# CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

Patient's Last Name       Social Security Number       Ethnology (voin)         First Name/Initial       Birth Date       Non-Higgen (Non-AmericanBluck)         Address:       Apt/Unit Number       Birth Date         (MyTown       State       Apt/Unit Number         CityTown       State       Apt/Unit Number         CityTown       State       Apt/Unit Number         CityTown       State       ZIP Code         CityTown       State       City Code         Area Code       Mone Telephone       Gender         Programming       Mark To Coccupation/Station       Non-Higging         Area Code       Work Telephone       Pattername       Communicable Dates of the State of the St	DISEASE BEING F	REPORTED:			
First NameMiddle Name (or initial)       Birth Date       Age         Store       Day       Yoar       Age         Address:       ApL/Unit Number       Image and the store of the store	Patient's Last Name		Social Security Numbe	r	Ethnicity (✓ one)
First Name/Middle Name (or initial)       Birth Date by Year       Age Age       Age Age       Age Address: Number, Street       Age Address: Number, Street       Address: Number, Street       Number, Street       Address: Number, Street       Number, Street       Address: Number, Stree				_	Hispanic/Latino
First Number, Street       Apt.Unit Number         Address: Number, Street       Apt.Unit Number         City/Town       State         City/Town       State         ZIP Code       Fallence         City/Town       Commonic         City/Town       Commonic         City/Town       Commonic         City/Town       Commonic         City/Town       Commonic         City/Town       Commonic         DATE OF ONSET       Reporting Number         Nomin       Commonic Call Streec         Date of Dealer       (a)         Nomin       Commonic Call Streec         Date of Dealer       (b)         Nomin       Commonic Call Streec         State       Code         Date State       Code         Date S			Birth Data		Non-Hispanic/Non-Latino
Address: Number, Street       Apt/Linit Number         Address: Number, Street       Apt/Linit Number         CityTown       State         CityTown       State         Area Code       Home Telephone         Gender       Pregnant?         Estimated Delivery Date       Code         Mailer Andreican/Alastan Nalve       Code         Area Code       Work Telephone         Patient's Occupation/Setting       Convectional facility         Area Dody       Telephone         Patient's Occupation/Setting       Other         DATE OF ONSET       Reporting Heath Care Previder         Meet       Day Year       Reporting Heath Care Provider         Setting       County of Santa Cruz       County of Santa Cruz         Correctional facility       County of Santa Cruz       County of Santa Cruz         Correctional facility       County of Santa Cruz       County of Santa Cruz         Setting       Sate Care       Sate Cruz       County of Santa Cruz         Setting Con proventing       Sate Care	First Name/Middle Name	(or initial)		Age	Race (✓ one)
Address: Number, Street       AptLinit Number         [clyTown       State       ZIP Code         [clyTown       M E       Prognant?         Area Code       Home Telephone       Petient's Occupation/Stiting       Native American/Auskan Native         [clyTown       [] Close State       Correctional facility       White:         [] DATE OF ONSET       Reporting Health Care FreeNater       Station Correctional facility       Other:         [] DATE OF ONSET       Reporting Health Care FreeNater       State       ZIP Code         [] Address       Interview       State       ZIP Code       State Cruz, Communicable Disease Unit         [] Address       [] Cly       State       ZIP Code       State Cruz, Cost State Gree Free         [] Address       [] Close State Cruz, Cost State Gree Free       [] Close State Gree Free       Communicable Disease Unit         [] Address       [] Close State Cruz, Cost State Gree Free       [] Close State Gree Free       Cost State Gree Free         [] Address					African-American/Black
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City/Town       State       ZIP Code       Chinese       Lacian         Area Code       Home Telephone       Gender       Pregnant7       Estimated Delivery Date       Samaan         Area Code       Work Telephone       Patient's Occupation/Setting       Date Ander Anderican/Atastan Native       Heavaian         Area Code       Work Telephone       Patient's Occupation/Setting       Concrectional facility       While       Heavaian         DATE OF ONSET       Reperting Health Care Previder       Other       County of Santa Cruz       Communicable Disease Unit         DATE OF ONSET       Reperting Health Care Fealthy       County of Santa Cruz       Communicable Disease Unit         Mont       Day Year       Fax       (Santa Sature Cruz, CA Spote)       Santa Cruz, CA Spote)         Mont       Day Year       Fax       (Santa Sature Cruz, CA Spote)       (Data sational terms from year					🗖 Asian-Indian 🛛 Japanese
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Area Code       Work Telephone       Patient's Occupation/Setting       Other:       Other:         Area Code       Work Telephone       Patient's Occupation/Setting       Other:       Other:         DATE OF ONSET       Feod service       Day care       Correctional facility       Other:       Other:         DATE OF ONSET       Reporting Health Care Provider       REPORT TO:       County of Santa Cruz       Communicable Disease Unit 1060 Emeline Ave., Bidg F         Mom       Day       Year       Orby       State       ZIP Code       Santa Cruz, CA 95060         DATE OF DEATH       Telephone Number       [***       Phone: (831) 454-4114       Fax:       (831) 454-5049         Mom       Day       Year       Orby       State       ZIP Code       Santa Cruz, CA 95060         Securation       Care Code       State       ZIP Code       Phone: (831) 454-5049       Other more voor too to testh department.         Securation       Care Code       Securation       Care Code       Nata       Code code code code code code code code c			Estimated	I Delivery Date	🗍 Guamanian 🛛 Vietnamese
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DATE OF ONSET       Reporting Health Care Fooder       Other       Other         Month       Day Year       Reporting Health Care Fooder       County of Santa Cruz         DATE DIAGNOSED       Address       County of Santa Cruz       Communicable Disease Unit 1060 Emeline Ave., Bidg F         Month       Day Year       City       State       ZIP Code       Phone: (831) 454-4114         Fax:       (31) 454-4114       Fax:       (331) 454-4114       Fax:       (331) 454-64114         Fax:       (331) 454-4114       Fax:       (331) 454-6419       Fax:       (331) 454-6419         Sebunitted by       Date Submitted       (biten additional form form you local health department)       Fax:       (331) 454-64114         Sebunitted by       Date Submitted       (biten additional form form you local health department)       Fax:       (331) 454-64114         Sebunitted by       Date Submitted       (biten additional form form you local health department)       Fax:       (331) 454-64114         Sebunitted by       Date Early latent < year	Area Code Work Tele	phone Patient's Occup	ation/Setting		Native American/Alaskan Native
DATE OF ONSET     Reporting Health Care Provider     REPORT TO:       Montin     Day     Year     County of Santa Cruz       DATE DIAGNOSED     Address     Communicable Disease Unit       Montin     Day     Year     City     State       City     State     ZIP Code     Santa Cruz, CA 95060       DATE DIAGNOSED     Telephone Number     [***]     Phone: (831) 454-4114       Montin     Day     Year     [***]       SEXUALLY TRANSMITTED DISEASES (STD)     Syphilis     State State     VIRAL HEPATITIS       Syphilis     Secondary     Late latent > 1 year     SPR     REF       Dates function of unitonow duration:     Late (tertiary)     State     VIRAL HEPATITIS       Perimary (lesion present)     Late (tertiary)     State     Product Park       Descondary     Congenital     PID (Unknown Etiology)     PHep B     HBeAg     Image: Picked Park       Medit     Date Teatment Initiated     PID (Unknown Etiology)     PR     PR     Primary (Beion present)     Image: Picked Park       Interruited (Drugs, Dosage, Route):     Date Treatment Initiated     PID (Unknown Etiology)     PR     PR     Primary (Picked Park     Picked Park       Other     Date Treatment Initiated     Image: Picked Park     Picked Park     Picked Park     <		Food service	Day care Correctional fac	cility	<b>D</b> White:
Notifi       Output       Pagenting Health Care Facility       County of Santa Cruz         DATE DIAGNOSED       Address       County of Santa Cruz         Mominicable Disease Unit       1060 Emeline Ave., Bidg F         Santa Cruz, CA 95060       Phone: (831) 454-4114         Pate OF DEATH       Fax         Mominicable Disease Unit       1060 Emeline Ave., Bidg F         Submitted by       Date Submitted         Submitted by       Date Submitted         Mominicable Diseases (STD)       Syphilis Test Results         Primary (lesion present)       Late latent > 1 year         Batent (unknown duration)       Congenital         Primary (lesion present)       Late latent > 1 year         Batent (unknown duration)       Charnydia         NeuroszyPhilis       Congenital         Gonorrhea       Charnydia         Murchary/Law       Charnydia         Mater Disease, Route):       Date Treatment Initiated         Monin Day Year       Bacteriology         Mater Disease, Route):       Date Treatment Initiated         Monin Day Year       Bacteriology         MurcharyBater       Date Treatment Initiated         MurcharyBater       Bacteriology         Monin Day Year       Date Treatment Initiated		Health care	School Other		Other:
Image: Construct of Santa Cruz       Communicable Disease Unit 1060 Emetine Ave., Bidg F         Month       Day       Year       City       State       ZP Code       Santa Cruz, CA 95060         DATE DIAGNOSED       Integration Number       Fax       Phone: (831) 454-4114       Fax: (831) 454-4114         Month       Day       Year       Submitted       Image: Construction Number       Fax: (831) 454-4049         Month       Day       Year       Submitted by       Date Submitted       Phone: (831) 454-4114         Fax:       Submitted by       Date Submitted (Image: Construction Number)       Column odditional forms from your local health department.)         SEXUALLY TRANSMITTED DISEASES (STD)       Syphilis Test Results       VIRAL HEPATITIS       Pos       Neg         Secondary       Late latent > 1 year       Syphilis Test Results       IHep A       Acute       anti-HAV IgM       Image: Construction Number         Other       Congenital       CTANAHA:       Pos       Neg       Acute       anti-HAV IgM       Image: Construction Number         Internet       Other       Congenital       Confirmed       Other       Image: Confirmed       Image: C	DATE OF ONSET	Reporting Health Care Provider		REP	ORT TO:
County of Sania Cruz         DATE DIAGNOSED         Address         Monin       Day Year         City       State         DATE OF DEATH         Momin       Day Year         Submitted by       Date Submitted         Momin       Day Year         Submitted by       Date Submitted         Momin       Day Year         Secondary       Late latent > 1 year         Barly latent < 1 year	Month Day Year				
DATE DIAGNOSED       Address       Communicable Disease Unit 1060 Emeline Ave., Bldg F Santa Cruz, CA 95060         DATE OF DEATH       Telephone Number       Fax       Phone: (831) 454-4114         Month       Day Year       Submitted       Phone: (831) 454-4114         Security Transmitter by       Date Submitted       Phone: (831) 454-5049         Synthilis       Submitted by       Date Submitted       Phone: (831) 454-4114         Fax:       (831) 454-5049       Obtain additional forms form your local health department.         Synthilis       Submitted by       Date Submitted       Phone: (831) 454-4114         Fax:       (831) 454-4114       Fax:       (831) 454-4114         Secondary       Late (tertiany)       Date Submitted       Phone: (831) 454-4114         Secondary       Late (tertiany)       Date Submitted       Phone: (831) 454-4114         Secondary       Late (tertiany)       Date Submitted       Phone: (831) 454-4114         Bax       Phone: (Bax       Phone: (Bax       Phone: (Bax       Phone: (Bax         Secondary       Late (tertiany)       Date Submitted       Phone: (Bax       Phone: (Bax       Phone: (Bax         Inderted:       Competition       Phone: (Bax       Phone: (Bax       Phone: (Bax       Phone: (Bax		Reporting Health Care Facility		Cour	nty of Santa Cruz
DATE OF DEATH       City       State       2IP Code       Santa Cruz, CA 95060         DATE OF DEATH       Telephone Number       Fax       Phone: (831) 454-4114       Fax: (831) 454-45049         Month       Day       Year       Submitted       Date Submitted       Phone: (831) 454-45049         SEXUALLY TRANSMITTED DISEASES (STD)       Supplifis       Date Submitted       ViRAL HEPATITIS       Pos       Not         Secondary       Late latent > 1 year       Congenital       PFIT Titer:       Hep A       anti-HAV IgM       Image: State		Address			
image: city       State       ZIP Code       Santa Cruz, CA 95060         DATE OF DEATH       Telephone Number       fax       Phone: (831) 454-4114         Month       Day Year       Submitted by       Date Submitted       Phone: (831) 454-4114         SEXUALLY TRANSMITTED DISEASES (STD)       Syphilis Test Results       VIRAL HEPATITIS       Pos       Neg Pend Done         Sphilis       Primary (lesion present)       Late (tertiary)       VDRL       Titer:       Hep A       anti-HAV IgM       Image: Charge Pend Done         Beary later 1 year       Congenital       PYDRL       Titer:       Hep A       anti-HAV IgM       Image: Charge Pend Done         Neurosyphilis       Other:       Congenital       PFD       Other:       Image: Charge Pend Done       Done         Other:       Other:       Other:       Other:       Image: Charge Pend Done       Image: Charge Pending Pind Pending       Image: Charge Pending Pind Pending       Image: Charge Pending Pind Pending       Ima		Autess		1060	Emeline Ave Blda F
