

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	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				
Current Gender Identity (check one)				Sex Assigned at Birth (check one)		
<input type="checkbox"/> Male <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Female <input type="checkbox"/> Identity not listed (specify) _____ <input type="checkbox"/> Trans male/transman <input type="checkbox"/> Declined to answer <input type="checkbox"/> Trans female/transwoman				<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer		
Sexual Orientation (check one)						
<input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay, lesbian, or same gender loving <input type="checkbox"/> Orientation not listed (specify) _____ <input type="checkbox"/> Questioning/Unsure/Client doesn't know <input type="checkbox"/> Declined to answer						
Pregnant?		Est. Delivery Date (mm/dd/yyyy)		Country of Birth		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
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			
Address: Number, Street			Suite/Unit No.			
City		State	ZIP Code			
Telephone Number			Fax Number			
Submitted by			Date Submitted (mm/dd/yyyy)			
Laboratory Name			City		State	ZIP Code

Madera County Dept. of Public Health
 Attn: CD
 1604 Sunrise Avenue
 Madera, CA 93638
 Ph: (559) 675-7893
 Fx: (559) 674-7262

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)		STD TREATMENT		Treatment Began		Untreated	
<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: _____		<input type="checkbox"/> Treated in office <input type="checkbox"/> Given prescription Drug(s), Dosage, Route _____ _____		(mm/dd/yyyy) _____ _____		<input type="checkbox"/> 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:		Syphilis Test Results		If reporting Gonorrhea: Specimen Source(s) (check all that apply)		Partner(s) Treated?	
<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		<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: _____		<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: _____		<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	
Clinical Manifestations?							
<input type="checkbox"/> Neurologic <input type="checkbox"/> Otic <input type="checkbox"/> Ocular <input type="checkbox"/> Late clinical							

Remarks:

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(continued)

Patient Name - Last Name	First Name	MI	Birth Date (mm/dd/yyyy)
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VIRAL HEPATITIS																																																																											
Diagnosis (check all that apply)	Is patient symptomatic?																																																																										
<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 C (perinatal) <input type="checkbox"/> Hepatitis D (acute) <input type="checkbox"/> Hepatitis D (chronic) <input type="checkbox"/> Hepatitis E	<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 style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> <th style="width: 10%;"></th> <th style="width: 10%; text-align: center;">Pos</th> <th style="width: 10%; text-align: center;">Neg</th> <th style="width: 10%;"></th> <th style="width: 10%;"></th> <th style="width: 10%; text-align: center;">Pos</th> <th style="width: 10%; text-align: center;">Neg</th> </tr> </thead> <tbody> <tr> <td>Hep A</td> <td>anti-HAV IgM</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Hep C</td> <td>anti-HCV</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Hep B</td> <td>HBsAg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>RIBA</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBc total</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td>HCV RNA (e.g., PCR)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBc IgM</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Hep D</td> <td>anti-HDV</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td>anti-HBs</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Hep E</td> <td>anti-HEV</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td></td> <td>HBeAg</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>anti-HBe</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>HBV DNA:</td> <td colspan="6">_____</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:	_____					
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