

# CONFIDENTIAL MORBIDITY REPORT- CD

**PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV. Please submit all relevant medical records, laboratory results and X-rays along with the completed CMR.**

## DISEASE BEING REPORTED

<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Ethnicity (check one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown	
<b>Home Address: Number, Street</b>				<b>Apt./Unit No.</b>		
<b>City</b>		<b>State</b>	<b>ZIP Code</b>			
<b>Home Telephone Number</b>		<b>Cell Telephone Number</b>		<b>Work Telephone Number</b>		
<b>Email Address</b>			<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
<b>Birth Date (mm/dd/yyyy)</b>		<b>Age</b>	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		<b>Gender</b> <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: _____	
<b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<b>Est. Delivery Date (mm/dd/yyyy)</b>		<b>Country of Birth</b>		
<b>Occupation or Job Title</b>				<b>Occupational or Exposure Setting (check all that apply):</b> <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): _____		

<b>Date of Onset (mm/dd/yyyy)</b>	<b>Date of First Specimen Collection (mm/dd/yyyy)</b>	<b>Date of Diagnosis (mm/dd/yyyy)</b>	<b>Date of Death (mm/dd/yyyy)</b>
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<b>Reporting Health Care Provider</b>		<b>Reporting Health Care Facility</b>		<b>REPORT TO:</b>  <b>Orange County Public Health</b>  <b>Fax:</b> (714) 564-4050  <b>Mail:</b> P.O. Box 6128 Santa Ana, CA 92706-0128  <b>Phone:</b> (714) 834-8180	
<b>Address: Number, Street</b>		<b>Suite/Unit No.</b>			
<b>City</b>		<b>State</b>	<b>ZIP Code</b>		
<b>Telephone Number</b>		<b>Fax Number</b>			
<b>Submitted by</b>		<b>Date Submitted (mm/dd/yyyy)</b>			

<b>Laboratory Name</b>	<b>City</b>	<b>State</b>	<b>ZIP Code</b>
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### SEXUALLY TRANSMITTED DISEASES (STDs)

<b>Gender of Sex Partners (check all that apply)</b> <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: _____	<b>STD TREATMENT</b> <input type="checkbox"/> Treated in office <input type="checkbox"/> Given prescription <b>Drug(s), Dosage, Route</b> _____	<b>Treatment Began (mm/dd/yyyy)</b> _____	<input type="checkbox"/> <b>Untreated</b> <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Patient refused treatment <input type="checkbox"/> Referred to: _____
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<b>If reporting Syphilis, Stage:</b> <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 <b>Neurosyphilis?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Syphilis Test Results</b> <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: _____	<b>Titer</b> _____	<b>If reporting Chlamydia and/or Gonorrhea:</b> <b>Specimen Source(s) (check all that apply)</b> <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: _____	<b>Symptoms?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>If reporting Pelvic Inflammatory Disease:</b> (check all that apply) <input type="checkbox"/> Gonococcal PID <input type="checkbox"/> Chlamydial PID <input type="checkbox"/> Other/Unknown Etiology PID  <b>Partner(s) Treated?</b> <input type="checkbox"/> Yes, treated in this clinic <input type="checkbox"/> No, instructed patient to refer partner(s) for treatment <input type="checkbox"/> Yes, Meds/Prescription given to patient for their partner(s) <input type="checkbox"/> No, referred partner(s) to: _____ <input type="checkbox"/> Yes, other: _____ <input type="checkbox"/> Unknown
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### VIRAL HEPATITIS

<b>Diagnosis (check all that apply)</b> <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	<b>Is patient symptomatic?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <b>Suspected Exposure Type(s)</b> <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: _____	<b>ALT (SGPT)</b> Upper Limit: _____ Result: _____  <b>AST (SGOT)</b> Upper Limit: _____ Result: _____  <b>Bilirubin result:</b> _____	<table border="1"> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th></th> <th>Pos</th> <th>Neg</th> </tr> <tr> <td><b>Hep A</b> anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><b>Hep C</b> anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><b>Hep B</b> HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>RIBA</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> <td>HCV RNA (e.g., PCR)</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> <td><b>Hep D</b> anti-HDV</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> <td><b>Hep E</b> anti-HEV</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> <td></td> <td></td> <td></td> </tr> <tr> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HBV DNA: _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table>		Pos	Neg		Pos	Neg	<b>Hep A</b> anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep C</b> anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep B</b> HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	RIBA	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>	HCV RNA (e.g., PCR)	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep D</b> anti-HDV	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep E</b> anti-HEV	<input type="checkbox"/>	<input type="checkbox"/>	HBeAg	<input type="checkbox"/>	<input type="checkbox"/>				anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>				HBV DNA: _____					
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