

**CONFIDENTIAL MORBIDITY REPORT**

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

**DISEASE BEING REPORTED:** \_\_\_\_\_ If applicable, specimen date    MONTH DAY YEAR Source: \_\_\_\_\_

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| <b>Patient's Last Name</b><br><input style="width:100%;" type="text"/>   |  | <b>Social Security Number</b><br><input style="width:20%;" type="text"/> - <input style="width:20%;" type="text"/> - <input style="width:20%;" type="text"/> |  | <b>Ethnicity</b> (✓ one)<br><input type="checkbox"/> Hispanic/Latino<br><input type="checkbox"/> Non-Hispanic / Non-Latino   |  |
| <b>First Name and Middle Name</b><br><input style="width:100%;" type="text"/>  |  | <b>Birth Date</b><br><input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> MONTH DAY YEAR  |  | <b>Age</b><br><input style="width:20%;" type="text"/>  |  |
| <b>Address: Number, Street</b><br><input style="width:100%;" type="text"/>   |  |  |  |  |  |
| <b>City/Town</b><br><input style="width:100%;" type="text"/>   |  | <b>State</b><br><input style="width:20%;" type="text"/>  |  | <b>Zip Code</b><br><input style="width:20%;" 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"/> |  | <b>Gender</b><br><input type="checkbox"/> M <input type="checkbox"/> F   |  | <b>Pregnant?</b><br><input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK   |  |
| <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"/> |  | <b>Patient's Occupation/Setting</b>  |  | <b>Estimated Delivery Date</b><br><input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> MONTH DAY YEAR |  |
|  |  | <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility                                       |  | <input type="checkbox"/> African-American/Black  |  |
|  |  | <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other: _____   |  | <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><br><input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> MONTH DAY YEAR  |  | <b>Reporting Health Care Provider</b><br>_____   |  | <b>REPORT TO:</b><br><br><b>Orange County Public Health</b><br><br><b>Fax: (714) 834-8196</b><br><br><b>Mail: P.O. Box 6128</b><br><b>Santa Ana, CA 92706-0128</b><br><br><b>Phone: (714) 834-8180</b> |  |
| <b>DATE DIAGNOSED</b><br><input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> MONTH DAY YEAR |  | <b>Reporting Health Care Facility</b><br>_____   |  |  |  |
| <b>DATE OF DEATH</b><br><input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> MONTH DAY YEAR  |  | <b>Address</b><br>_____  |  |  |  |
|   |  | <b>City</b> _____ <b>State</b> _____ <b>Zip Code</b> _____   |  |  |  |
|   |  | <b>Telephone Number</b> ( ) _____ <b>Fax</b> ( ) _____   |  |  |  |
|   |  | <b>Submitted By</b> _____ <b>Date Submitted</b> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> <input style="width:20%;" type="text"/> MONTH DAY YEAR |  |  |  |

**SEXUALLY TRANSMITTED DISEASES (STD)**

**Syphilis**  
 Primary (lesion present)  Late latent > 1 year  
 Secondary  Late (tertiary)  
 Early latent < 1 year  Congenital  
 Latent (unknown duration)  
 Neurosyphilis

**Syphilis Test Results**  
 RPR Titer: \_\_\_\_\_  
 VDRL Titer: \_\_\_\_\_  
 FTA/MHA:  Pos  Neg  
 CSF-VDRL:  Pos  Neg  
 Other: \_\_\_\_\_

**Gonorrhea**  
 Urethral/Cervical  
 PID  
 Other: \_\_\_\_\_

**Chlamydia**  
 Urethral/Cervical  
 PID  
 Other: \_\_\_\_\_

PID (Unknown Etiology)  
 Chancroid  
 Non-Gonococcal Urethritis

**VIRAL HEPATITIS**

Hep A  
 Hep B  
 Acute  
 Chronic  
 Hep C  
 Acute  
 Chronic  
 Hep D (Delta)  
 Other: \_\_\_\_\_

