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***

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***

Occupation or Job Title

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

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)*

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

STD Control Reports
Fax: (951) 358-6007

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

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ 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 latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

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 Chlamydia and/or 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

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

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 D
☐ 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	☐	☐

Remarks: