

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		Race (check all that apply)		
			<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		<input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (check all that apply) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown		
Birth Date (mm/dd/yyyy)		Age		Gender			
		<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		<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)	
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)				
Laboratory Name			City		State		ZIP Code

(Obtain additional forms from your local health department.)

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"/> Gonococcal PID <input type="checkbox"/> Chlamydial PID <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"/> Yes, Meds/Prescription given to patient for their partner(s) <input type="checkbox"/> Yes, other: _____		<input type="checkbox"/> No, instructed patient to refer partner(s) for treatment <input type="checkbox"/> No, referred partner(s) to: _____ <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) Upper Limit: _____ Result: _____ AST (SGOT) Upper Limit: _____ Result: _____ Bilirubin result: _____		<table border="1"> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th></th> <th>Pos</th> <th>Neg</th> </tr> <tr> <td>Hep A</td> <td>anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep C</td> <td>anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep B</td> <td>HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBc total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td>HCV RNA (e.g., PCR)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep D</td> <td>anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep E</td> <td>anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td></td> <td>HBeAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>HBV DNA:</td> <td colspan="6">_____</td> </tr> </table>			Pos	Neg		Pos	Neg	Hep A	anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep C	anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	Hep B	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>		RIBA	<input type="checkbox"/>	<input type="checkbox"/>		anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>		HCV RNA (e.g., PCR)	<input type="checkbox"/>	<input type="checkbox"/>		anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep D	anti-HDV	<input type="checkbox"/>	<input type="checkbox"/>		anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	Hep E	anti-HEV	<input type="checkbox"/>	<input type="checkbox"/>		HBeAg	<input type="checkbox"/>	<input type="checkbox"/>						anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>						HBV DNA:	_____					
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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)

- Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
- FAX Ⓢ ⓧ Amebiasis
- Anaplasmosis/Ehrlichiosis
- Ⓢ ! Anthrax, human or animal
- FAX Ⓢ ⓧ Babesiosis
- Ⓢ ! Botulism (Infant, Foodborne, Wound, Other)
- Brucellosis, animal (except infections due to *Brucella canis*)
- Ⓢ ! Brucellosis, human
- FAX Ⓢ ⓧ Campylobacteriosis
- Chancroid
- FAX Ⓢ ⓧ Chickenpox (Varicella) (only hospitalizations and deaths)
- Chlamydia trachomatis* infections, including lymphogranuloma venereum (LGV)
- Ⓢ ! Cholera
- Ⓢ ! Ciguatera Fish Poisoning
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- FAX Ⓢ ⓧ Cryptosporidiosis
- Cyclosporiasis
- Cysticercosis or taeniasis
- Ⓢ ! Dengue
- Ⓢ ! Diphtheria
- Ⓢ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- FAX Ⓢ ⓧ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- Ⓢ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
- † FAX Ⓢ ⓧ Foodborne Disease
- Giardiasis
- Gonococcal Infections
- FAX Ⓢ ⓧ *Haemophilus influenzae*, invasive disease (report an incident of less than 15 years of age)
- Ⓢ ! Hantavirus Infections
- Ⓢ ! Hemolytic Uremic Syndrome
- FAX Ⓢ ⓧ 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
- Ⓢ ! Influenza, novel strains (human)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- FAX Ⓢ ⓧ Listeriosis
- Lyme Disease
- FAX Ⓢ ⓧ Malaria
- Ⓢ ! 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
- FAX Ⓢ ⓧ Poliovirus Infection
- FAX Ⓢ ⓧ Psittacosis

- FAX Ⓢ ⓧ Q Fever
- Ⓢ ! Rabies, human or animal
- FAX Ⓢ ⓧ 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 Ⓢ ⓧ Salmonellosis (Other than Typhoid Fever)
- Ⓢ ! Scombroid Fish Poisoning
- Ⓢ ! Severe Acute Respiratory Syndrome (SARS)
- Ⓢ ! Shiga toxin (detected in feces)
- FAX Ⓢ ⓧ Shigellosis
- Ⓢ ! Smallpox (Variola)
- FAX Ⓢ ⓧ *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 Ⓢ ⓧ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
- FAX Ⓢ ⓧ Syphilis
- Tetanus
- Toxic Shock Syndrome
- FAX Ⓢ ⓧ Trichinosis
- FAX Ⓢ ⓧ Tuberculosis
- Tularemia, animal
- Ⓢ ! Tularemia, human
- FAX Ⓢ ⓧ Typhoid Fever, Cases and Carriers
- FAX Ⓢ ⓧ *Vibrio* Infections
- Ⓢ ! Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
- FAX Ⓢ ⓧ West Nile virus (WNV) Infection
- Ⓢ ! Yellow Fever
- FAX Ⓢ ⓧ Yersiniosis
- Ⓢ ! OCCURRENCE of ANY UNUSUAL DISEASE
- Ⓢ ! 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.