COUNTY OF LOS ANGELES • DEPARTMENT OF PUBLIC HEALTH

MORBIDITY UNIT
CONFIDENTIAL MORBIDITY REPORT

NOTE: This form is not intended for reporting STDs, HIV, AIDS or TB. See comments below

DISEASE BEING REPORTED:

DISTRICT CODE (internal use only):

Patient's Last Name:

Social Security Number:

Ethnicity (check one):
☐ Hispanic ☐ Non-Hispanic / Non-Latino

First Name and Middle Name (or initial):

Birthdate (MM/DD/YYYY):

Age:

Race (check one):
☐ American Indian / Alaskan Native
☐ Asian (specify one):
☐ Asian Indian ☐ Hmong ☐ Laotian
☐ Cambodian ☐ Japanese ☐ Thai
☐ Chinese ☐ Korean ☐ Vietnamese
☐ Filipino ☐ Other ______
☐ Black / African American
☐ Native Hawaiian / Other Pacific Islander (ie. Guam,Samoa)
☐ White
☐ Other ______

Address (Street and number):

City/Town

State

Zip code

Home Telephone Number:

Work Telephone Number:

Gender:
☐ Male ☐ Female ☐ Other ______
Pregnant? ☐ Yes ☐ No ☐ Unknown
Estimated Delivery Date: ______

Patient's Occupation or Setting:
☐ Day Care ☐ Correctional Facility ☐ Food Service (Explain): ______
☐ Health Care ☐ School ☐ Other (Explain): ______

Risk Factors / Suspected Exposure Type: (check all that apply)
☐ Blood transfusion
☐ Needle or blood exposure
☐ Child care
☐ Food / drink
☐ Recreational water exposure
☐ Foreign travel
☐ Sexual activity
☐ Household exposure
☐ Unknown
☐ Other ______

Date of Onset (MM/DD/YYYY): ______

Health Care Provider:

Health Care Facility:

Date of Diagnosis (MM/DD/YYYY): ______

Address:

City:

Date of Hospitalization (MM/DD/YYYY): ______

Telephone:

FAX:

Date of Death (MM/DD/YYYY): ______

Submitted by:

Date CMR submitted (MM/DD/YYYY): ______

Type of diagnostic specimen: (check all that apply)
☐ Blood ☐ CSF
☐ Stool ☐ Urine
☐ Clinical ☐ No test
☐ Other ______

Hepatitis Diagnosis:
☐ Hep A, acute
☐ Hep B, acute
☐ Hep B, chronic
☐ Hep C, acute
☐ Hep C, chronic
☐ Hep D
☐ Other Hepatitis
______

Elevated LFTs?
☐ No ☐ Yes ______ ALT
______ AST

Jaundiced? ☐ No ☐ Yes

Type of Hepatitis Testing (check all that apply):

	Pos.	Neg.	Pend.	Not Done
anti-HAV IgM	☐	☐	☐	☐
HBsAg	☐	☐	☐	☐
anti-HBc (total)	☐	☐	☐	☐
anti-HBc IgM	☐	☐	☐	☐
anti-HBs	☐	☐	☐	☐
anti-HCV	☐	☐	☐	☐
- anti-HCV signal to cut off ratio = ______				
HCV-PCR	☐	☐	☐	☐
anti-Delta	☐	☐	☐	☐
Other test	☐	☐	☐	☐

specify ______

DO NOT use this form to report HIV/AIDS, chancroid, chlamydia infections, gonorrhea, non-gonococcal urethritis, pelvic inflammatory disease, syphilis, or tuberculosis.

For Adult HIV and AIDS: Report to DHSP/HIV Epidemiology. Reporting information and forms are available by phone at 213-351-8516 or at: www.publichealth.lacounty.gov/dhsp/reportcase.htm.

For Acute HIV Infection Reporting: Health care providers shall report all cases within one working day of diagnosis by telephone, to the local health officer of the jurisdiction in which the patient resides. Laboratories and providers may call 213-351-8516 to report a case of acute HIV infection.

For Pediatric HIV and AIDS: Report to DHSP/Pediatric HIV/AIDS Reporting. Reporting information is available by calling 213-351-8153 or at www.publichealth.lacounty.gov/dhsp/reportcase.htm.

For Tuberculosis: report cases and suspected cases to the TB Control Program within 24 hours of identification. Reporting information is available by phone at 213-745-0800, or at www.publichealth.lacounty.gov/tb/index.htm
Fax reports to: 213-749-0926.

For STDs: The STDs that are reportable to the STD Program include: chlamydial infections, syphilis, gonorrhea, chancroid, non-gonoccocal urethritis (NGU), and pelvic inflamatory disease. Reporting information is available at www.publichealth.lacounty.gov/dhsp/reportcase.htm.

REMARKS:

FAX THIS REPORT TO: 888-397-3778 or 213-482-5508
For assistance, please call the Morbidity Unit at 888-397-3993, or mail to Morbidity Unit, 313 N. Figueroa St., #117, Los Angeles, CA 90012.

H-794

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