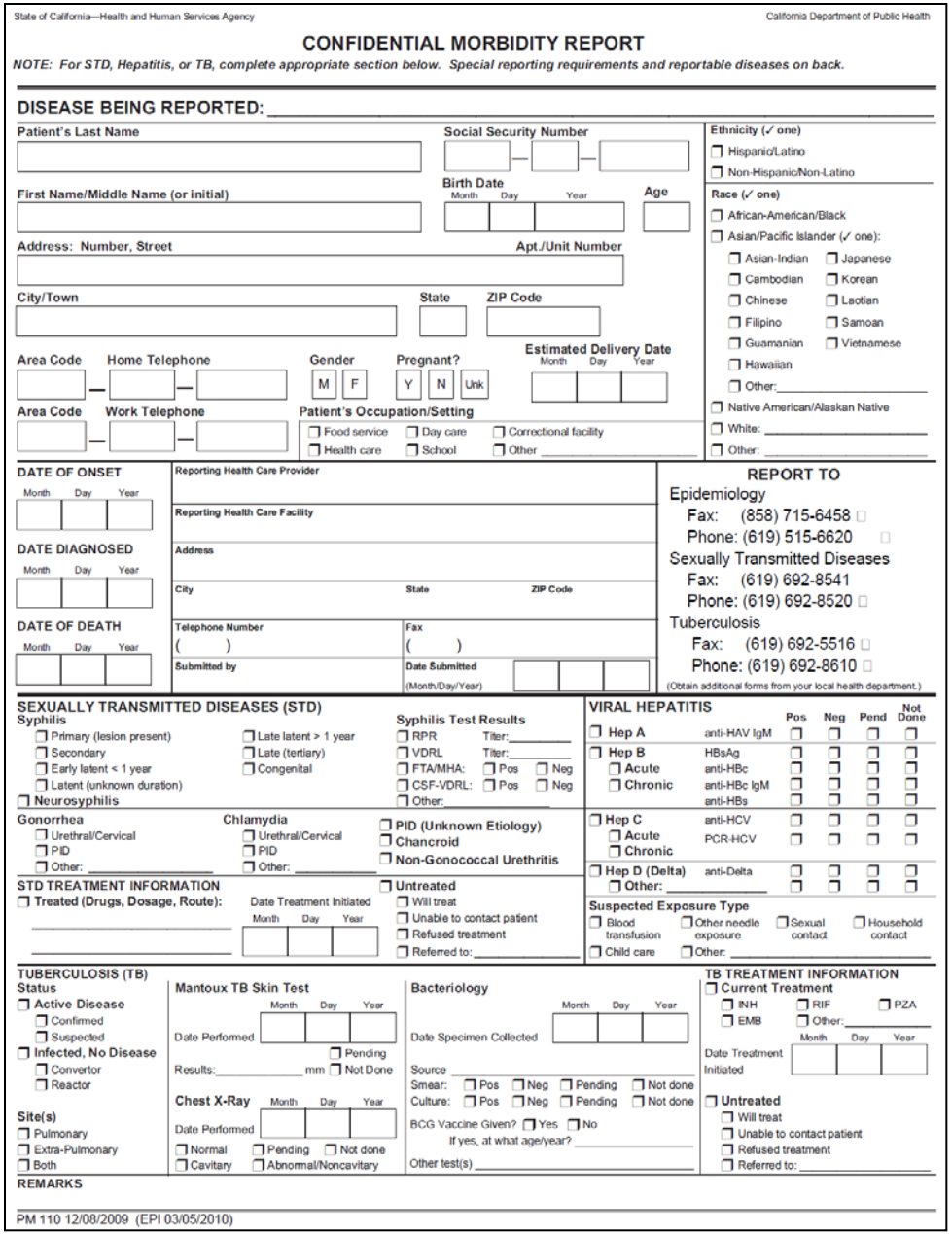
2011 Update to Confidential Morbidity Report for STD Reporting

COUNTY OF SAN DIEGO
HHSA
HEALTH AND HUMAN SERVICES AGENCY

Old Version of CMR



State of California—Health and Human Services Agency

California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

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

DISEASE BEING REPORTED: _____

Patient's Last Name

Social Security Number ___ — ___ — ____

First Name/Middle Name (or initial)

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

Epidemiology
Fax: (858) 715-6458 ☐
Phone: (619) 515-6620 ☐

Sexually Transmitted Diseases
Fax: (619) 692-8541
Phone: (619) 692-8520 ☐

Tuberculosis
Fax: (619) 692-5516 ☐
Phone: (619) 692-8610 ☐

(Obtain additional forms from your local health department.)

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

		Pos	Neg	Pend	Not Done
☐ Hep A	anti-HAV IgM	☐	☐	☐	☐
☐ Hep B	HBsAg	☐	☐	☐	☐
☐ Acute	anti-HBc	☐	☐	☐	☐
☐ Chronic	anti-HBc IgM	☐	☐	☐	☐
	anti-HBs	☐	☐	☐	☐
☐ Hep C	anti-HCV	☐	☐	☐	☐
☐ Acute ☐ Chronic	PCR-HCV	☐	☐	☐	☐
☐ Hep D (Delta)	anti-Delta	☐	☐	☐	☐
☐ Other: _____		☐	☐	☐	☐

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
  - ☐ Convertor
  - ☐ Reactor

Site(s)

