

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: - -

First Name/Middle Name (or Initial): Birth Date: / / Age:

Address: Number, Street: Apt/Unit Number:

City/Town: State: Zip Code:

Area Code: - Home Telephone: - Gender: M F Pregnant?: Y N Ukn Estimated Delivery Date: / /

Area Code: - Work Telephone: -

Food service Day Care Correctional Facility
 Health care School Other: _____

Ethnicity (check one)
 Hispanic/Latino
 Non-Hispanic/Non-Latino

Race (check all that apply)
 African-American/Black
 Asian
 Asian-Indian Korean
 Cambodian Laotian
 Chinese Thai
 Hmong Vietnamese
 Japanese
 Other: _____

Pacific Islander
 Filipino Hawaiian
 Guamanian Samoan
 Other: _____

Native American/Alaska Native
 White: _____
 Other: _____

DATE OF ONSET
Month Day Year: / /

DATE DIAGNOSED
Month Day Year: / /

DATE OF DEATH
Month Day Year: / /

Reporting Health Care Provider: _____
Reporting Health Care Facility: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Telephone Number: () _____ Fax: () _____
Submitted by: _____ Date Submitted (Month/Day/Year): / /

REPORT TO:
MICHAEL MAC LEAN, M.D.
Kings County Health Officer
330 Campus Dr. Hanford, CA 93230
(559) 852-2689 FAX (559) 589-0482
Nancy Hitchcock, SPHN
AFTER HOURS: (559) 584-1401
Select #1 for "Reporting Condition"

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STD)

Syphilis
 Primary (lesion present) Late latent >1 year RPR Titer: _____
 Secondary Late (tertiary) VDRL Titer: _____
 Early Latent <1 year Congenital FTA/MHA: Pos Neg
 Latent (unknown duration) CSF-VDRL Pos Neg
 Other: _____

Neurosyphilis

Gonorrhea
 Urethral/Cervical PID Other: _____

Chlamydia
 Urethral/Cervical PID Other: _____

PID (Unknown Etiology)
 Chancroid
 Non-Gonococcal Urethritis

STD TREATMENT INFORMATION
 Treated (Drugs, Dosage, Route): _____ Date Treatment Initiated: / /

Untreated
 Will treat Unable to contact patient Refused treatment 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"/> Hep B	HBsAG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Acute	Anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic	Anti-HBs	<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"/> Acute	PCR-HVC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Chronic	Anti-Delta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Hep D (Delta)	Anti-Delta	<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"/>

Suspected Exposure Type
 Blood transfusion Other needle exposure Sexual Contact Household contact
 Child care Other: _____

TUBERCULOSIS (TB)

Status
 Active Disease
 Confirmed Suspected
 Infected, No Disease
 Converter Reactor

Sites
 Pulmonary
 Extra-Pulmonary
 Both

Mantoux TB Skin Test
Month Day Year: / /

Date Performed: / /

Results: _____ mm Pending Not Done

Chest X-Ray
Month Day Year: / /

Date Performed: / /

Normal Pending Not Done
 Cavitory Abnormal/Non Cavitory

Coccidiomycosis
 Clinical Illness
 Influenza-like signs and symptoms
 Pneumonia or other pulmonary lesion
 Meningitis
 Involvement of bones, joints, or skin by dissemination
 OTHER

Date Specimen Collected: / /

ATTACH LAB RESULTS

REMARKS

§ 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)]

- ⓪ ! = 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 ⓪ ☒ = 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(j)(1)

- Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
- FAX ⓪ ☒ Amebiasis
- Anaplasmosis/Ehrlichiosis
- ⓪ ! Anthrax, human or animal
- FAX ⓪ ☒ Babesiosis
- ⓪ ! Botulism (Infant, Foodborne, Wound, Other)
- Brucellosis, animal (except infections due to *Brucella canis*)
- ⓪ ! Brucellosis, human
- FAX ⓪ ☒ Campylobacteriosis
- Chancroid
- FAX ⓪ ☒ Chickenpox (Varicella) (only hospitalizations and deaths)
- Chlamydia trachomatis* infections, including lymphogranuloma venereum (LGV)
- ⓪ ! Cholera
- ⓪ ! Ciguatera Fish Poisoning
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- FAX ⓪ ☒ Cryptosporidiosis
- Cyclosporiasis
- Cysticercosis or taeniasis
- ⓪ ! Dengue
- ⓪ ! Diphtheria
- ⓪ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- FAX ⓪ ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ⓪ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
- † FAX ⓪ ☒ Foodborne Disease
- Giardiasis
- Gonococcal Infections
- FAX ⓪ ☒ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
- ⓪ ! Hantavirus Infections
- ⓪ ! Hemolytic Uremic Syndrome
- FAX ⓪ ☒ Hepatitis A, acute infection
- Hepatitis B (specify acute case or chronic)
- Hepatitis C (specify acute case or chronic)
- Hepatitis D (Delta) (specify acute case or chronic)
- Hepatitis E, acute infection
- Influenza, deaths in laboratory-confirmed cases for age 0-64 years
- ⓪ ! Influenza, novel strains (human)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- FAX ⓪ ☒ Listeriosis
- Lyme Disease
- FAX ⓪ ☒ Malaria
- ⓪ ! Measles (Rubeola)
- FAX ⓪ ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ⓪ ! Meningococcal Infections
- Mumps
- ⓪ ! Paralytic Shellfish Poisoning
- Pelvic Inflammatory Disease (PID)
- FAX ⓪ ☒ Pertussis (Whooping Cough)
- ⓪ ! Plague, human or animal
- FAX ⓪ ☒ Poliovirus Infection
- FAX ⓪ ☒ Psittacosis

- FAX ⓪ ☒ Q Fever
- ⓪ ! Rabies, human or animal
- FAX ⓪ ☒ Relapsing Fever
- Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- FAX ⓪ ☒ Salmonellosis (Other than Typhoid Fever)
- ⓪ ! Scombroid Fish Poisoning
- ⓪ ! Severe Acute Respiratory Syndrome (SARS)
- ⓪ ! Shiga toxin (detected in feces)
- FAX ⓪ ☒ Shigellosis
- ⓪ ! Smallpox (Variola)
- FAX ⓪ ☒ *Staphylococcus aureus* 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 ⓪ ☒ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
- FAX ⓪ ☒ Syphilis
- Tetanus
- Toxic Shock Syndrome
- FAX ⓪ ☒ Trichinosis
- FAX ⓪ ☒ Tuberculosis
- Tularemia, animal
- ⓪ ! Tularemia, human
- FAX ⓪ ☒ Typhoid Fever, Cases and Carriers
- FAX ⓪ ☒ *Vibrio* Infections
- ⓪ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
- FAX ⓪ ☒ West Nile virus (WNV) Infection
- ⓪ ! Yellow Fever
- FAX ⓪ ☒ Yersiniosis
- ⓪ ! OCCURRENCE of ANY UNUSUAL DISEASE
- ⓪ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.

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 & 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.
CDPH 110a (revised 10/03/2011)