**Please send copies of the hepatitis serologies (required for diagnosis) and liver enzymes (if done).**

**STD TREATMENT INFORMATION**

Treated (Drugs, Dosage, Route) \_\_\_\_\_ Date Treatment Initiated    MONTH DAY YEAR

Untreated  
 Will treat  
 Unable to contact patient  
 Refused treatment  
 Referred to: \_\_\_\_\_

**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

**Mantoux TB Skin Test**  
 Date Performed    MONTH DAY YEAR  
 Results \_\_\_\_\_ mm  Pending  Not done

**Chest X-ray**  
 Date Performed    MONTH DAY YEAR  
 Normal  Pending  Not done  
 Cavitory  Abnormal/Noncavitory

**Bacteriology**  
 Date Specimen Collected    MONTH DAY YEAR  
 Source: \_\_\_\_\_  
 Smear:  Pos  Neg  Pending  Not done  
 Culture:  Pos  Neg  Pending  Not done  
 Other test(s): \_\_\_\_\_

**TB TREATMENT INFORMATION**

Current Treatment  
 INH  RIF  PZA  
 EMB  Other: \_\_\_\_\_

Date Treatment Initiated    MONTH DAY YEAR

Untreated  
 Will treat  
 Unable to contact patient  
 Refused treatment  
 Referred to: \_\_\_\_\_

**REMARKS**

Please report the following diseases/conditions, including suspected cases, to  
Epidemiology & Assessment using the *specified method and time frame*.

**Epidemiology and Assessment**  
**P.O. Box 6128, Santa Ana, CA 92706-0128**  
**Telephone: (714) 834-8180, Fax: (714) 834-8196**

If a report is urgent and it is a holiday, weekend, or after regular work hours,  
please contact the public health official on call at (714) 628-7008.

**Report cases and suspected cases to Epidemiology:**

☎ **IMMEDIATELY** by telephone.

① Within **ONE (1) WORKING DAY** of identification by telephone, fax, or mail.

⑦ Within **SEVEN (7) CALENDAR DAYS** of identification by telephone, fax, or mail.

★ **IMMEDIATELY when two (2) or more cases or suspected cases of foodborne illness from separate households are suspected to have the same source of illness.**

*Note: Cases of reportable diseases that are suspected on clinical grounds should be reported prior to laboratory confirmation. Examples: tuberculosis, pertussis, measles.*