- ☐ Pulmonary
- ☐ Extra-Pulmonary
- ☐ Both

Mantoux TB Skin Test

Date Performed Month Day Year

☐ Pending

Results: _____ mm ☐ Not Done

Chest X-Ray Month Day Year

Date Performed

☐ 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

BCG Vaccine Given? ☐ Yes ☐ No

If yes, at what age/year? _____

Other test(s) _____

TB TREATMENT INFORMATION

☐ **Current Treatment**

☐ INH ☐ RIF ☐ PZA
☐ EMB ☐ Other: _____

Date Treatment Initiated Month Day Year

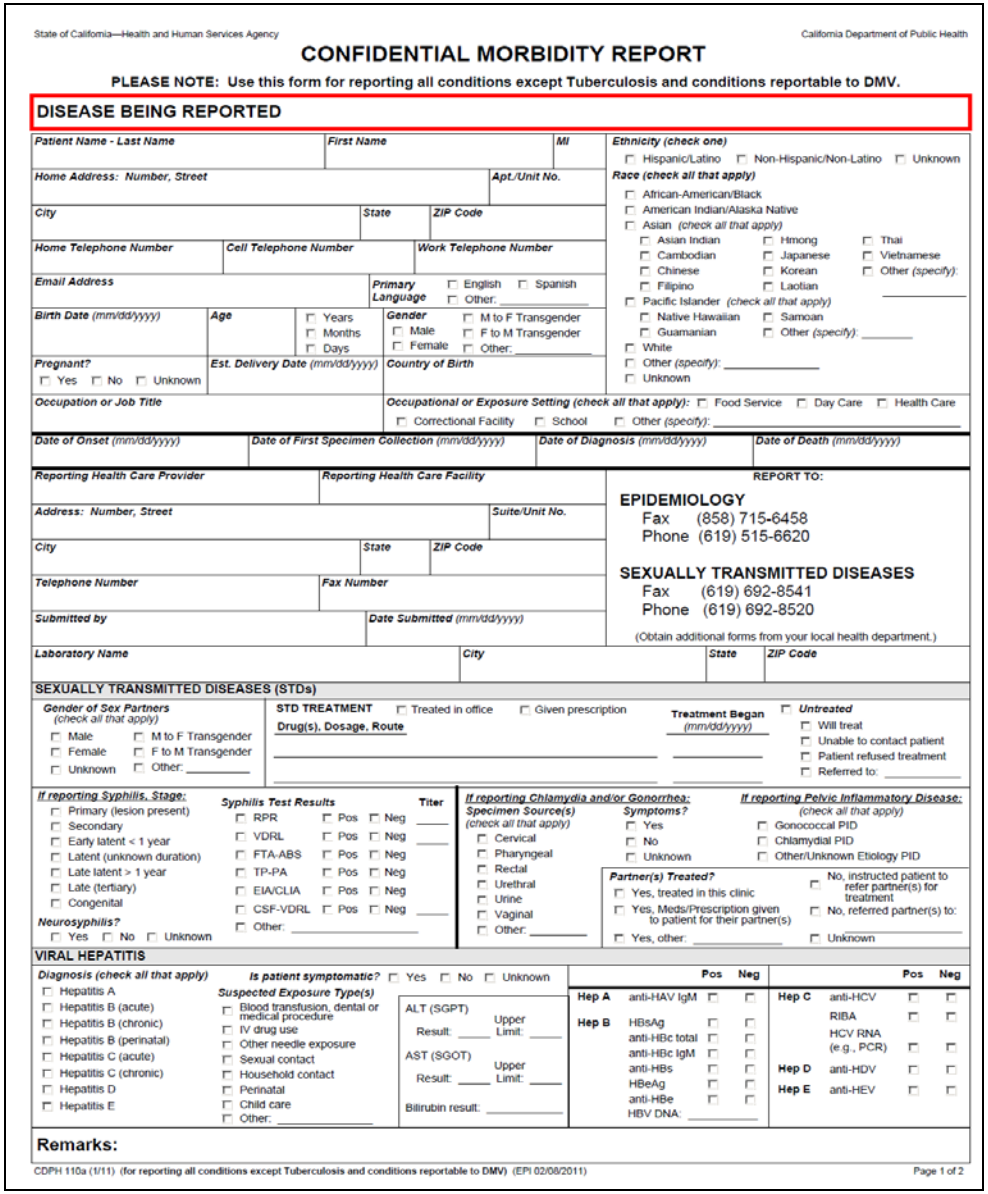
☐ **Untreated**

- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Refused treatment
- ☐ Referred to: _____

REMARKS

PM 110 12/08/2009 (EPI 03/05/2010)

New Version of CMR



State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian (check all that apply)
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other (specify): _____
☐ Filipino ☐ Laotian
☐ Pacific Islander (check all that apply)
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other (specify): _____
☐ White
☐ Other (specify): _____
☐ Unknown

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

REPORT TO:

EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 515-6620

SEXUALLY TRANSMITTED DISEASES
Fax (619) 692-8541
Phone (619) 692-8520

(Obtain additional forms from your local health department.)

Laboratory Name | City | State | ZIP Code

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | Treatment Began (mm/dd/yyyy)
☐ Untreated
☐ Will treat
☐ Unable to contact patient
☐ Patient refused treatment
☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | Titer
☐ RPR ☐ Pos ☐ Neg _____
☐ VDRL ☐ Pos ☐ Neg _____
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg _____
☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) (check all that apply)
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply)
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

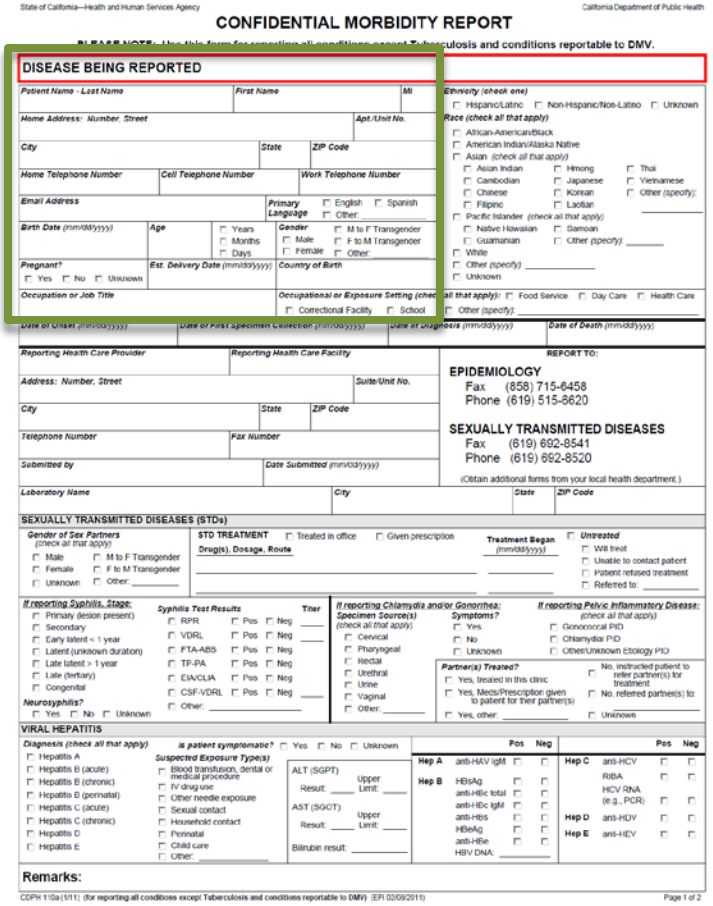
CDPH 110a (1/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 02/08/2011) — Page 1 of 2

Available on the County website at
http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CMRa.pdf

Changes to CMR 2011

- Additional/More Specific Information Regarding:
  - Patient Contact Information
  - Patient Demographics
  - Laboratory Information
  - Neurosyphilis
  - Patient STD Treatment Information
  - Chlamydia and Gonorrhea Symptoms and Site of Infection
  - Partner STD Treatment Information

Patient Contact Information



State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language ☐ English ☐ Spanish ☐ Other:

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other:

Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify):

Ethnicity (check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply): ☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian (check all that apply): ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other (specify): ☐ Pacific Islander (check all that apply): ☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other (specify): ☐ White ☐ Other (specify): ☐ Unknown

Date of Onset | Date of First Specimen Collection | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

Laboratory Name | City | State | ZIP Code

REPORT TO:

EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 515-8620

SEXUALLY TRANSMITTED DISEASES
Fax (619) 692-8541
Phone (619) 692-8520

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply): ☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other:

STD TREATMENT ☐ Treated in office ☐ Given prescription — Drug(s), Dosage, Route — Treatment Began (mm/dd/yyyy) — ☐ Untreated ☐ Will treat ☐ Unable to contact patient ☐ Patient refused treatment ☐ Referred to:

If reporting Syphilis, Stage: ☐ Primary (lesion present) ☐ Secondary ☐ Early latent < 1 year ☐ Latent (unknown duration) ☐ Late latent > 1 year ☐ Late (tertiary) ☐ Congenital — Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results: ☐ RPR ☐ VDRL ☐ FTA-ABS ☐ TP-PA ☐ EIA/CLIA ☐ CSF-VDRL ☐ Other: — Titer — ☐ Pos ☐ Neg

If reporting Chlamydia and/or Gonorrhea: Specimen Source(s) (check all that apply): ☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other: — Symptoms? ☐ Yes ☐ No ☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply) ☐ Gonococcal PID ☐ Chlamydial PID ☐ Other/Unknown Etiology PID

