CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting lapses of consciousness or control, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).

CONDITION 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 | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

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

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

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)*

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:

County of Riverside Department of Public Health
Disease Control Branch
P.O. Box 7600, Riverside, CA 92513-7600
Phone: (951) 358-5107 Fax: (951) 358-5102

AFTER HOURS, HOLIDAY & WEEKEND
EMERGENCY: (951) 782-2974

DEPARTMENT OF MOTOR VEHICLES (DMV)

California Driver License or Identification Card Number (eight characters): ☐☐☐☐☐☐☐☐

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode?: _____ *(mm/dd/yyyy)*
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.

   (a): _____ *(mm/dd/yyyy)* (b): _____ *(mm/dd/yyyy)* (c): _____ *(mm/dd/yyyy)* (d): _____ *(mm/dd/yyyy)* (e): _____ *(mm/dd/yyyy)* (f): _____ *(mm/dd/yyyy)*
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving? ☐ Yes ☐ No ☐ Uncertain
4. Are additional lapses of consciousness likely to occur? ☐ Yes ☐ No ☐ Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake? ☐ Yes ☐ No ☐ Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease? ☐ Yes ☐ No ☐ Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition? ☐ Yes ☐ No ☐ Uncertain
8. Does this patient's condition represent a permanent driving disability? ☐ Yes ☐ No ☐ Uncertain
9. Would you recommend a driving evaluation by DMV? ☐ Yes ☐ No ☐ Uncertain

Remarks: