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):
☐ White
☐ African American / Black
☐ Native American / Alaskan Native
☐ Other _____
☐ Asian / Pacific Islander
- ☐ Asian-Indian ☐ Japanese
- ☐ Cambodian ☐ Korean
- ☐ Chinese ☐ Laotian
- ☐ Filipino ☐ Samoan
- ☐ Hawaiian ☐ Other _____

Address (Street and number):

City/Town

State CA

Zip code

Home Telephone Number:

Work Telephone Number:

Gender:
☐ Male
☐ Female 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):

Date of Diagnosis (MM/DD/YYYY):

Date of Hospitalization (MM/DD/YYYY):

Date of Death (MM/DD/YYYY):

Health Care Provider:

Health Care Facility:

Address:

City:

Telephone:

FAX:

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, chancorid, chlamydia infections, gonorrhea, non-gonococcal urethritis, pelvic inflammatory disease, syphilis, or tuberculosis.

For HIV and AIDS: report to the HIV Epidemiology Program. Reporting information and forms are available by phone 213-351-8516 or at: www.publichealth.lacounty.gov/hiv/index.htm

For Pediatric AIDS: report to the Pediatric HIV/AIDS Reporting Program. Reporting information is available by calling 213-351-7319

For Tuberculosis: report cases and suspected cases to the TB Control Program within 24 hours of identification. Reporting information is available by phone 213-744-6160, or at www.publichealth.lacounty.gov/tb/index.htm Fax reports to: 213-744-0926.

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

REMARKS:

FAX THIS REPORT TO: 888-397-3778

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.

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