Partner(s) Treated? ☐ Yes, treated in this clinic ☐ Yes, Meds/Prescription given to patient for their partner(s) ☐ Yes, other: ☐ No, instructed patient to refer partner(s) for treatment ☐ No, referred partner(s) to: ☐ Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply): ☐ Hepatitis A ☐ Hepatitis B (acute) ☐ Hepatitis B (chronic) ☐ Hepatitis B (perinatal) ☐ Hepatitis C (acute) ☐ Hepatitis C (chronic) ☐ Hepatitis D ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

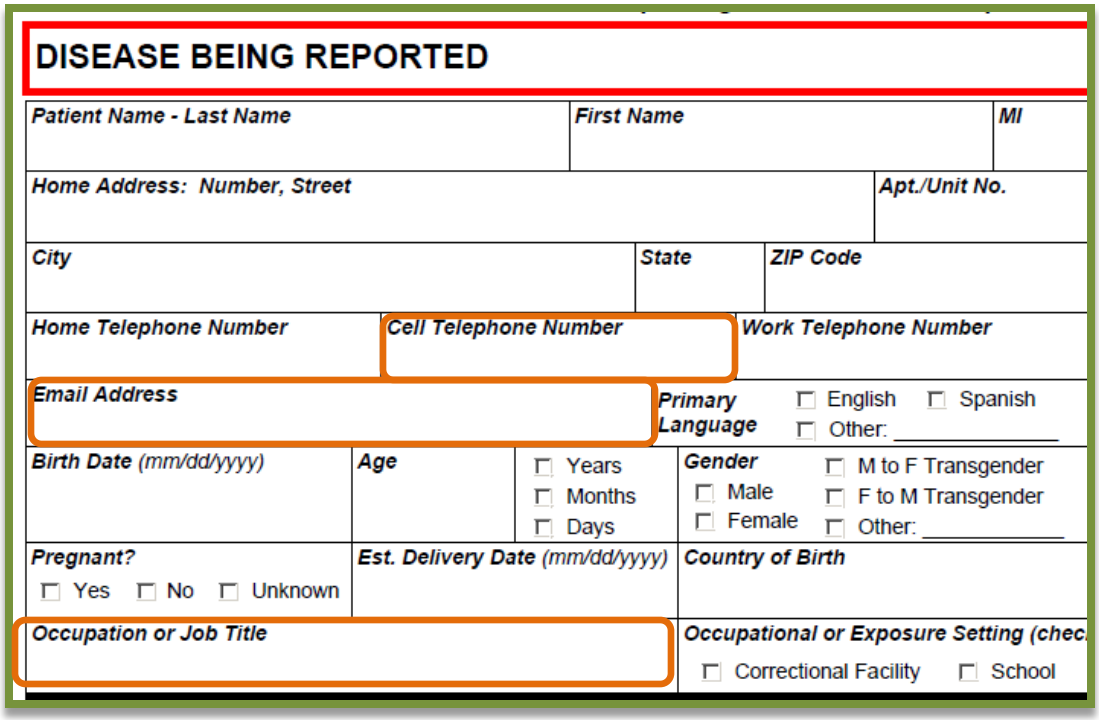
Suspected Exposure Type(s): ☐ Blood transfusion, dental or medical procedure ☐ IV drug use ☐ Other needle exposure ☐ Sexual contact ☐ Household contact ☐ Perinatal ☐ Child care ☐ Other:

ALT (SGPT) Result: Upper Limit: — AST (SGOT) Result: Upper Limit: — Bilirubin result:

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA:	☐	☐
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR):	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

CDPH 1102a (1/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 02/09/2011) — Page 1 of 2



DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language ☐ English ☐ Spanish ☐ Other:

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other:

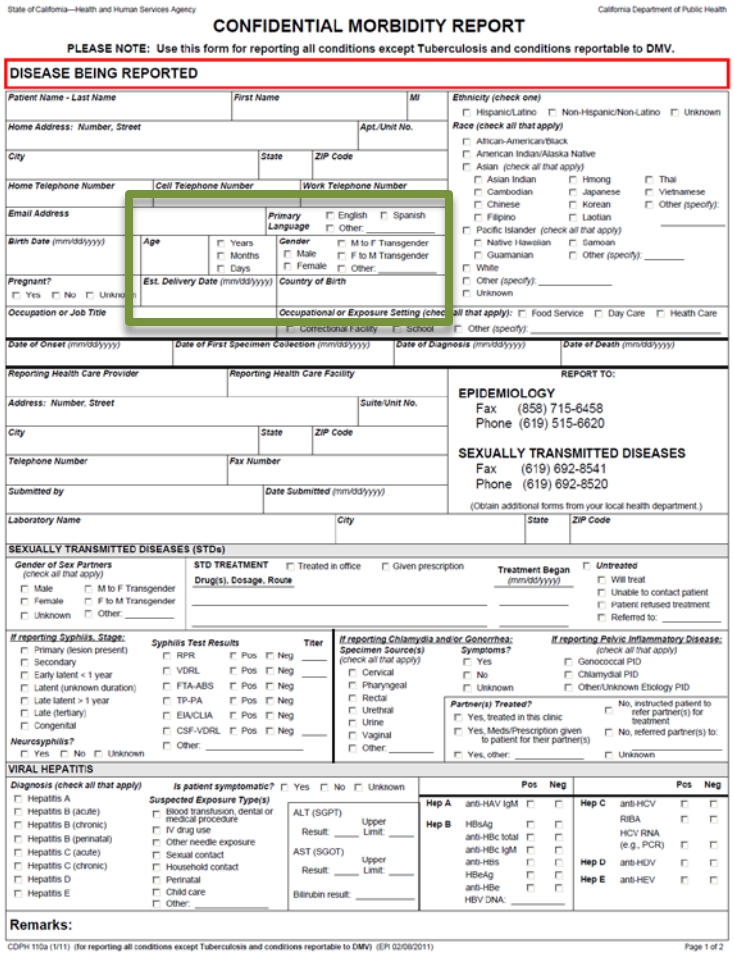
Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (chec ☐ Correctional Facility ☐ School

New Fields for

- Cell Telephone Number
- Email Address
- Occupation or Job Title

Patient Demographics



State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address

Primary Language ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply): ☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian (check all that apply) ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other (specify): _____ ☐ Pacific Islander (check all that apply) ☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other (specify): _____ ☐ White ☐ Other (specify): _____ ☐ Unknown

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

Laboratory Name | City | State | ZIP Code

REPORT TO:

EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 515-6620

SEXUALLY TRANSMITTED DISEASES
Fax (619) 692-8541
Phone (619) 692-8520

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply): ☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription — Drug(s), Dosage, Route — Treatment Began (mm/dd/yyyy) — ☐ Untreated ☐ Will treat ☐ Unable to contact patient ☐ Patient refused treatment ☐ Referred to: _____

If reporting Syphilis, Stage: ☐ Primary (lesion present) ☐ Secondary ☐ Early latent < 1 year ☐ Latent (unknown duration) ☐ Late latent > 1 year ☐ Late (tertiary) ☐ Congenital — Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | Titer: ☐ RPR ☐ VDRL ☐ FTA-ABS ☐ TP-PA ☐ EIA/CLIA ☐ CSF-VDRL ☐ Other: _____ (each: ☐ Pos ☐ Neg)

