

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)	
Home Address: Number, Street		Apt./Unit No.		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		
City		State	ZIP Code		Race (check all that apply)	
Home Telephone Number		Cell Telephone Number		<input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (check all that apply)		
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?	Est. Delivery Date (mm/dd/yyyy)	Country of Birth		<input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <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		REPORT TO:		
Address: Number, Street		Suite/Unit No.		Monterey County Health Department Communicable Disease Unit 1270 Natividad Rd., Salinas, CA 93906 Phone: 831-755-4521 Fax: 831-754-6682 After Hours Urgent Reporting: 831-755-5100 and ask for the Hazardous Materials Team (Obtain additional forms from your local health department.)		
City		State	ZIP Code			
Telephone Number		Fax Number				
Submitted by		Date Submitted (mm/dd/yyyy)				
Laboratory Name		City	State			

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)		STD TREATMENT		Treatment Began (mm/dd/yyyy)		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 _____ _____		_____ _____		<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		Titer	If reporting Chlamydia and/or Gonorrhea:		If reporting Pelvic Inflammatory Disease:			
<input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Secondary <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Latent (unknown duration) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Late (tertiary) <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: _____		_____	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		<input type="checkbox"/> Gonococcal PID <input type="checkbox"/> Chlamydial PID <input type="checkbox"/> Other/Unknown Etiology PID	
Neurosyphilis?		Other:		Partner(s) Treated?						
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		_____		<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)		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 D <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) Result: _____ Upper Limit: _____ AST (SGOT) Result: _____ Upper Limit: _____ Bilirubin result: _____		<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th></th> <th>Pos</th> <th>Neg</th> </tr> <tr> <td>Hep A anti-HAV IgM</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> </tr> <tr> <td>anti-HBc total</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> </tr> <tr> <td>anti-HBs</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> </tr> <tr> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HBV DNA:</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Pos	Neg	Hep A anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep B HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	HBeAg	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>	HBV DNA:	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th></th> <th>Pos</th> <th>Neg</th> </tr> <tr> <td>Hep C anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HCV RNA (e.g., PCR)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep D anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep E anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Pos	Neg	Hep C anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	RIBA	<input type="checkbox"/>	<input type="checkbox"/>	HCV RNA (e.g., PCR)	<input type="checkbox"/>	<input type="checkbox"/>	Hep D anti-HDV	<input type="checkbox"/>	<input type="checkbox"/>	Hep E anti-HEV	<input type="checkbox"/>	<input type="checkbox"/>
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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(i)(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!

Disease Name	Urgency	Disease Name	Urgency
Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)	FAX ☐☑	Pertussis (Whooping Cough)	FAX ☐☑
Chikungunya Virus Infection	FAX ☐☑	Plague, human or animal	☐!
<i>Chlamydia trachomatis</i> infections, including lymphogranuloma venereum (LGV)	WEEK	Poliovirus Infection	FAX ☐☑
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 ☐☑

Disease Name	Urgency	Disease Name	Urgency
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 ☉☑
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.ccrca.org