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Month       Day       Year       ()       ()       Fax:       (831) 454-5049         Submitted by       Date Submitted       ()       ()       ()       ()       ()         SEXUALLY TRANSMITED DISEASES (STD)       Syphilis       Test Results       ()       <	DATE OF DEATH Telephone Number Fax Phone: (831) 454-4114				
Submitted by       Date Submitted (Month/Day/Year)       (Obtain additional forms from your local health department.)         SEXUALLY TRANSMITTED DISEASES (STD) Syphilis       Syphilis Test Results       VIRAL HEPATITIS       Pos       Neg       Pend Done         Secondary       Late latent > 1 year       Softward       WRR       Titer.       Hep A       anti-HAV IgM       Image: Imag	Month Day Year	( )	( )		. ,
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Secondary       Late (tertiary)       VDRL       Titer:       Image: Construction of the secondary of the sec			Syphilis Test Results	_	Pos Neg Pend Done
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Latent (unknown duration) CSF-VDRL: Pos Neg Chronic anti-HBc lgM I   Neurosyphilis Other: Other: anti-HBs I   Gonorrhea Chlamydia I Urethral/Cervical PID (Unknown Etiology) Acute PCR-HCV I   I Urethral/Cervical PID Other: Chacrooid Acute PCR-HCV I I   Other: Other: Other: Image: Status Other: Image: Status Image: Status Anti-Daty Image: Status Image: St					
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Outlet. Outlet.   STD TREATMENT INFORMATION   Treated (Drugs, Dosage, Route):   Date Treatment Initiated   Month   Day   Year   Unable to contact patient   Refured to:   Other:   Blood   Child care   Other:      Blood   Child care   Other:               Blood   Confirmed   Suspected   Infected, No Disease   Confirmed   Date Performed   Pending   Results:   mm   Not Dore   Site(s)   Pulmonary   Both               Date Performed   Date Perfor					PCR-HCV
Treated (Drugs, Dosage, Route):       Date Treatment Initiated       Will treat       Suspected Exposure Type         Month       Day       Year       Unable to contact patient       Blood       Other needle       Sexual       Household         Contact       Refused treatment       Refused treatment       Child care       Other needle       Sexual       Household         TUBERCULOSIS (TB)       Total       Referred to:       Child care       Other:       Total         Status       Mantoux TB Skin Test       Bacteriology       Month       Day       Year         Confirmed       Date Performed       Date Performed       Date Specimen Collected       Month       Day       Year         Bacteriology       Month       Day       Year       Date Specimen Collected       Month       Day       Year         Infected, No Disease       Pending       Results:       mm       Not Done       Source       Smear:       Pos       Neg       Pending       Not done         Site(s)       Date Performed       Date       Chier test(s)       Other test(s)       Other test(s)       Unable to contact patient         Both       Normal       Pending       Not done       Month       Refused treatment       Refused treatment <t< td=""><td></td><td></td><td></td><td></td><td></td></t<>					
Month       Day       Year       Unable to contact patient       Blood       Other needle       Sexual       Household         Blood       Other needle       Sexual       Contact       Contact       Contact       Contact         TUBERCULOSIS (TB)       T       Referred to:       Child care       Other:       Current Treatment         Confirmed       Suspected       Date Performed       Date Specimen Collected       Month       Day Year         Infected, No Disease       Pending       Results:       mm       Not Done       Source       Month       Day Year         Site(s)       Date Performed       Date Performed       Source       Source       Month       Day Year         Site(s)       Date Performed       Date Year       Other test(s)       Other test(s)       Other test(s)       Unable to contact patient         Pulmonary       Normal       Pending       Not done       Other test(s)       Other test(s)       Unable to contact patient         Both       Other       Cavitary       Abnormal/Noncavitary       Other test(s)       Pending       Not done       Performed					