If reporting Chlamydia and/or Gonorrhea: Specimen Source(s) (check all that apply): ☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other: _____

Symptoms? ☐ Yes ☐ No ☐ Unknown

Partner(s) Treated? ☐ Yes, treated in this clinic ☐ Yes, Meds/Prescription given to patient for their partner(s) ☐ Yes, other: _____ ☐ No, instructed patient to refer partner(s) for treatment ☐ No, referred partner(s) to: _____ ☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply) ☐ Gonococcal PID ☐ Chlamydial PID ☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply): ☐ Hepatitis A ☐ Hepatitis B (acute) ☐ Hepatitis B (chronic) ☐ Hepatitis B (perinatal) ☐ Hepatitis C (acute) ☐ Hepatitis C (chronic) ☐ Hepatitis D ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s): ☐ Blood transfusion, dental or medical procedure ☐ IV drug use ☐ Other needle exposure ☐ Sexual contact ☐ Household contact ☐ Perinatal ☐ Child care ☐ Other: _____

ALT (SGPT) Result: ____ Upper Limit: ____

AST (SGOT) Result: ____ Upper Limit: ____

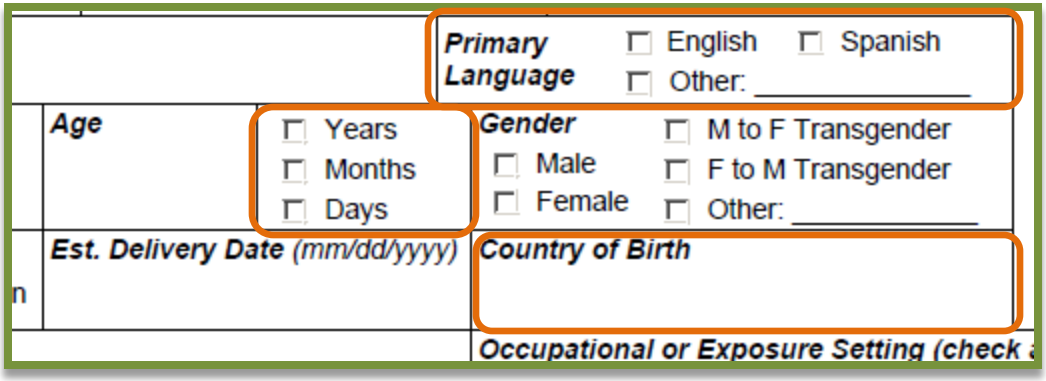
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-Hbs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA:		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

CDPH 110a (1/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 02/08/2011) — Page 1 of 2



Primary Language ☐ English ☐ Spanish ☐ Other: _____

Age ☐ Years ☐ Months ☐ Days

Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Est. Delivery Date (mm/dd/yyyy)

Country of Birth

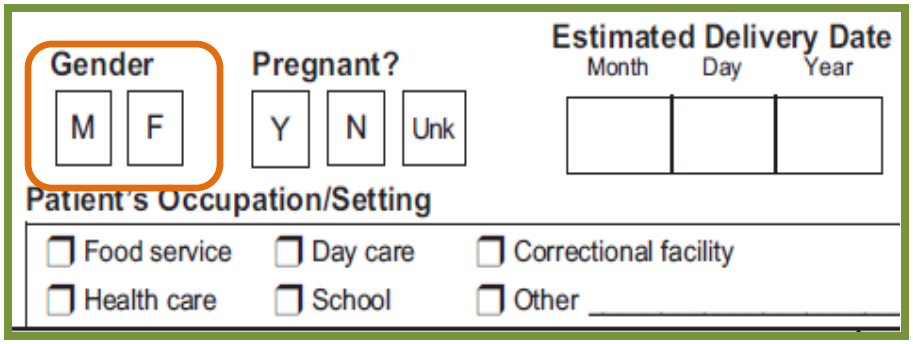
Occupational or Exposure Setting (check

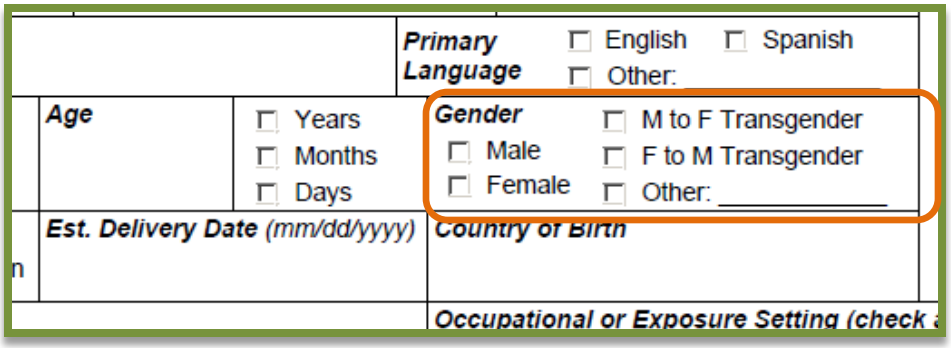
New Fields for

- Primary Language
- Age – specify if in years, months, days
- Country of Birth

Patient Demographics

Old CMR vs. New CMR





Expanded options for "Gender" to include:

- M to F Transgender
- F to M Transgender
- Other, with space to describe

Patient Demographics

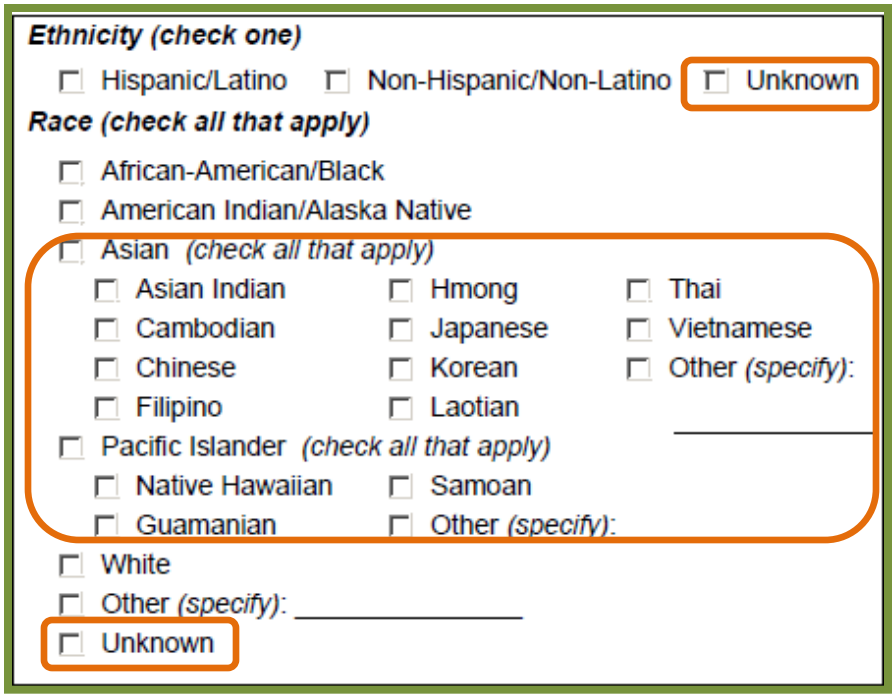
Old CMR vs. New CMR

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: _____



Ethnicity (check one)

☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

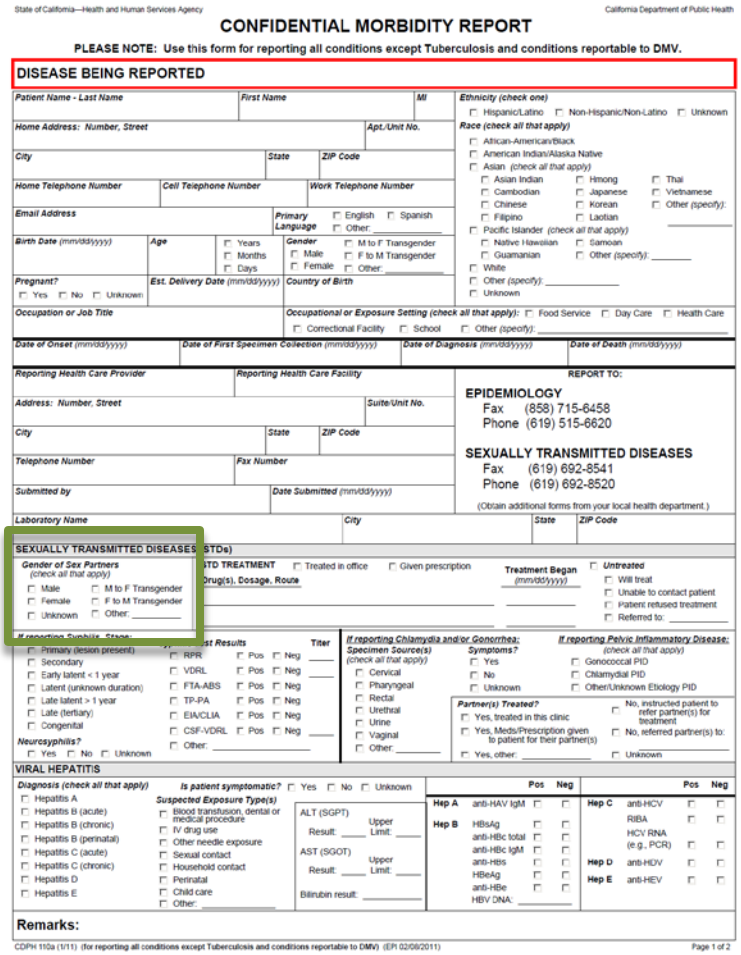
Race (check all that apply)

- ☐ African-American/Black
- ☐ American Indian/Alaska Native
- ☐ Asian *(check all that apply)*
  - ☐ Asian Indian ☐ Hmong ☐ Thai
  - ☐ Cambodian ☐ Japanese ☐ Vietnamese
  - ☐ Chinese ☐ Korean ☐ Other *(specify)*:
  - ☐ Filipino ☐ Laotian _____
- ☐ Pacific Islander *(check all that apply)*
  - ☐ Native Hawaiian ☐ Samoan
  - ☐ Guamanian ☐ Other *(specify)*:
- ☐ White
- ☐ Other *(specify)*: _____
- ☐ Unknown

Expanded options for "Race" and "Ethnicity":

- Ethnicity – addition of "Unknown"
- Race
  - Separation of Asian and Pacific Islander
  - Additional options listed
  - Check all that apply rather than only one

Patient Demographics



State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language ☐ English ☐ Spanish ☐ Other:

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other:

Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify):

Ethnicity (check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply): ☐ African-American/Black ☐ American Indian/Alaska Native ☐ Asian (check all that apply) ☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other (specify): ☐ Pacific Islander (check all that apply) ☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other (specify): ☐ White ☐ Other (specify): ☐ Unknown

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

Laboratory Name | City | State | ZIP Code

REPORT TO:

EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 515-6620

SEXUALLY TRANSMITTED DISEASES
Fax (619) 692-8541
Phone (619) 692-8520

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply): ☐ Male ☐ M to F Transgender ☐ Female ☐ F to M Transgender ☐ Unknown ☐ Other:

STD TREATMENT ☐ Treated in office ☐ Given prescription — Drug(s), Dosage, Route — Treatment Began (mm/dd/yyyy) — ☐ Untreated ☐ Will treat ☐ Unable to contact patient ☐ Patient refused treatment ☐ Referred to:

If reporting Syphilis, Stage: ☐ Primary (lesion present) ☐ Secondary ☐ Early latent < 1 year ☐ Latent (unknown duration) ☐ Late latent > 1 year ☐ Late (tertiary) ☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Test Results: ☐ RPR ☐ VDRL ☐ FTA-ABS ☐ TP-PA ☐ EIA/CLIA ☐ CSF-VDRL ☐ Other: — ☐ Pos ☐ Neg — Titer

If reporting Chlamydia and/or Gonorrhea: Specimen Source(s) (check all that apply): ☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other:

Symptoms? ☐ Yes ☐ No ☐ Unknown

Partner(s) Treated? ☐ Yes, treated in this clinic ☐ Yes, Meds/Prescription given to patient for their partner(s) ☐ Yes, other: ☐ No, instructed patient to refer partner(s) for treatment ☐ No, referred partner(s) to: ☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply) ☐ Gonococcal PID ☐ Chlamydial PID ☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply): ☐ Hepatitis A ☐ Hepatitis B (acute) ☐ Hepatitis B (chronic) ☐ Hepatitis B (perinatal) ☐ Hepatitis C (acute) ☐ Hepatitis C (chronic) ☐ Hepatitis D ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s): ☐ Blood transfusion, dental or medical procedure ☐ IV drug use ☐ Other needle exposure ☐ Sexual contact ☐ Household contact ☐ Perinatal ☐ Child care ☐ Other:

ALT (SGPT) Result: — Upper Limit:

AST (SGOT) Result: — Upper Limit:

Bilirubin result:

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-Hbs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA:		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

CDPH 110a (1/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 02/08/2011) — Page 1 of 2