- |  |  |
|--|--|
| <p>⑦ AIDS [<b>Please call, DO NOT FAX REPORT</b>]</p> <p>① Amebiasis</p> <p>☎ Anthrax</p> <p>☎ Avian Influenza (human)</p> <p>① Babesiosis</p> <p>☎ Botulism (infant, foodborne, wound, other)</p> <p>☎ Brucellosis</p> <p>① Campylobacteriosis</p> <p>⑦ Chancroid</p> <p>① Chickenpox (only hospitalizations and deaths)</p> <p>⑦ Chlamydial infections, including Lymphogranuloma Venereum (LGV)</p> <p>☎ Cholera</p> <p>☎ Ciguatera Fish Poisoning</p> <p>⑦ Coccidioidomycosis</p> <p>① Colorado Tick Fever</p> <p>① Conjunctivitis, acute infections of the newborn—please specify etiology</p> <p>⑦ Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</p> <p>① Cryptosporidiosis</p> <p>⑦ Cysticercosis or Taeniasis</p> <p>☎ Dengue</p> <p>☎ Diarrhea of newborn, outbreaks only</p> <p>☎ Diphtheria</p> <p>☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>⑦ Ehrlichiosis</p> <p>① Encephalitis—please specify etiology</p> <p>☎ <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli</i> O157</p> <p>★ Foodborne disease</p> <p>⑦ Giardiasis</p> <p>⑦ Gonococcal infections</p> <p>① <i>Haemophilus influenzae</i>, invasive disease (persons under 15 years of age)</p> <p>☎ Hantavirus infections</p> <p>☎ Hemolytic Uremic Syndrome</p> <p>① Hepatitis A</p> <p>⑦ Hepatitis B (specify acute case or chronic)</p> <p>⑦ Hepatitis C (specify acute case or chronic)</p> <p>⑦ Hepatitis D (Delta)</p> <p>⑦ Hepatitis, other, acute</p> <p>⑦ HIV [<b>Please call, DO NOT FAX REPORT</b>]</p> <p>⑦ Influenza deaths (persons under 18 years of age)</p> <p>⑦ Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)</p> <p>⑦ Legionellosis</p> <p>⑦ Leprosy (Hansen's Disease)</p> <p>⑦ Leptospirosis</p> <p>① Listeriosis</p> <p>⑦ Lyme Disease</p> <p>① Malaria</p> | <p>① Measles (Rubeola)</p> <p>① Meningitis—please specify etiology</p> <p>☎ Meningococcal infections</p> <p>⑦ Mumps</p> <p>☎ Outbreaks</p> <p>☎ Paralytic Shellfish Poisoning</p> <p>⑦ Pelvic Inflammatory Disease (PID)</p> <p>① Pertussis (Whooping Cough)</p> <p>☎ Plague, human or animal</p> <p>① Pneumococcal disease, invasive<sup>†</sup></p> <p>① Poliomyelitis, paralytic</p> <p>① Psittacosis</p> <p>① Q Fever</p> <p>☎ Rabies, human or animal</p> <p>① Relapsing Fever</p> <p>⑦ Rheumatic Fever, acute</p> <p>⑦ Rocky Mountain Spotted Fever</p> <p>⑦ Rubella (German Measles)</p> <p>⑦ Rubella syndrome, congenital</p> <p>① Salmonellosis (other than Typhoid Fever)</p> <p>☎ Scombroid Fish Poisoning</p> <p>☎ Severe Acute Respiratory Syndrome (SARS)</p> <p>☎ Shiga toxin (detected in feces)</p> <p>① Shigellosis</p> <p>☎ Smallpox (Variola)</p> <p>☎ <i>Staphylococcus aureus</i> infection, severe (resulting in death or admission to an intensive care unit of a person without hospitalization, surgery, dialysis, or residency in a long-term care facility in the past year, and without an indwelling catheter or percutaneous medical device at the time of culture)</p> <p>① Streptococcal infections (invasive disease caused by group A streptococcus<sup>†</sup>; outbreaks of any type; individual cases in food handlers and dairy workers only)</p> <p>① Syphilis</p> <p>⑦ Tetanus</p> <p>⑦ Toxic Shock Syndrome</p> <p>⑦ Toxoplasmosis</p> <p>① Trichinosis</p> <p>① Tuberculosis (including suspected cases)</p> <p>☎ Tularemia</p> <p>① Typhoid Fever, cases and carriers</p> <p>⑦ Typhus Fever</p> <p>☎ Unusual diseases</p> <p>① <i>Vibrio</i> infections</p> <p>☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)</p> <p>① Water-associated diseases (e.g., Swimmer's Itch)</p> <p>① West Nile Virus infection</p> <p>☎ Yellow Fever</p> <p>① Yersiniosis</p> |
|--|--|

<sup>†</sup>At the request of local health officer

Reportable Noncommunicable Diseases/Conditions: Disorders characterized by lapses of consciousness, Alzheimer's disease and related disorders; cancer [except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix]; animal bites and scratches; child lead levels  $\geq 10\mu\text{g}/\text{dL}$ ; suspected/confirmed pesticide-related illnesses; child and elder abuse; and domestic violence. To report noncommunicable diseases/conditions, please see the "Reportable Diseases/Reporting Other Than Communicable Diseases" page on the website below.