

# CONFIDENTIAL MORBIDITY REPORT

**PLEASE NOTE: Use this form for reporting all conditions except HIV/AIDS, Tuberculosis, and conditions reportable to DMV.**

## 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>Race (check all that apply)</b> <input type="checkbox"/> African-American/Black <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian (check all that apply) <input type="checkbox"/> Asian Indian <input type="checkbox"/> Hmong <input type="checkbox"/> Thai <input type="checkbox"/> Cambodian <input type="checkbox"/> Japanese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Chinese <input type="checkbox"/> Korean <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <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		
<b>Current Gender Identity (check one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Genderqueer or non-binary <input type="checkbox"/> Female <input type="checkbox"/> Identity not listed (specify) _____ <input type="checkbox"/> Trans male/transman <input type="checkbox"/> Declined to answer <input type="checkbox"/> Trans female/transwoman				<b>Sex Assigned at Birth (check one)</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Declined to answer		
<b>Sexual Orientation (check one)</b> <input type="checkbox"/> Heterosexual or straight <input type="checkbox"/> Bisexual <input type="checkbox"/> Gay, lesbian, or same gender loving <input type="checkbox"/> Orientation not listed (specify) _____ <input type="checkbox"/> Questioning/Unsure/Client doesn't know <input type="checkbox"/> Declined to answer						
<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>
<b>Reporting Health Care Provider</b>		<b>Reporting Health Care Facility</b>			<b>REPORT TO:</b>  Alameda County Public Health Department Div. Communicable Disease Control & Prevention 1100 San Leandro Blvd., San Leandro, CA 94803  FAX (CD): (510) 273-3744 FAX (STD): (510) 268-2036 FAX (TB): (510) 273-3916 Phone: (510) 267-3250 (Business hours)  (Obtain additional forms from your local health department.)	
<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>

## 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: _____			
<b>If reporting Syphilis, Stage:</b> <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Secondary <input type="checkbox"/> Early, non-primary, non-secondary <input type="checkbox"/> Unknown Duration or Late <input type="checkbox"/> Congenital  <b>Clinical Manifestations?</b> <input type="checkbox"/> Neurologic <input type="checkbox"/> Otic <input type="checkbox"/> Ocular <input type="checkbox"/> Late clinical		<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>If reporting 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>Partner(s) Treated?</b> <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	

**Remarks:**

# CONFIDENTIAL MORBIDITY REPORT

(continued)

<b>Patient Name - Last Name</b>	<b>First Name</b>	<b>MI</b>	<b>Birth Date (mm/dd/yyyy)</b>
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**VIRAL HEPATITIS**

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

# 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(j)

Disease Name	Urgency	Disease Name	Urgency
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!	Melioidosis	⓪!
Brucellosis, animal (except infections due to <i>Brucella canis</i> )	WEEK	Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ⓪☒
Brucellosis, human	FAX ⓪☒	Middle East Respiratory Syndrome (MERS)	⓪!
Campylobacteriosis	FAX ⓪☒	Monkeypox or orthopox virus infection	⓪!
<i>Candida auris</i> , colonization or infection	FAX ⓪☒	Multisystem inflammatory syndrome in children (MIS-C)	FAX ⓪☒