SEXUALLY TRANSMITTED DISEASES

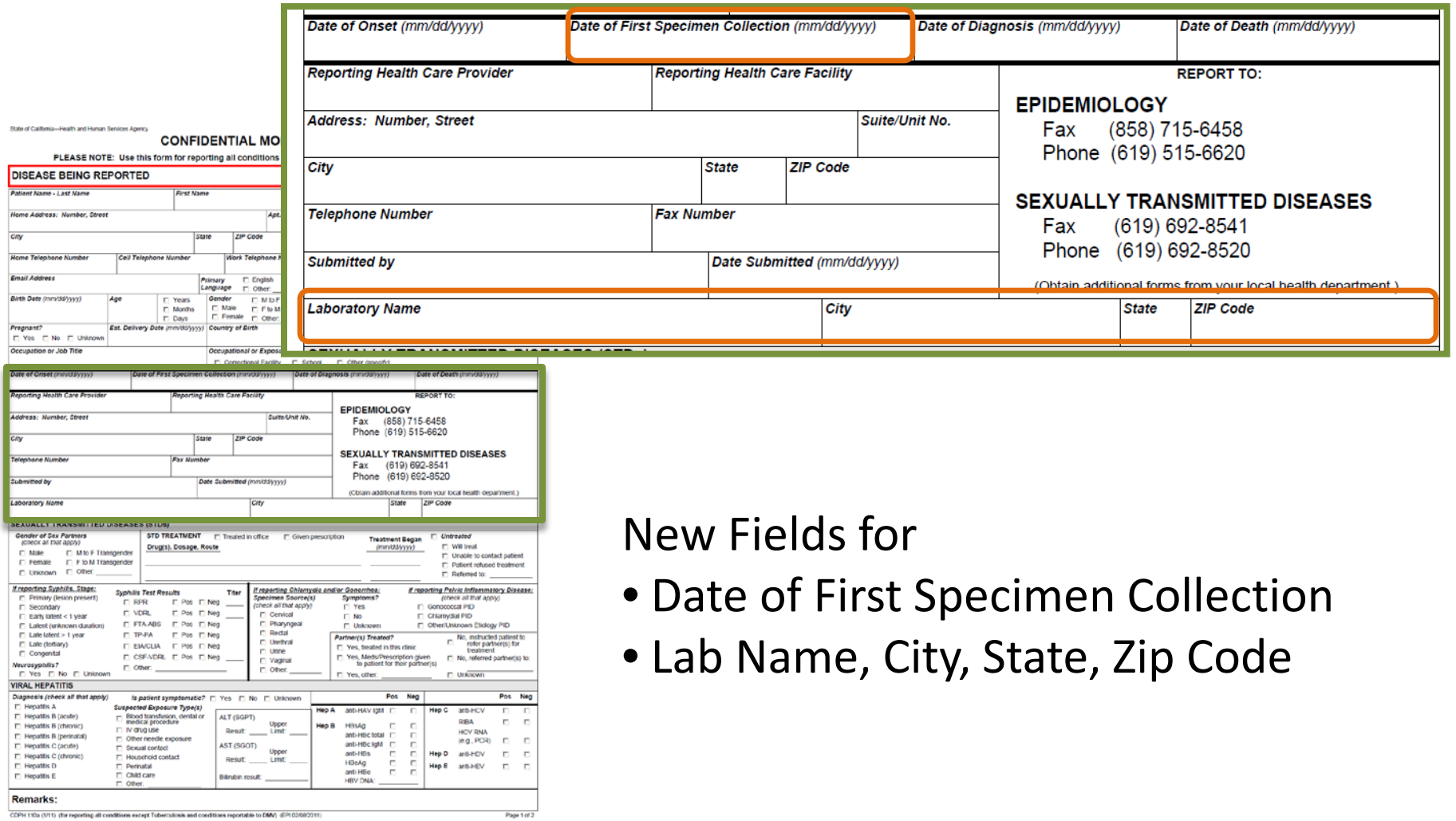
Gender of Sex Partners
(check all that apply)

- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ M to F Transgender
- ☐ F to M Transgender
- ☐ Other: _____

New Fields for

- Gender of Sex Partners
  - Under STD-specific section

Laboratory Information



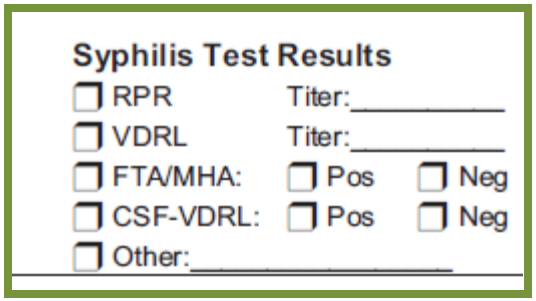
Date of Onset (mm/dd/yyyy)	Date of First Specimen Collection (mm/dd/yyyy)	Date of Diagnosis (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
Reporting Health Care Provider	Reporting Health Care Facility	REPORT TO:	
Address: Number, Street	Suite/Unit No.	EPIDEMIOLOGY Fax (858) 715-6458 Phone (619) 515-6620	
City	State / ZIP Code	SEXUALLY TRANSMITTED DISEASES Fax (619) 692-8541 Phone (619) 692-8520	
Telephone Number	Fax Number	(Obtain additional forms from your local health department.)	
Submitted by	Date Submitted (mm/dd/yyyy)		
Laboratory Name	City	State	ZIP Code

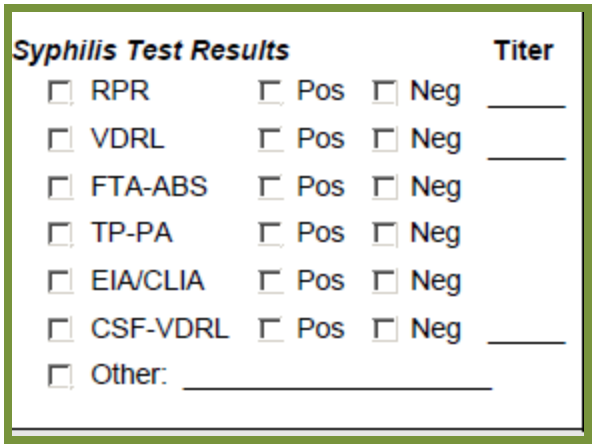
New Fields for

- Date of First Specimen Collection
- Lab Name, City, State, Zip Code

Laboratory Information - Syphilis

Old CMR vs. New CMR

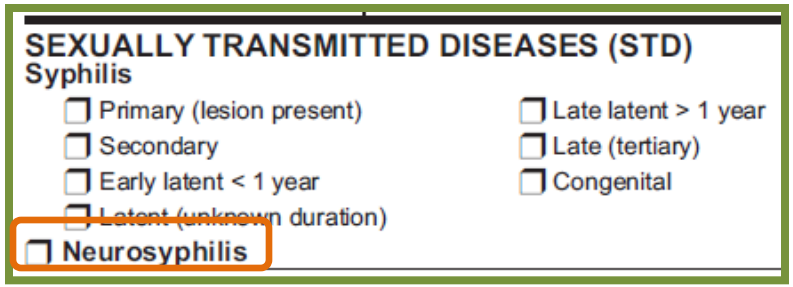


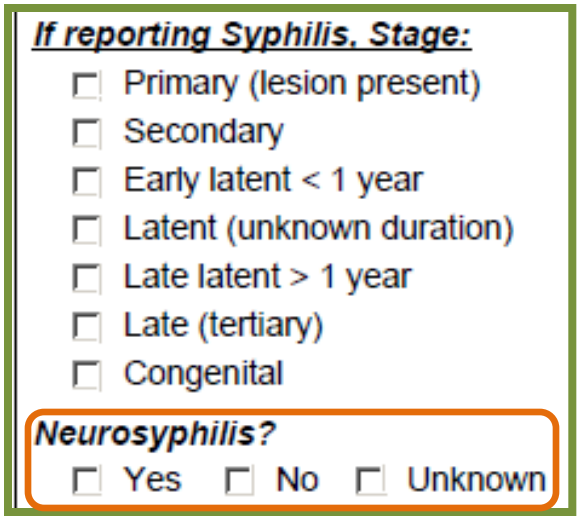


Expanded test types/results for syphilis

Neurosyphilis

Old CMR vs. New CMR

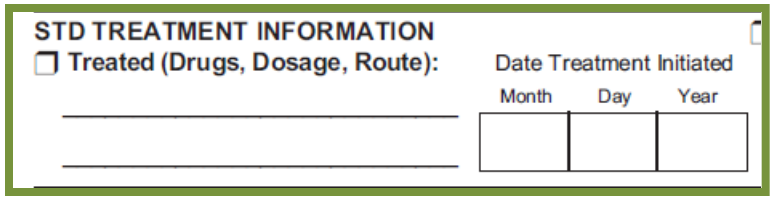


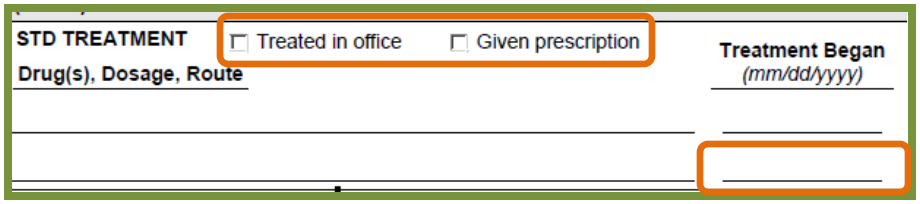


Rather than a single checkbox for neurosyphilis, provider is to indicate as Yes, No or Unknown

