CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except HIV/AIDS, Tuberculosis, and conditions reportable to DMV.

DISEASE BEING REPORTED Coronavirus Disease 2019 (COVID-19)

Patient Name - Last Name | *First Name* | *MI*

Home Address: Number, Street | *Apt./Unit No.*

City | *State* | *ZIP Code*

Home Telephone Number | *Cell Telephone Number* | *Work Telephone Number*

Email Address | *Primary Language* ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | *Age* | ☐ Years ☐ Months ☐ Days | *Gender* ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | *Est. Delivery Date (mm/dd/yyyy)* | *Country of Birth*

Occupation or Job Title

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

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

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ 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*

Address: Number, Street | *Suite/Unit No.*

City | *State* | *ZIP Code*

Telephone Number | *Fax Number*

Submitted by | *Date Submitted (mm/dd/yyyy)*

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | *City* | *State* | *ZIP Code*

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription

Drug(s), Dosage, Route | Treatment Began *(mm/dd/yyyy)*

_____ | _____

_____ | _____

☐ *Untreated*
- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Patient refused treatment
- ☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early, non-primary, non-secondary
☐ Unknown Duration or Late
☐ Congenital

Clinical Manifestations?
☐ Neurologic ☐ Otic
☐ Ocular ☐ Late clinical

Syphilis Test Results | | | Titer
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Gonorrhea:

Specimen Source(s) (check all that apply)
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis C (perinatal)
☐ Hepatitis D (acute)
☐ Hepatitis D (chronic)
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____

AST (SGOT) Result: _____ Upper Limit: _____

Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks: