COUNTY OF ORANGE, CA · HEALTH CARE AGENCY · PUBLIC HEALTH

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below.

DISEASE BEING REPORTED: _____ If applicable, specimen date ___ ___ ___ (MONTH DAY YEAR) Source: _____

Patient's Last Name

Social Security Number ___ — ___ — ___

First Name and Middle Name

Birth Date ___ ___ ___ (MONTH DAY YEAR) **Age**

Address: Number, Street **Apt./Unit Number**

City/Town **State** **Zip Code**

Area Code **Home Telephone** ___ — ___ — ___

Gender M F

Pregnant? Y N UNK

Estimated Delivery Date ___ ___ ___ (MONTH DAY YEAR)

Area Code **Work Telephone** ___ — ___ — ___

Patient's Occupation/Setting
- ❑ Food service ❑ Day care ❑ Correctional facility
- ❑ Health care ❑ School ❑ Other: _____

Ethnicity (√ one)
- ❑ Hispanic/Latino
- ❑ Non-Hispanic / Non-Latino

Race (√ one)
- ❑ African-American/Black
- ❑ Asian/Pacific Islander (√ one)
  - ❑ Asian-Indian ❑ Japanese
  - ❑ Cambodian ❑ Korean
  - ❑ Chinese ❑ Laotian
  - ❑ Filipino ❑ Samoan
  - ❑ Guamanian ❑ Vietnamese
  - ❑ Hawaiian
- ❑ Other: _____
- ❑ Native American/Alaskan Native
- ❑ White
- ❑ Other: _____

DATE OF ONSET ___ ___ ___ (MONTH DAY YEAR)

DATE DIAGNOSED ___ ___ ___ (MONTH DAY YEAR)

DATE OF DEATH ___ ___ ___ (MONTH DAY YEAR)

Reporting Health Care Provider

Reporting Health Care Facility

Address

City **State** **Zip Code**

Telephone Number ( ) **Fax** ( )

Submitted By **Date Submitted** ___ ___ ___ (MONTH DAY YEAR)

REPORT TO:

Orange County Public Health

Fax: (714) 834-8196

Mail: P.O. Box 6128
Santa Ana, CA 92706-0128

Phone: (714) 834-8180

SEXUALLY TRANSMITTED DISEASES (STD)

Syphilis
- ❑ Primary (lesion present)
- ❑ Secondary
- ❑ Early latent < 1 year
- ❑ Latent (unknown duration)
- ❑ Late latent > 1 year
- ❑ Late (tertiary)
- ❑ Congenital
- ❑ **Neurosyphilis**

Syphilis Test Results
- ❑ RPR Titer: _____
- ❑ VDRL Titer: _____
- ❑ FTA/MHA: ❑ Pos ❑ Neg
- ❑ CSF-VDRL: ❑ Pos ❑ Neg
- ❑ Other: _____

Gonorrhea
- ❑ Urethral/Cervical
- ❑ PID
- ❑ Other: _____

Chlamydia
- ❑ Urethral/Cervical
- ❑ PID
- ❑ Other: _____

- ❑ **PID (Unknown Etiology)**
- ❑ **Chancroid**
- ❑ **Non-Gonococcal Urethritis**

STD TREATMENT INFORMATION
- ❑ **Treated (Drugs, Dosage, Route)** Date Treatment Initiated ___ ___ ___ (MONTH DAY YEAR)

_____

_____

- ❑ **Untreated**
  - ❑ Will treat
  - ❑ Unable to contact patient
  - ❑ Refused treatment
  - ❑ Referred to: _____

VIRAL HEPATITIS
- ❑ **Hep A**
- ❑ **Hep B**
  - ❑ **Acute**
  - ❑ **Chronic**
- ❑ **Hep C**
  - ❑ **Acute**
  - ❑ **Chronic**
- ❑ **Hep D (Delta)**
- ❑ **Other:** _____

Please send copies of the hepatitis serologies (required for diagnosis) and liver enzymes (if done).

Suspected Exposure Type
- ❑ Blood transfusion ❑ Other needle exposure
- ❑ Sexual contact ❑ Household contact
- ❑ Child care ❑ Other: _____

TUBERCULOSIS (TB)

Status
- ❑ **Active Disease**
  - ❑ Confirmed
  - ❑ Suspected
- ❑ **Infected, No Disease**
  - ❑ Converter
  - ❑ Reactor

Site(s)
- ❑ Pulmonary
- ❑ Extra-Pulmonary
- ❑ Both

Mantoux TB Skin Test

Date Performed ___ ___ ___ (MONTH DAY YEAR)

Results _____ mm ❑ Pending ❑ Not done

Chest X-ray

Date Performed ___ ___ ___ (MONTH DAY YEAR)
- ❑ Normal ❑ Pending ❑ Not done
- ❑ Cavitary ❑ Abnormal/Noncavitary

Bacteriology

Date Specimen Collected ___ ___ ___ (MONTH DAY YEAR)

Source: _____

Smear: ❑ Pos ❑ Neg ❑ Pending ❑ Not done

Culture: ❑ Pos ❑ Neg ❑ Pending ❑ Not done

Other test(s): _____

_____

_____

TB TREATMENT INFORMATION
- ❑ **Current Treatment**
  - ❑ INH ❑ RIF ❑ PZA
  - ❑ EMB ❑ Other: _____

Date Treatment Initiated ___ ___ ___ (MONTH DAY YEAR)
- ❑ **Untreated**
  - ❑ Will treat
  - ❑ Unable to contact patient
  - ❑ Refused treatment
  - ❑ Referred to: _____

REMARKS