# CONFIDENTIAL MORBIDITY REPORT

***NOTE: For STD, Hepatitis, or TB, complete appropriate section below***

DISEASE BEING REPORTED:　　MR#

**PATIENT** Last Name　First Name　Middle Initial　**DATE OF BIRTH** ___/___/___　**AGE** ___　**GENDER** ☐ Male ☐ Female　**PREGNANT?** ☐ No ☐ Yes: EDC______

Address　Apt. / Unit No.　**PHONE NUMBERS** Work ( ) ______ Home ( ) ______ Cell ( ) ______　**EMPLOYERS NAME** ______ ______ Phone: ______

City　State　Zip

**RACE** (check all that apply)
☐ African-American ☐ American Indian/Alaska Native ☐ Asian ☐ Pacific Islander ☐ White
☐ Unknown ☐ Other (specify):

**ETHNICITY** (check one)
☐ Non-Hispanic/Non-Latino
☐ Hispanic/Latino ☐ Unknown

**MARITAL STATUS** (check one)
☐ Single ☐ Married
☐ Other______

If **Asian**, check all that apply
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other (specify):

If **Pacific Islander**, check all that apply
☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other (specify):

**COUNTRY OF BIRTH**　If not born in the U.S. Date of Arrival in the U.S. ___/___/___　Language(s) Spoken

**OCCUPATIONAL SETTING**
☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify)

| | Month | Day | Year |
|---|---|---|---|
| **DATE OF ONSET** | ___/ | ___/ | ___ |
| **DATE DIAGNOSED** | ___/ | ___/ | ___ |
| **DATE OF DEATH** | ___/ | ___/ | ___ |
| **DATE OF FIRST SPECIMEN COLLECTION** | ___/ | ___/ | ___ |

**REPORTING HEALTH CARE PROVIDER**

**REPORTING HEALTH CARE FACILITY**

**CITY**　**STATE**　**ZIP**

**PHONE NUMBERS**
Ofc: ( )______ Fax: ( )______

**Submitted by:**　**Date Submitted** ___/___/___

**LABORATORY NAME**　**CITY**　**STATE**　**ZIP**

**REPORT TO:**

**WESTERN COUNTY — RIVERSIDE**
County of Riverside Department of Public Health
Disease Control Branch
PO Box 7600, Riverside, CA 92513-7600
PHONE (951) 358-5107　FAX (951) 358-5102

**EASTERN COUNTY — INDIO**
County of Riverside Department of Public Health
Disease Control Branch
47923 Oasis Street, Indio, CA 92201
PHONE (760) 863-8448　FAX (760) 863-8183

**AFTER HOURS, HOLIDAY & WEEKEND EMERGENCY: (951) 782-2974**
*(Obtain additional forms from www.rivco-diseasecontrol.org/cmr/pdf)*

## SEXUALLY TRANSMITTED DISEASES (STDs)

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

**Syphilis Test Results**
☐ RPR Titer ______
☐ VDRL Titer ______
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ MHA-TP ☐ Pos ☐ Neg
☐ EIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg

**Gonorrhea**
☐ Cervical
☐ Urethral
☐ Urine
☐ Rectal
☐ Pharyngeal
☐ Other ______

**Chlamydia**
☐ Cervical ☐ Rectal
☐ Urethral ☐ Pharyngeal
☐ Urine
☐ Other ______
☐ **Chancroid**
☐ **Lymphogranuloma Venereum**

**PID**
☐ Gonococcal PID
☐ Chlamydial PID
☐ Unknown Etiology PID
☐ Other Etiology PID
______

## STD TREATMENT INFORMATION

☐ **TREATED** ☐ On Site
Date Treatment Began ___/___/___
Rx given: ______

☐ **UNTREATED** ☐ Will Treat ☐ Refused Treatment
☐ Unable to Contact Pt.
Referred to: ______

**SEX PARTNER(S)**
☐ Untreated ☐ Treated
______

**GENDER**
☐ Male ☐ Female

## TUBERCULOSIS (TB)

**STATUS**
☐ **Active Disease**
☐ Confirmed ☐ Suspected
**Site(s)**
☐ Pulmonary ☐ Extra Pulmonary ☐ Both
☐ **Infected, No Disease**
☐ Converter (≤ 2years) ☐ Reactor

**Mantoux TB Skin Test**
Date Performed ___/___/___
Results______mm ☐ Not done ☐ Pending
**QuantiFERON – TB Test**
Date Collected ___/___/___
☐ Pos ☐ Neg ☐ Indeterminate ☐ Not Done
**Other TB blood assay test:** ______
Date Collected ___/___/___
☐ Pos ☐ Neg ☐ Indeterminate ☐ Not Done

**Bacteriology**
Date Specimen Collected ___/___/___
Source: ______
Smear: ☐ Pos ☐ Neg ☐ Pending ☐ Not Done
Culture: ☐ Pos ☐ Neg ☐ Pending ☐ Not Done
Other: ______

**TB TREATMENT INFORMATION**

**Current Treatment**
☐ INH ☐ RIF ☐ PZA ☐ EMB
☐ Other ______
Date Treatment Began ___/___/___
☐ **Untreated** ☐ Will Treat
☐ Refused Treatment ☐ Unable to Contact Pt.
Referred to: ______

**Chest X-ray** DATE ___/___/___ **RESULT:** ☐ Normal ☐ Cavitary ☐ Abnormal/Non-cavitary ☐ Pending ☐ Not Done

## VIRAL HEPATITIS　Onset Date ___/___/___

**Reason for Testing** (Check all that apply)
☐ Symptoms of acute illness ☐ Pre-employment
☐ Asymptomatic w/risk factors ☐ Immune Status ☐ Unk
☐ Other ______

**Symptoms** (Check all that apply)
☐ Jaundice ☐ Fatigue ☐ Fever ☐ Abdominal pain
☐ Vomitting ☐ Anorexic ☐ Joint pain ☐ Nausea
☐ Light stools ☐ Dark urine ☐ Rash
☐ Diarrhea If diarrhea, Date of Onset: ___/___/___

**Diagnosis**
☐ Hep. A ☐ Hep. B (acute) ☐ Chronic Hep. B
☐ Hep. C (acute) ☐ Chronic Hep. C ☐ Hep. D
☐ Hep. E ☐ Other ☐ Unspecified ☐ No report
☐ Hep. NANBNC ☐ Perinatal HBV

**Suspected Exposure Type** (Check all that apply)
☐ Blood Transfusion ☐ Household contact
☐ Other needle exposure ☐ Sexual contact
☐ Child Care ☐ Other ______

**Liver Enzymes at time of Diagnosis**
☐ ALT [SGPT] Result ______
ALT [SGPT] upper limit of normal ______
Date of ALT result ___/___/___
☐ AST [SGOT] Result ______
AST [SGOT] upper limit of normal ______
Date of AST result ___/___/___
Elevated serum aminotransferase levels: ☐ Yes ☐ No
Total bilirubin result ______
Bilirubin upper limit ______

| | | Pos | Neg | Pend | Not Done |
|---|---|---|---|---|---|
| **Hep A** | Anti-HAV IgM | ☐ | ☐ | ☐ | ☐ |
| **Hep B** | HBsAg | ☐ | ☐ | ☐ | ☐ |
| ☐ Acute | Anti-HBc ☐ IgM | ☐ | ☐ | ☐ | ☐ |
| ☐ Chronic | Anti-HBs | ☐ | ☐ | ☐ | ☐ |
| | HBeAg | ☐ | ☐ | ☐ | ☐ |
| | Anti-HBe | ☐ | ☐ | ☐ | ☐ |
| | HBV | ☐ | ☐ | ☐ | ☐ |
| | DNA/PCR | ☐ | ☐ | ☐ | ☐ |
| | EIA/CIA | ☐ | ☐ | ☐ | ☐ |
| **Hep C** (confirmed) | Signal to cut-off ratio (s/co) ______ | | | | |
| ☐ Acute | RIBA | ☐ | ☐ | ☐ | ☐ |
| ☐ Chronic | PCR/HCV | ☐ | ☐ | ☐ | ☐ |
| | Other: ______ | | | | |
| **Hep D** | Anti-HDV | ☐ | ☐ | ☐ | ☐ |
| **Hep E** | Anti-HEV | ☐ | ☐ | ☐ | ☐ |

**COMMENTS:**