Image: Status       Mantoux TB Skin Test       Bacteriology       TB TREATMENT INFORMATION         Image: Suspected       Month       Day       Year         Image: Suspected       Date Performed       Pending         Results:       mm       Not Done         Status       Convertor       Results:       mm         Results:       month       Day       Year         Site(s)       Date Performed       Source       Surce         Image: Status       Chest X-Ray       Month       Day       Year         Site(s)       Date Performed       Source       Surce       Initiated         Image: Pulmonary       Date Performed       Other test(s)       Other test(s)       Other test(s)         Both       Cavitary       Abnormal/Noncavitary       Abnormal/Noncavitary       Other test(s)       Image: Pulmonary	_) Treated (Drugs, Dosage			· ·	
TUBERCULOSIS (TB)       Mantoux TB Skin Test       Bacteriology         Active Disease       Month       Day       Year         Confirmed       Date Performed       Date Performed       Date Specimen Collected       INH       RIF       PZA         Infected, No Disease       Pending       Results:       mm       Not Done       Source       Date Specimen Collected       Date Treatment       Initiated       Date Treatment         Site(s)       Date Performed        Pos       Neg       Pending       Not done         Site(s)       Date Performed        Other test(s)        Other test(s)				transfusion e	xposure contact contact
Status       Mantoux TB Skin Test       Bacteriology         Active Disease       Month       Day       Year         Confirmed       Date Performed       Date Performed       Date Specimen Collected       Date Specimen Collected         Infected, No Disease       Pending       Source       Date Specimen Collected       Date Treatment         Results:       mm       Not Dow       Year         Chest X-Ray       Month       Day       Year         Site(s)       Date Performed       Source       Smear:       Pos       Neg       Pending       Not done         Pulmonary       Date Performed       Other test(s)       Other test(s)       Unable to contact patient         Both       Cavitary       Abnormal/Noncavitary       Pending       Not done       Refured to:			Referred to:	Child care	
Active Disease       Month       Day       Year         Confirmed       Date Performed       Date Performed       Date Specimen Collected       Date Specimen Collected         Infected, No Disease       Pending       North       Day       Year         Convertor       Results:       mm       Not Done       Source       Date Treatment         Site(s)       Date Performed       Source       Smear:       Pos       Neg       Pending       Not done         Site(s)       Date Performed       Source       Other test(s)       Other test(s)       Untreated       Will treat         Pulmonary       Date Performed       Normal       Pending       Not done       Month       Date Specimen Collected       Will treat         Both       Chest X-Ray       Month       Day       Year       Month       Day       Year		Mantoux TB Skin Test	Bacteriology		
Date Performed       Date Performed       Date Specimen Collected       Month       Day       Year         Infected, No Disease       Pending       Source       Date Treatment       Initiated       Initiated         Convertor       Results:       mm       Not Done       Source       Initiated       Initiated       Initiated         Site(s)       Date Performed       Image: Source       Source       Source       Image: Source			0,	h Day Year	
Infected, No Disease       Pending         Convertor       Results:mm Not Done         Reactor       Chest X-Ray       Month       Day       Year         Cluture:       Pos       Neg       Pending       Not done         Site(s)       Date Performed       Culture:       Pos       Neg       Pending       Not done         Pulmonary       Date Performed       Other test(s)       Other test(s)       Unable to contact patient         Both       Cavitary       Abnormal/Noncavitary       Other test(s)       Referred to:					
Convertor       Results:mmNot Done       Source       Initiated			Date Specimen Collected		
Chest X-Ray       Month       Day       Year       Culture:       Pos       Neg       Pending       Not done       Untreated         Site(s)       Date Performed       Image: Comparison of the pending			Source		
Site(s)       Date Performed       Image: Contract patient         Pulmonary       Date Performed       Other test(s)       Image: Contract patient         Extra-Pulmonary       Normal       Pending       Not done         Both       Cavitary       Abnormal/Noncavitary       Other test(s)       Image: Contract patient	Reactor				