Patient Treatment Information

Old CMR vs. New CMR

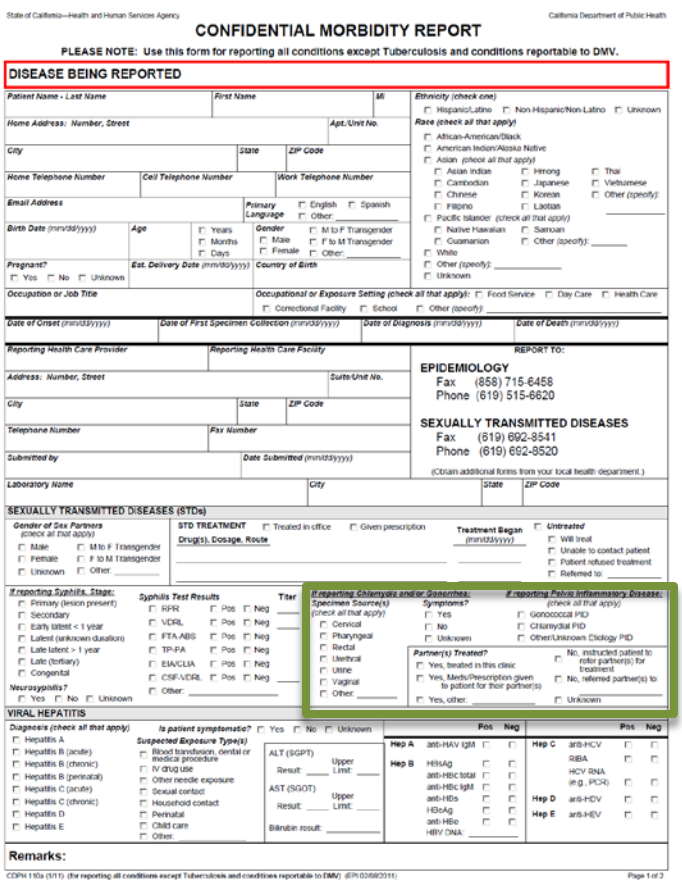




New Fields for

- Treated in office vs. Given prescription
- Additional line for second treatment date

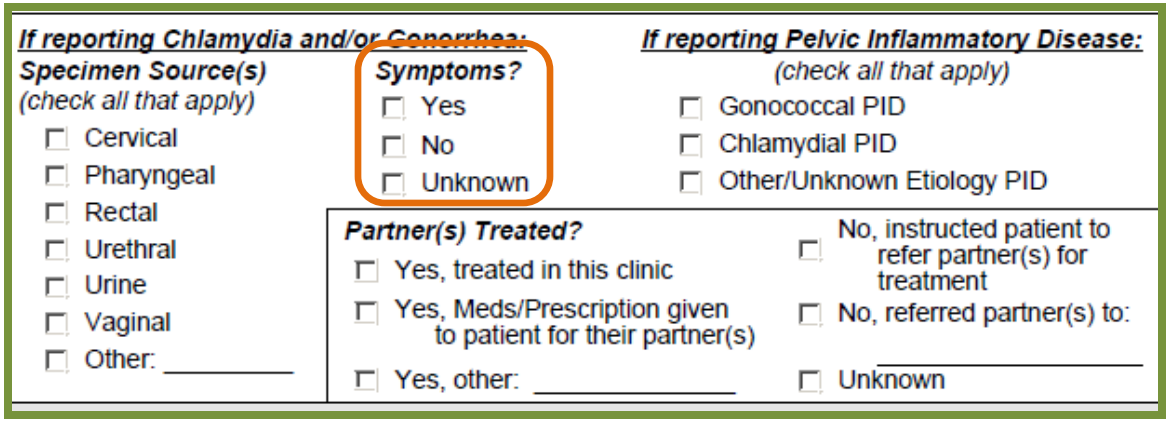
CT/GC Symptoms



CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED



If reporting Chlamydia and/or Gonorrhea:

Specimen Source(s)
(check all that apply)

- ☐ Cervical
- ☐ Pharyngeal
- ☐ Rectal
- ☐ Urethral
- ☐ Urine
- ☐ Vaginal
- ☐ Other: _____

Symptoms?

- ☐ Yes
- ☐ No
- ☐ Unknown

Partner(s) Treated?

- ☐ Yes, treated in this clinic
- ☐ Yes, Meds/Prescription given to patient for their partner(s)
- ☐ Yes, other: _____
- ☐ No, instructed patient to refer partner(s) for treatment
- ☐ No, referred partner(s) to: _____
- ☐ Unknown

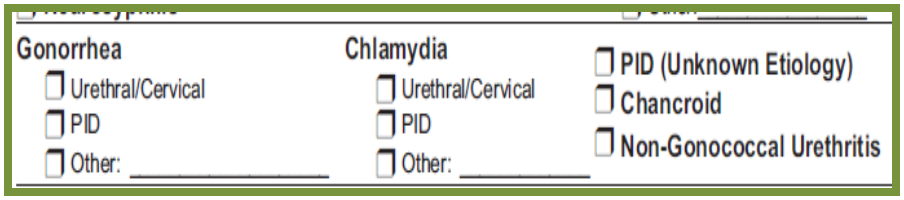
If reporting Pelvic Inflammatory Disease:
(check all that apply)

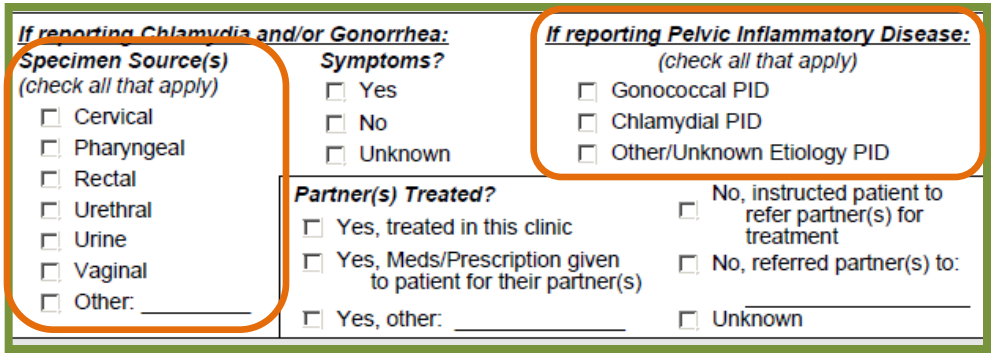
- ☐ Gonococcal PID
- ☐ Chlamydial PID
- ☐ Other/Unknown Etiology PID