Disease Name	Urgency	Disease Name	Urgency
Chancroid	WEEK	Mumps	WEEK
Chickenpox (Varicella)(Outbreaks, hospitalizations and deaths)	FAX ☏☑	<i>Neisseria meningitidis</i> (invasive disease)	☏!
Chikungunya Virus Infection	FAX ☏☑	Novel Coronavirus Infection	☏!
Cholera	☏!	Novel Virus Infection with Pandemic Potential	☏!
Ciguatera Fish Poisoning	☏!	Paralytic Shellfish Poisoning	☏!
Coccidioidomycosis	WEEK	Paratyphoid Fever	FAX ☏☑
Coronavirus Disease 2019 (COVID-19) (hospitalizations only)	FAX ☏☑	Pertussis (Whooping Cough)	FAX ☏☑
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)	WEEK	Plague, human or animal	☏!
<i>Cronobacter sakazakii</i> infections in infants less than one year of age	FAX ☏☑	Poliovirus Infection	FAX ☏☑
Cryptosporidiosis	FAX ☏☑	Psittacosis	FAX ☏☑
Cyclosporiasis	FAX ☏☑	Q Fever	FAX ☏☑
Cysticercosis or taeniasis	WEEK	Rabies, human or animal	☏!
Dengue Virus Infection	FAX ☏☑	Relapsing Fever	FAX ☏☑
Diphtheria	☏!	Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age	WEEK
Domoic Acid Poisoning (Amnesic Shellfish Poisoning)	☏!	Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses	WEEK
Ehrlichiosis	WEEK	Rocky Mountain Spotted Fever	WEEK
Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic	FAX ☏☑	Rubella (German Measles)	WEEK
<i>Escherichia coli</i> : shiga toxin producing (STEC) including <i>E. coli</i> O157	FAX ☏☑	Rubella Syndrome, Congenital	WEEK
Flavivirus infection of undetermined species	☏!	Salmonellosis (Other than Typhoid Fever)	FAX ☏☑
Foodborne Disease	†FAX ☏☑	Scombroid Fish Poisoning	☏!
Giardiasis	WEEK	Shiga toxin (detected in feces)	FAX ☏☑
Gonococcal Infections	WEEK	Shigellosis	FAX ☏☑
<i>Haemophilus influenzae</i> , invasive disease, all serotypes (report an incident less than 5 years of age)	FAX ☏☑	Silicosis	WEEK

Disease Name	Urgency	Disease Name	Urgency
Hantavirus infections	FAX ☉☐	Syphilis (all stages, including congenital)	FAX ☉☐
Hemolytic Uremic Syndrome	FAX ☉☐	Tetanus	WEEK
Hepatitis A, acute infection	FAX ☉☐	Trichinosis	FAX ☉☐
Hepatitis B (specify acute, chronic, or perinatal)	WEEK	Tuberculosis	FAX ☉☐
Hepatitis C (specify acute, chronic, or perinatal)	WEEK	Tularemia, animal	WEEK
Hepatitis D (Delta) (specify acute case or chronic)	WEEK	Tularemia, human	☉!
Hepatitis E, acute infection	WEEK	Typhoid Fever, Cases and Carriers	FAX ☉☐
Human Immunodeficiency Virus (HIV) infection, acute infection	☉	<i>Vibrio</i> Infections	FAX ☉☐
Human Immunodeficiency Virus (HIV) infection, any stage	WEEK	Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)	☉!
Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS)	WEEK	West Nile Virus (WNV) Infection	FAX ☉☐
Influenza-associated deaths in laboratory- confirmed cases less than 18 years of age	WEEK	Yellow Fever	FAX ☉☐
Influenza due to novel strains (humans)	☉!	Yersiniosis	FAX ☉☐
Legionellosis	FAX ☉☐	Zika Virus Infection	FAX ☉☐
Leprosy (Hansen Disease)	WEEK	OCCURANCE of ANY UNUSUAL DISEASE	☉!
Leptospirosis	WEEK	OUTBREAKS of ANY DISEASE (Including diseases not listed in <b>§2500</b> ). Specify if institutional and/or open community.	☉!
Listeriosis	FAX ☉☐		

### **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 ([www.cdph.ca.gov/Programs/CID/DOA/Pages/OA\\_case\\_surveillance\\_resources.aspx](http://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):**

- Carbapenem-resistant Enterobacteriaceae (CRE)
- Mammalian Animal bites to Humans (§2606 a)
- All cases of histologically diagnosed cervical intraepithelial neoplasia (CIN) grades 2 and 3, and adenocarcinoma in situ (AIS) for residents of Alameda County over 18 years of age. Select cases of cervical cancer, upon request. Call HPV-Impact Surveillance Unit, California Department of Public Health, at 510-620-2379 to set up reporting method

A complete list of diseases and conditions reportable in Alameda County can be found at:

<http://www.acphd.org/communicable-disease/disease-reporting-and-control/>

\* The Confidential Morbidity Report (CMR) 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](http://www.ccrca.org).

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