ☒	Foodborne Disease				Tularemia
	Giardiasis			FAX ☎ ☒	Typhoid Fever, Cases and Carriers
	Gonococcal Infections				Typhus Fever
FAX ☎ ☒	<i>Haemophilus influenzae</i> invasive disease (report an incident			FAX ☎ ☒	<i>Vibrio</i> Infections
	less than 15 years of age)			☎	Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa,
☎ ☎ ☎	Hantavirus Infections				and Marburg viruses)
	Hemolytic Uremic Syndrome			FAX ☎ ☒	Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)
	Hepatitis, Viral			FAX ☎ ☒	West Nile Virus (WNV) Infection
FAX ☎ ☒	Hepatitis A				Yellow Fever
	Hepatitis B (specify acute case or chronic)			FAX ☎ ☒	Yersiniosis
	Hepatitis C (specify acute case or chronic)			☎	<b>OCCURRENCE of ANY UNUSUAL DISEASE</b>
	Hepatitis D (Delta)			☎	<b>OUTBREAKS of ANY DISEASE</b> (Including diseases not listed
	Hepatitis, other, acute				in §2500). Specify if institutional and/or open community.
	Human Immunodeficiency Virus (HIV) (§2641-2643)				
	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				

**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](http://www.ccrca.org).