County of Los Angeles Public Health

Reset Form

COUNTY OF LOS ANGELES - DEPARTMENT OF PUBLIC HEALTH

REPORT PROCESSING UNIT

CONFIDENTIAL MORBIDITY REPORT

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

DISEASE BEING REPORTED:

DISTRICT CODE (internal use only):

Patient's Last Name:

Birthdate (MM/DD/YYYY):

Age:

First Name and Middle Name (or initial):

Address (Number, Street):

City/Town:

State:

ZIP Code:

Email Address:

At the time of positive test, admission, or clinic visit, patient resided in:

- ☐ Private residence ☐ Group home
- ☐ Worker housing ☐ Psychiatric facility
- ☐ Homeless shelter ☐ Unsheltered
- ☐ Homeless encampment
- ☐ School/university housing
- ☐ Drug rehab fac ☐ Longterm care fac
- ☐ Correctional/Detention
- ☐ Other: _____

Race or ethnicity? (select [or mark] all that apply)

- ☐ White
- ☐ Hispanic, Latino, or Spanish origin
- ☐ Black or African American
- ☐ Asian:
  - ☐ Asian Indian ☐ Korean
  - ☐ Cambodian ☐ Laotian
  - ☐ Chinese ☐ Thai
  - ☐ Filipino ☐ Vietnamese
  - ☐ Hmong ☐ Other: _____
  - ☐ Japanese
- ☐ American Indian or Alaskan Native
- ☐ Native Hawaiian or Other Pacific Islander:
  - ☐ Native Hawaiian
  - ☐ Guamanian ☐ Samoan
  - ☐ Other: _____
- ☐ Some other race; specify _____
- ☐ Refused
- ☐ Unknown

Home Telephone Number:

Cell Telephone Number:

Work Telephone Number:

Medical Record No.

Gender Identity (check one):

- ☐ Male ☐ Female ☐ Transgender Male/Trans Man
- ☐ Transgender Female/Trans Woman ☐ Gender Non-Binary/Non-conforming
- ☐ Another gender category or another identity: _____
- ☐ Prefer not to state

Sex at birth?

- ☐ Male ☐ Female
- ☐ Non-Binary or X
- ☐ Other: _____
- ☐ Prefer not to answer

Sexual Orientation (check one):

- ☐ Gay or Lesbian ☐ Bisexual ☐ Straight/Heterosexual ☐ Not sure
- ☐ Something else: _____ ☐ Don't understand the question
- ☐ Prefer not to State

Pregnant?

☐ Yes ☐ No ☐ Unk

Estimated Delivery Date:

Occupation or Job Title

Business/Industry

Patient's Occupation or Exposure Setting: (specify if indicated)

- ☐ Health care ☐ Day care ☐ Food service: _____
- ☐ Correctional facility ☐ School ☐ Other: _____

Risk Factors/Suspected Exposure Type:
(check all that apply)

- ☐ Blood Transfusion ☐ Needle Blood Exposure
- ☐ Child Care ☐ Household Exposure
- ☐ Food and Drink ☐ Sexual Contact
- ☐ Foreign Travel ☐ Recreational Water
- ☐ IV Drugs ☐ Unknown
- ☐ Other: _____

Date of Onset (MM/DD/YYYY):

Reporting Health Care Provider:

Date of Diagnosis (MM/DD/YYYY):

Reporting Health Care Facility:

Address (Number, Street):

Date of First Specimen Collection (MM/DD/YYYY):

City:

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

Date of Hospitalization (MM/DD/YYYY):

Telephone Number:

FAX Number:

Reporting information and forms are available via the following hyperlinks: 1) HIV/AIDS/STDs and 2) TB.

Date of Death (MM/DD/YYYY):

Submitted by:

Date CMR submitted (MM/DD/YYYY):

Hepatitis Diagnosis:

- ☐ Hep A, acute
- ☐ Hep B, acute
- ☐ Hep B, chronic
- ☐ Hep B, perinatal
- ☐ Hep C, acute
- ☐ Hep C, chronic
- ☐ Hep C, perinatal
- ☐ Hep D
- ☐ Hep E
- ☐ Other Hepatitis: _____

Elevated LFTs? ☐ No ☐ Yes
ALT: _____ AST: _____

Bilirubin result: _____

Jaundiced? ☐ No ☐ Yes

Symptoms? ☐ No ☐ Yes

Has patient been informed of hepatitis infection?
☐ No ☐ Yes ☐ Unk

Type of Hepatitis Testing (check all that apply):
(Attach test and liver function test results)

	Pos.	Neg.	Pend.	Not Done
anti-HAV IgM	☐	☐	☐	☐
HBsAg	☐	☐	☐	☐
anti-HBc (total)	☐	☐	☐	☐
anti-HBc IgM	☐	☐	☐	☐
anti-HBs	☐	☐	☐	☐
HBV DNA PCR	☐	☐	☐	☐
anti-HCV	☐	☐	☐	☐
HCV RNA PCR	☐	☐	☐	☐
anti-Delta	☐	☐	☐	☐
HDV PCR	☐	☐	☐	☐
Anti-HEV IgM	☐	☐	☐	☐
Other test	☐	☐	☐	☐

Specify: _____

If HCV RNA positive, was the patient linked to HCV care?
☐ No ☐ Yes: Date 1st visit to provider: _____
☐ Unk Treatment start date: _____

Diagnostic Test Type (non-hepatitis): **(Attach laboratory result)**

Type of Diagnostic Specimen: (check all that apply)
☐ Blood ☐ CSF ☐ Stool ☐ Urine ☐ Clinical ☐ No test
☐ Other: _____

Test Result:
☐ Pos ☐ Neg ☐ Not Done ☐ Other: _____

Laboratory Name:

City:

State:

Zip code:

To report a case of any disease, contact the Communicable Disease Reporting System
Tel: (888) 397-3993 or (213) 240-7821
Fax: (888) 397-3778 or (213) 482-5508
Send via Secure Email: rpu@ph.lacounty.gov
or Mail: Report Processing Unit, 313 N. Figueroa St., Room 117, Los Angeles, CA 90012.

REMARKS: