CONFIDENTIAL MORBIDITY REPORT

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

Mome Address: Number, Surver	DISEASE BEING REPORTED Coronavirus Disease 2019 (COVID-19)															
Age	Patient Name - Last Name First				rst Name Mi											
American Indian/Nation Native American Indian/Nation American Indi	Home Address: Number, Street		Race (check all that apply)													
Additional forms Additional	City State					ZIP Code			American Indian/Alaska Native							
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Garder G	Email Address	1				ish	Filipino Lactian									
Perparation Days Female Other: Other: Other Imposity Impos	Birth Date (mm/dd/yyyy)						☐ Native i	Hawaiian	. [Samoa	n					
Programm?					_					nian	[Other (specify):	_		
Occupation or Jab Title	Pregnant?							Other (spe	cify):							
Date of Onset (mmidd/yyyy) Date of First Specimen Collection (mmidd/yyyy) Date of Diagnosis (Yes No Unknown															
Date of Disset (mm/dd/yyyy) Date of First Specimen Collection (mm/dd/yyyy) Date of Disgnosts (mm/dd/yyyyy) Date of Disgnosts (mm/dd/yyyy) Date of Disgnosts	Occupation or Job Title	g (check			Serv	ice 🔲	Day Care 🔲	Health	Care							
Reporting Health Care Provider State ZIP Code City State ZIP Code City State ZIP Code SEXUALLY TRANSMITTED DISEASES (STDs) Cender of Sax Partners (shield all hell apply) Will treat I Treatment Began (mm/dd/yyyy) Will treat Unitable to contact patient Patent refused treatment Patent refused treatment Patent refused treatment Referred to: If reporting Syphilits. Stage: Primary (selon present) Secondary VoRL Pes Secondary VoRL Pes Neg Congenital Treatment Began (mm/dd/yyyy) Will treat Unitable to contact patient Patent refused treatment Referred to: If reporting Syphilits. Stage: Primary (selon present) Secondary Pos Neg Congenital Treatment Began (mm/dd/yyyy) Will treat Unitable to contact patient Patent refused treatment Referred to: Ves, beautify reserved to: Ves, beautify primary, non-accondary VoRL Pos Neg Congenital Treatment Began (mm/dd/yyyy) Will treat Unitable to contact patient Patent refused treatment Referred to: Ves, beautify primary, non-accondary Ves, beautify of treatment No. referred partner(s) for tre	Date of County (and Utilization															
Address: Number, Street City State ZIP Code SEXUALLY TRANSMITTED DISEASES (STDs) Cender of Sex Partners (check all find apply) Male Penable Ponable Ponab	Date of Onset (mm/dd/yyyy)	Date	or First S	specimen C	70/lection) (mm/dd/	yyyy) Date	of Diagi	nosis (mm/dd/yyy	y)	Di	ite of Dea	th (mm/dd/yyy	y)		
City State ZIP Code	Reporting Health Care Provider		F	Reporting H	lealth Ca	re Facilit	У				RE	PORT TO				
Date Submitted by Date Submitted (mm/dd/yyyy) Cottain additional forms from your local health department.)	Address: Number, Street						Suite/Unit No									
Date Submitted by Date Submitted (mm/dd/yyyy) (Obtain additional forms from your local fleatift department.)	City State					ZIP Code	+									
City State ZiP Code	Telephone Number Fax Number															
City State ZIP Code	Submitted by			Dа	te Submi	itted (mm	/dd/yyyy)	-								
SEXUALLY TRANSMITTED DISEASES (STDs)									(Obtain additional forms from your local health department.)							
Gender of Sex Partners (check all that apply)	Laboratory Name					Cit	y			State ZIP Code						
Check all thet apply Male M to F Transgender F to M Transgender P to M Transgender Unknown Other:	SEXUALLY TRANSMITTED (
Male M to F Transgender From M Transgender Patient refused treatment Patient refused research									1100							
Fenale F to M Transgender	. = =	sgender	Drug(s), Dosage, Route													
		- ,						_		Patient refused	treatm	ent				
Primary (lesion present)									Referred to: _							
Secondary	_	esults	Specimen Source(s)					me 2								
Carry, non-secondary						(check all that	apply)									
Congenite TP-PA Pos Neg Urethral Urethral Urine Vaginal Urine Vaginal Unknown VIRAL HEPATITIS		ioary									- Breat	' patier	nt for their part	her(s)		
Clinical Manifestations? EIA/CLIA Pos Neg Urine Vaginal Unknown	C ammunit in Said							peran	Unkr	nown						
Neurologic Otic Other: Other: Other: Unknown Other: Other: Unknown Other: Other: Unknown Other: Other: Unknown Other: Other: Other: Unknown Other: Othe	Clinical Manifestations?			Pos	Neg			l				No, instru partni	acted patient to er(s) for treatm	ent		
VIRAL HEPATITIS Diagnosis (check all that apply) Is patient symptomatic? Yes No Unknown Pos Neg Pos Neg Hepatitis A Suspected Exposure Type(s) Blood transfusion, dental or medical procedure No Unknown Pos Neg Pos Neg Hepatitis B (acute) Blood transfusion, dental or medical procedure No Unknown Pos Neg Pos Neg Hepatitis B (acute) Hep A anti-HAV lgM Hep C anti-HCV Hep B HBsAg HCV RNA HCV	_	_		lL Pos	Neg							No, refer	red partner(s)	10:		
Diagnosis (check all that apply) Is patient symptomatic? Yes No Unknown Pos Neg	Ocular Late clinical		Other: _			_			_			Unknown	1			
Hepatitis A Hepatitis B (acute) Blood transfusion, dental or medical procedure Hepatitis B (chronic) IV drug use Hepatitis B (perinatal) Other needle exposure Hepatitis C (acute) He	VIRAL HEPATITIS															
Hepatitis B (acute) Blood transfusion, dental or medical procedure N drug use N drug use Cother needle exposure N drug use Cother needle exposure N drug use Cother needle exposure N drug use N		Is pa	tient symp	ptomatic?	Yes	□ No	Unknown			Pos I	Neg			Pos	Neg	
Hepatitis B (chronic) medical procedure Upper Hep B HBsAg HCV RNA HCV RNA	_ '	☐ Blood to	ransfusion	dental or	ALT	SCOT)		Hep A	anti-HAV IgM			Hep C	anti-HCV			
Hepatitis 6 (perinatal) Other needle exposure Other needle exposure Other needle exposure		medica	I procedun	ф				Hep B	HBsAg							
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The same of the sa	Hepatitis C (chronic)		-1	AST	(SGOT)	Upper		anti-HBc IgM anti-HBs		님	Hep D	-				
☐ Hepatitis D (acute) ☐ Perinatal ☐ Hep E anti-HEV ☐ ☐	Hepatitis C (permatal) Hepatitis D (acute) Perinatal			-	Res	sult:	_ Limit:		HBeAg		₫	,				
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	Remarks:							1								