Date Performed       Other test(s)       Unable to contact patient         Extra-Pulmonary       Normal       Pending       Not done         Both       Cavitary       Abnormal/Noncavitary       Main contact patient	Site(s)	Chest X-Ray Month Day Year	Culture: Pos Neg P	ending 🔲 Not done	
Extra-Pulmonary       Normal       Pending       Not done       Refused treatment         Both       Cavitary       Abnormal/Noncavitary       Referred to:		Date Performed	Other test(s)		
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DEWADD-3					

### 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 juridiction 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)]

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

- FAX  $\mathcal{O}$  = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
  - =All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

#### Acquired Immune Deficiency Syndrome (AIDS) FAX 0 🗵 Poliovirus Infection FAX (HIV infection only: see "Human Immunodeficiency Virus") (7) Psittacosis FAX FAX 🕜 🖂 O Fever Amebiasis 00 Anaplasmosis/Ehrlichiosis Rabies, Human or Animal 00 FAX Anthrax $\bigcirc$ $\boxtimes$ Relapsing Fever Avian Influenza (human) Rheumatic Fever, Acute $\bigcirc \bigcirc$ Rockv Mountain Spotted Fever FAX 🕜 🖂 Babesiosis Botulism (Infant, Foodborne, Wound) OORubella (German Measles) $\circ \circ$ Brucellosis Rubella Syndrome, Congenital FAX 🕜 🖂 Campylobacteriosis FAX Salmonellosis (Other than Typhoid Fever) Chancroid $\bigcirc \bigcirc$ Scombroid Fish Poisoning FAX 🕜 🖂 Chickenpox (only hospitalizations and deaths) © © Severe Acute Respiratory Syndrome (SARS) Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV) 00 Shiga toxin (detected in feces) $\circ \circ$ FΔY 0 🗵 Cholera Shiaellosis Ciguatera Fish Poisoning Ø O O O Smallpox (Variola) FAX $\bigcirc$ Staphylococcus aureus infection (only a case resulting in death or admission to an Coccidioidomycosis $\mathbf{X}$ FAX 🕜 🖂 Colorado Tick Fever intensive care unit of a person who has not been hospitalized or had surgery, dialysis, Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture) Encephalopathies (TSE) Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food FAX 🕜 🖂 Cryptosporidiosis FAX Cysticercosis or Taeniasis Handlers and Dairy Workers Only) O O FAX Denaue Syphilis $\circ \circ$ Diphtheria Tetanus O O Domoic Acid Poisoning (Amnesic Shellfish Poisoning) Toxic Shock Syndrome FAX 🕜 🖂 Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic FAX Trichinosis Escherichia coli: shiga toxin producing (STEC) including E. coli O157 FAX Tuberculosis OO© © † FAX 🖉 🖂 Foodborne Disease Tularemia Typhoid Fever, Cases and Carriers Giardiasis FAX Gonococcal Infections Typhus Fever FAX 🕐 🗷 Haemophilus influenzae invasive disease (report an incident FAX $\bigcirc$ $\boxtimes$ Vibrio Infections less than 15 years of age) $\bigcirc$ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) 00 Hantavirus Infections FAX Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash) Hemolytic Uremic Syndrome FAX 0 🗵 West Nile Virus (WNV) Infection 00 Hepatitis, Viral $\circ$ Yellow Fever Yersiniosis FAX 🕜 🖂 Hepatitis A FAX Hepatitis B (specify acute case or chronic) 00 OCCURRENCE of ANY UNUSUAL DISEASE Hepatitis C (specify acute case or chronic) 00 OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if Hepatitis D (Delta) institutional and/or open community. Hepatitis, other, acute Influenza deaths (report an incident of less than 18 years of age) HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20 Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome) Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person Legionellosis transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) Leprosy (Hansen Disease) available from the local health department. For completing HIV-specific reporting requirements, see Leptospirosis Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx FAX 🕜 🖂 Listeriosis Lyme Disease REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800-2812 and §2593(b) FAX 🕜 🖂 Disorders Characterized by Lapses of Consciousness (§2800-2812) Malaria Pesticide-related illness or injury (known or suspected cases)\*\* FAX 🕜 🖂 Measles (Rubeola) Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer FAX 🕖 🖂 O O Meningococcal Infections unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (§ 2593)\*\*\* Mumps Paralytic Shellfish Poisoning LOCALLY REPORTABLE DISEASES (If Applicable): OOPelvic Inflammatory Disease (PID) FAX 🕐 🖂 Pertussis (Whooping Cough) $\circ \circ$ Plague, Human or Animal

\* This form 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 and 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.ccccal.org.