COUNTY OF LOS ANGELES
Public Health
313 N. Figueroa St., Rm. 117
Los Angeles, CA 90012
888-397-3993 (tel.)
888-397-3778 (fax.)

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 (check one below):
☐ Asian-Indian ☐ Japanese
☐ Cambodian ☐ Korean
☐ Chinese ☐ Laotian
☐ Filipino ☐ Samoan
☐ Hawaiian ☐ Other _____

Address (Street and number):

City/Town:

State:

Zip Code:

Home Telephone Number: ( )

Work Telephone Number: ( )

Gender:
☐ Male
☐ Female → Pregnant? ☐ Yes ☐ No ☐ Unknown
Estimated Delivery Date (MM/DD/YYYY): ___/___/___

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 ☐ Recreational water exposure
☐ Food / drink ☐ Sexual activity
☐ Foreign travel ☐ Unknown
☐ Household exposure ☐ Other (specify) _____

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 = _____				
PCR-HCV	☐	☐	☐	☐
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 HIV and AIDS : report to the HIV Epidemiology Program. Reporting information and forms are available by phone (213-351-8516) or at: www.lapublichealth.org/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.lapublichealth.org/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 available by phone (213-744-3070) or at: www.lapublichealth.org/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.