CONFIDENTIAL MORBIDITY REPORT

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

DISEASE BEING REPORTED

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

Current Gender Identity (check one)
☐ Male ☐ Female ☐ Trans male/transman ☐ Trans female/transwoman ☐ Genderqueer or non-binary ☐ Identity not listed *(specify)* _____ ☐ Declined to answer

Sex Assigned at Birth (check one)
☐ Male ☐ Female ☐ Declined to answer

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

Sexual Orientation (check one)
☐ Heterosexual or straight ☐ Bisexual ☐ Gay, lesbian, or same gender loving ☐ Orientation not listed *(specify)* _____ ☐ Questioning/Unsure/ Client doesn't know ☐ Declined to answer

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

Occupation or Job Title | ***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 ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ 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

Remarks:

CONFIDENTIAL MORBIDITY REPORT
(continued)

Patient Name - Last Name	***First Name***	***MI***	***Birth Date*** *(mm/dd/yyyy)*

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	☐	☐

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)(15)** "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).

✆ = Report by telephone within one working day of identification (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).

WEEK = 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)

Disease Name	Urgency	Disease Name	Urgency
Anaplasmosis	WEEK	Listeriosis	FAX ✆ ✉
Anthrax, human or animal	✆ !	Lyme Disease	WEEK
Babesiosis	FAX ✆ ✉	Malaria	FAX ✆ ✉
Botulism (Infant, Foodborne, wound, Other)	✆ !	Measles (Rubeola)	✆ !
Brucellosis, animal (except infections due to *Brucella canis*)	WEEK	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆ ✉
Brucellosis, human	✆ !	Meningococcal Infections	✆ !
Campylobacteriosis	FAX ✆ ✉	Middle East Respiratory Syndrome (MERS)	✆ !
Candida auris, colonization or infection	✆	Monkeypox or orthopox virus infection	✆
Chancroid	WEEK	Mumps	WEEK
Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)	FAX ✆ ✉	Novel Coronavirus Infection	✆ !
Chikungunya Virus Infection	FAX ✆ ✉	Novel Virus Infection with Pandemic Potential	✆ !
Cholera	✆ !	Paralytic Shellfish Poisoning	✆ !
Ciguatera Fish Poisoning	✆ !	Paratyphoid Fever	FAX ✆ ✉
Coccidioidomycosis	WEEK	Pertussis (Whooping Cough)	FAX ✆ ✉
Coronavirus Disease 2019 (COVID-19)	✆	Plague, human or animal	✆ !

Disease Name	Urgency	Disease Name	Urgency
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	WEEK	Poliovirus Infection	✆ !
Cryptosporidiosis	FAX ✆ ✉	Psittacosis	FAX ✆ ✉
Cyclosporiasis	WEEK	Q Fever	FAX ✆ ✉
Cysticercosis or taeniasis	WEEK	Rabies, human or animal	✆ !
Dengue Virus Infection	FAX ✆ ✉	Relapsing Fever	FAX ✆ ✉
Diphtheria	✆ !	Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age	WEEK
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	✆ !	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses	WEEK
Ehrlichiosis	WEEK	Rocky Mountain Spotted Fever	WEEK
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ✆ ✉	Rubella (German Measles)	WEEK
Escherichia coli: shiga toxin producing (STEC) including *E. coli* O157	✆ !	Rubella Syndrome, Congenital	WEEK
Flavivirus infection of undetermined species	✆ !	Salmonellosis (Other than Typhoid Fever)	FAX ✆ ✉
Foodborne Disease	† FAX ✆ ✉	Scombroid Fish Poisoning	✆ !
Giardiasis	WEEK	Shiga toxin (detected in feces)	✆ !
Gonococcal Infections	WEEK	Shigellosis	FAX ✆ ✉
Haemophilus influenzae, invasive disease, all serotypes (report an incident less than 5 years of age)	FAX ✆ ✉	Smallpox(Variola)	✆ !
Hantavirus Infections	FAX ✆ ✉	Syphilis (all stages, including congenital)	FAX ✆ ✉
Hemolytic Uremic Syndrome	✆ !	Tetanus	WEEK
Hepatitis A, acute infection	FAX ✆ ✉	Trichinosis	FAX ✆ ✉
Hepatitis B (specify acute, chronic, or perinatal)	WEEK	Tuberculosis	FAX ✆ ✉
Hepatitis C (specify acute, chronic, or perinatal)	WEEK	Tularemia, animal	WEEK
Hepatitis D (Delta) (specify acute case or chronic)	WEEK	Tularemia, human	✆ !
Hepatitis E, acute infection	WEEK	Typhoid Fever, Cases and Carriers	FAX ✆ ✉
Human Immunodeficiency Virus (HIV), acute infection	✆	*Vibrio* Infections	FAX ✆ ✉
Human Immunodeficiency Virus (HIV) infection, any stage	WEEK	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)	✆ !
Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS)	WEEK	West Nile Virus (WNV) Infection	FAX ✆ ✉

Disease Name	Urgency	Disease Name	Urgency
Influenza-associate deaths in laboratory-confirmed cases less than 18 years of age	WEEK	Yellow Fever	FAX ✆ ✉
Influenza due to novel strains (human)	✆ !	Yersiniosis	FAX ✆ ✉
Legionellosis	WEEK	Zika Virus Infection	FAX ✆ ✉
Leprosy (Hansen Disease)	WEEK	OCCURRENCE of ANY UNUSUAL DISEASE	✆ !
Leptospirosis	WEEK	OUTBREAKS of ANY DISEASE (Including diseases not listed in **§2500**). Specify if institutional and/or open community.	✆ !

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20

Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person-to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and the California Department of Public Health's HIV Surveillance and Case Reporting Resource page (https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_case_surveillance_resources.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.ccrcal.org