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**

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

Current Gender Identity (check one)
☐ Male ☐ Female ☐ Trans male/transman ☐ Trans female/transwoman ☐ Genderqueer or non-binary ☐ Identity not listed *(specify)* _____ ☐ Declined to answer

Sex Assigned at Birth (check one)
☐ Male ☐ Female ☐ Declined to answer

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 ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other *(specify)*: _____

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

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Sexual Orientation (check one)
☐ Heterosexual or straight ☐ Bisexual ☐ Gay, lesbian, or same gender loving ☐ Orientation not listed *(specify)* _____ ☐ Questioning/Unsure/ Client doesn't know ☐ Declined to answer

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

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)* | **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**

REPORT TO:

Orange County Public Health
Fax: (714) 564-4050
Mail: P.O. Box 6128
Santa Ana, CA 92706-0128
Phone: (714) 834-8180

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ **Untreated**
☐ Will treat ☐ Unable to contact patient ☐ Patient refused treatment ☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present) ☐ Secondary ☐ Early, non-primary, non-secondary ☐ Unknown Duration or Late ☐ Congenital

Clinical Manifestations?
☐ Neurologic ☐ Otic ☐ Ocular ☐ Late clinical

Syphilis Test Results | **Titer**
☐ RPR ☐ Pos ☐ Neg _____
☐ VDRL ☐ Pos ☐ Neg _____
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg _____
☐ Other: _____

If reporting Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other: _____

Symptoms?
☐ Yes ☐ No ☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

Remarks:

CONFIDENTIAL MORBIDITY REPORT
(continued)

Patient Name - Last Name	***First Name***	***MI***	***Birth Date*** *(mm/dd/yyyy)*

VIRAL HEPATITIS

Diagnosis (check all that apply)

- ☐ Hepatitis A
- ☐ Hepatitis B (acute)
- ☐ Hepatitis B (chronic)
- ☐ Hepatitis B (perinatal)
- ☐ Hepatitis C (acute)
- ☐ Hepatitis C (chronic)
- ☐ Hepatitis C (perinatal)
- ☐ Hepatitis D (acute)
- ☐ Hepatitis D (chronic)
- ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)

- ☐ Blood transfusion, dental or medical procedure
- ☐ IV drug use
- ☐ Other needle exposure
- ☐ Sexual contact
- ☐ Household contact
- ☐ Perinatal
- ☐ Child care
- ☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____

AST (SGOT) Result: _____ Upper Limit: _____

Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