

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 <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____ | | |
| Birth Date (mm/dd/yyyy) | | Age <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days | Gender <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) | | | | |
| | | | | | | (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) <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 Drug(s), Dosage, Route _____ | |
| | | Treatment Began (mm/dd/yyyy) _____ | Untreated <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, non-primary, non-secondary <input type="checkbox"/> Unknown Duration or Late <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 _____ | |
| Clinical Manifestations? <input type="checkbox"/> Neurologic <input type="checkbox"/> Otic <input type="checkbox"/> Ocular <input type="checkbox"/> Late clinical | | 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: _____ | | Symptoms? <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"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th></th> <th>Pos</th> <th>Neg</th> </tr> </thead> <tbody> <tr> <td>Hep A anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep C anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep B HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBc total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HCV RNA (e.g., PCR)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep D anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep E anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HBeAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HBV DNA: _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </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: _____ | | | | | |
| | 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: _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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)]

- ⓪ ! = 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).
- ⓪ = Report by telephone within one working day of identification (designated by a + in regulations).
- FAX ⓪ ☒ = 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)(1)

| Disease Name | Urgency | Disease Name | Urgency |
|---|---------|---|---------|
| Amebiasis | FAX ⓪ ☒ | Listeriosis | FAX ⓪ ☒ |
| Anaplasmosis | WEEK | Lyme Disease | WEEK |
| Anthrax, human or animal | ⓪ ! | Malaria | FAX ⓪ ☒ |
| Babesiosis | FAX ⓪ ☒ | Measles (Rubeola) | ⓪ ! |
| Botulism (Infant, Foodborne, wound, Other) | ⓪ ! | Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic | FAX ⓪ ☒ |
| Brucellosis, animal (except infections due to <i>Brucella canis</i>) | WEEK | Meningococcal Infections | ⓪ ! |
| Brucellosis, human | ⓪ ! | Mumps | WEEK |
| Campylobacteriosis | FAX ⓪ ☒ | Novel Virus Infection with Pandemic Potential | ⓪ ! |
| Chancroid | WEEK | Paralytic Shellfish Poisoning | ⓪ ! |
| Chickenpox (Varicella) (outbreaks, hospitalizations and deaths) | FAX ⓪ ☒ | Pertussis (Whooping Cough) | FAX ⓪ ☒ |
| Chikungunya Virus Infection | FAX ⓪ ☒ | Plague, human or animal | ⓪ ! |
| <i>Chlamydia trachomatis</i> infections, including lymphogranuloma venereum (LGV) | WEEK | Poliovirus Infection | FAX ⓪ ☒ |

| Disease Name | Urgency | Disease Name | Urgency |
|---|-----------|---|---------|
| Cholera | ☉ ! | Psittacosis | FAX ☉ ☑ |
| Ciguatera Fish Poisoning | ☉ ! | Q Fever | FAX ☉ ☑ |
| Coccidioidomycosis | WEEK | Rabies, human or animal | ☉ ! |
| Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE) | WEEK | Relapsing Fever | FAX ☉ ☑ |
| Cryptosporidiosis | FAX ☉ ☑ | Respiratory Syncytial Virus (only report a death in a patient less than less than five years of age) | WEEK |
| Cyclosporiasis | WEEK | Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses | WEEK |
| Cysticercosis or taeniasis | WEEK | Rocky Mountain Spotted Fever | WEEK |
| Dengue Virus Infection | ☉ ! | Rubella (German Measles) | WEEK |
| Diphtheria | ☉ ! | Rubella Syndrome, Congenital | WEEK |
| Domoic Acid Poisoning (Amnesic Shellfish Poisoning) | ☉ ! | Salmonellosis (Other than Typhoid Fever) | FAX ☉ ☑ |
| Ehrlichiosis | WEEK | Scombroid Fish Poisoning | ☉ ! |
| Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic | FAX ☉ ☑ | Shiga toxin (detected in feces) | ☉ ! |
| <i>Escherichia coli</i> : shiga toxin producing (STEC) including <i>E. coli</i> O157 | ☉ ! | Shigellosis | FAX ☉ ☑ |
| Flavivirus infection of undetermined species | ☉ ! | Smallpox(Variola) | ☉ ! |
| Foodborne Disease | † FAX ☉ ☑ | Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only) | FAX ☉ ☑ |
| Giardiasis | WEEK | Syphilis | FAX ☉ ☑ |
| Gonococcal Infections | WEEK | Tetanus | WEEK |
| <i>Haemophilus influenzae</i> , invasive disease, all serotypes (report an incident less than 5 years of age) | FAX ☉ ☑ | Trichinosis | FAX ☉ ☑ |
| Hantavirus Infections | FAX ☉ ☑ | Tuberculosis | FAX ☉ ☑ |
| Hemolytic Uremic Syndrome | ☉ ! | Tularemia, animal | WEEK |
| Hepatitis A, acute infection | FAX ☉ ☑ | Tularemia, human | ☉ ! |
| Hepatitis B (specify acute case or chronic) | WEEK | Typhoid Fever, Cases and Carriers | FAX ☉ ☑ |
| Hepatitis C (specify acute case or chronic) | WEEK | <i>Vibrio</i> Infections | FAX ☉ ☑ |
| Hepatitis D (Delta) (specify acute case or chronic) | WEEK | Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) | ☉ ! |
| Hepatitis E, acute infection | WEEK | West Nile Virus (WNV) Infection | FAX ☉ ☑ |
| Human Immunodeficiency Virus (HIV) infection, stage 3 (AIDS) | WEEK | Yellow Fever | ☉ ! |
| Human Immunodeficiency Virus (HIV), acute infection | ☉ | Yersiniosis | FAX ☉ ☑ |

| Disease Name | Urgency | Disease Name | Urgency |
|--|---------|--|---------|
| Influenza, deaths in laboratory-confirmed cases for age 0-64 years | WEEK | Zika Virus Infection | ⊗ ! |
| Influenza, novel strains (human) | ⊗ ! | OCCURRENCE of ANY UNUSUAL DISEASE | ⊗ ! |
| Legionellosis | WEEK | OUTBREAKS of ANY DISEASE (Including diseases not listed in §2500). Specify if institutional and/or open community. | ⊗ ! |
| Leprosy (Hansen Disease) | WEEK | | |
| Leptospirosis | WEEK | | |

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.crcal.org