New fields for Chlamydia/Gonorrhea symptoms

CT/GC Site of Infection

Old CMR vs. New CMR



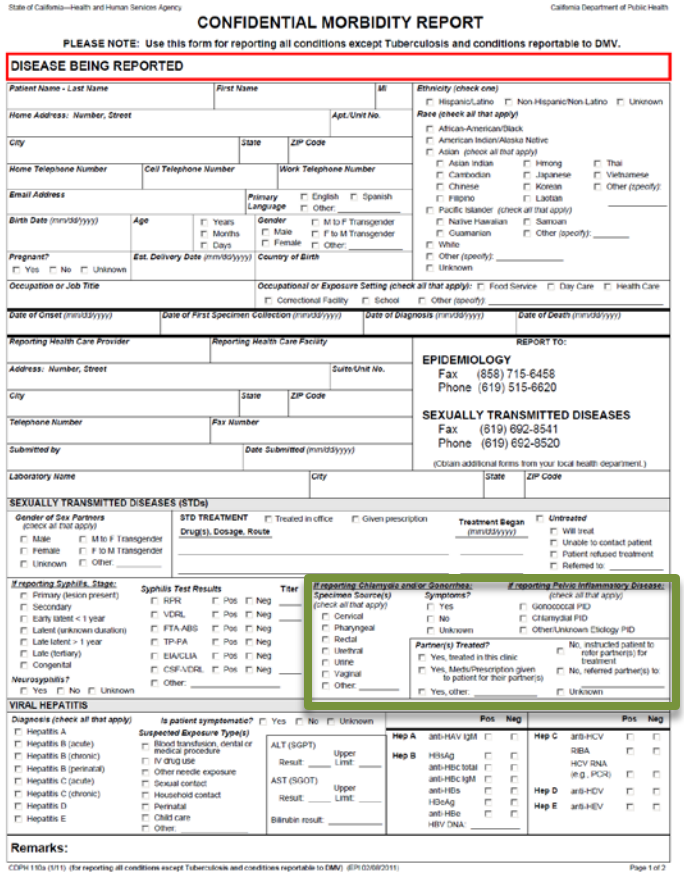


Expanded Chlamydia/Gonorrhea Specimen Source

- Separated out Urethral and Cervical
- Additional Choices
- Only indicate specimens with positive results

Separated out PID infection

Partner Treatment Information



State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language: English, Spanish, Other:

Birth Date (mm/dd/yyyy) | Age: Years, Months, Days | Gender: Male, Female, M to F Transgender, F to M Transgender, Other:

Pregnant? Yes, No, Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): Food Service, Day Care, Health Care, Correctional Facility, School, Other (specify):

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

Laboratory Name | City | State | ZIP Code

Ethnicity (check one): Hispanic/Latino, Non-Hispanic/Non-Latino, Unknown

Race (check all that apply): African-American/Black; American Indian/Alaska Native; Asian (check all that apply): Asian Indian, Cambodian, Chinese, Filipino, Hmong, Japanese, Korean, Laotian, Thai, Vietnamese, Other (specify):; Pacific Islander (check all that apply): Native Hawaiian, Guamanian, Samoan, Other (specify):; White; Other (specify):; Unknown

REPORT TO:

EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 515-6620

SEXUALLY TRANSMITTED DISEASES
Fax (619) 692-8541
Phone (619) 692-8520

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply): Male, Female, Unknown, M to F Transgender, F to M Transgender, Other:

STD TREATMENT: Treated in office, Given prescription | Drug(s), Dosage, Route | Treatment Began (mm/dd/yyyy) | Untreated: Will treat, Unable to contact patient, Patient refused treatment, Referred to:

If reporting Syphilis, Stage: Primary (lesion present), Secondary, Early latent < 1 year, Latent (unknown duration), Late latent > 1 year, Late (tertiary), Congenital

Neurosyphilis? Yes, No, Unknown

Syphilis Test Results | Titer

RPR	Pos	Neg	
VDRL	Pos	Neg	
FTA-ABS	Pos	Neg	
TP-PA	Pos	Neg	
EIA/CLIA	Pos	Neg	
CSF-VDRL	Pos	Neg	
Other:			

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) (check all that apply): Cervical, Pharyngeal, Rectal, Urethral, Urine, Vaginal, Other:
Symptoms? Yes, No, Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply) Gonococcal PID, Chlamydial PID, Other/Unknown Etiology PID

Partner(s) Treated? Yes, treated in this clinic; Yes, Meds/Prescription given to patient for their partner(s); Yes, other:; No, instructed patient to refer partner(s) for treatment; No, referred partner(s) to:; Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply): Hepatitis A, Hepatitis B (acute), Hepatitis B (chronic), Hepatitis B (perinatal), Hepatitis C (acute), Hepatitis C (chronic), Hepatitis D, Hepatitis E

Is patient symptomatic? Yes, No, Unknown

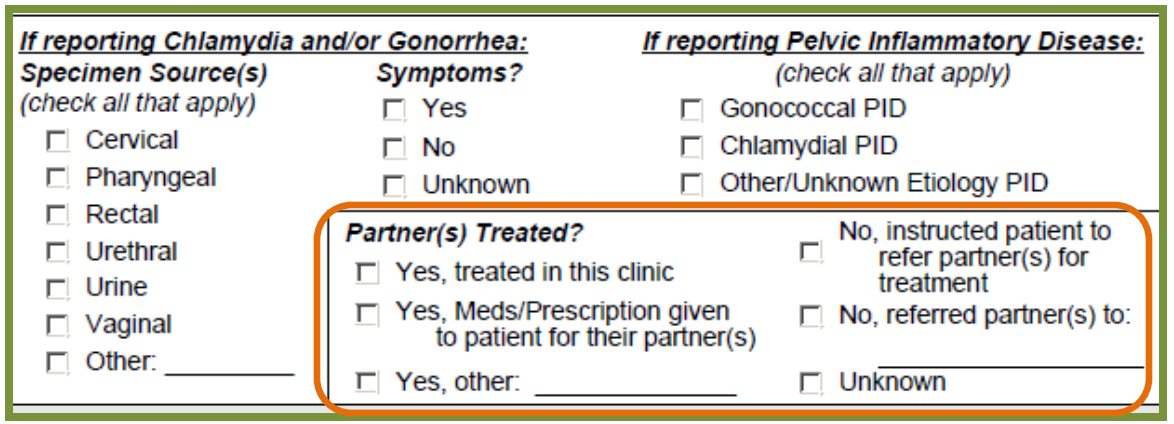
Suspected Exposure Type(s): Blood transfusion, dental or medical procedure; IV drug use; Other needle exposure; Sexual contact; Household contact; Perinatal; Child care; Other:

ALT (SGPT) Result: Upper Limit:
AST (SGOT) Result: Upper Limit:
Bilirubin result:

		Pos	Neg
Hep A	anti-HAV IgM		
Hep B	HBsAg		
	anti-HBc total		
	anti-HBc IgM		
	anti-HBs		
	HBeAg		
	anti-HBe		
	HBV DNA:		
Hep C	anti-HCV		
	RIBA		
	HCV RNA (e.g., PCR)		
Hep D	anti-HDV		
Hep E	anti-HEV		

Remarks:

CDPH 110a (5/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 02/08/2011) — Page 1 of 2



If reporting Chlamydia and/or Gonorrhea:

Specimen Source(s)
(check all that apply)
- ☐ Cervical
- ☐ Pharyngeal
- ☐ Rectal
- ☐ Urethral
- ☐ Urine
- ☐ Vaginal
- ☐ Other: _____

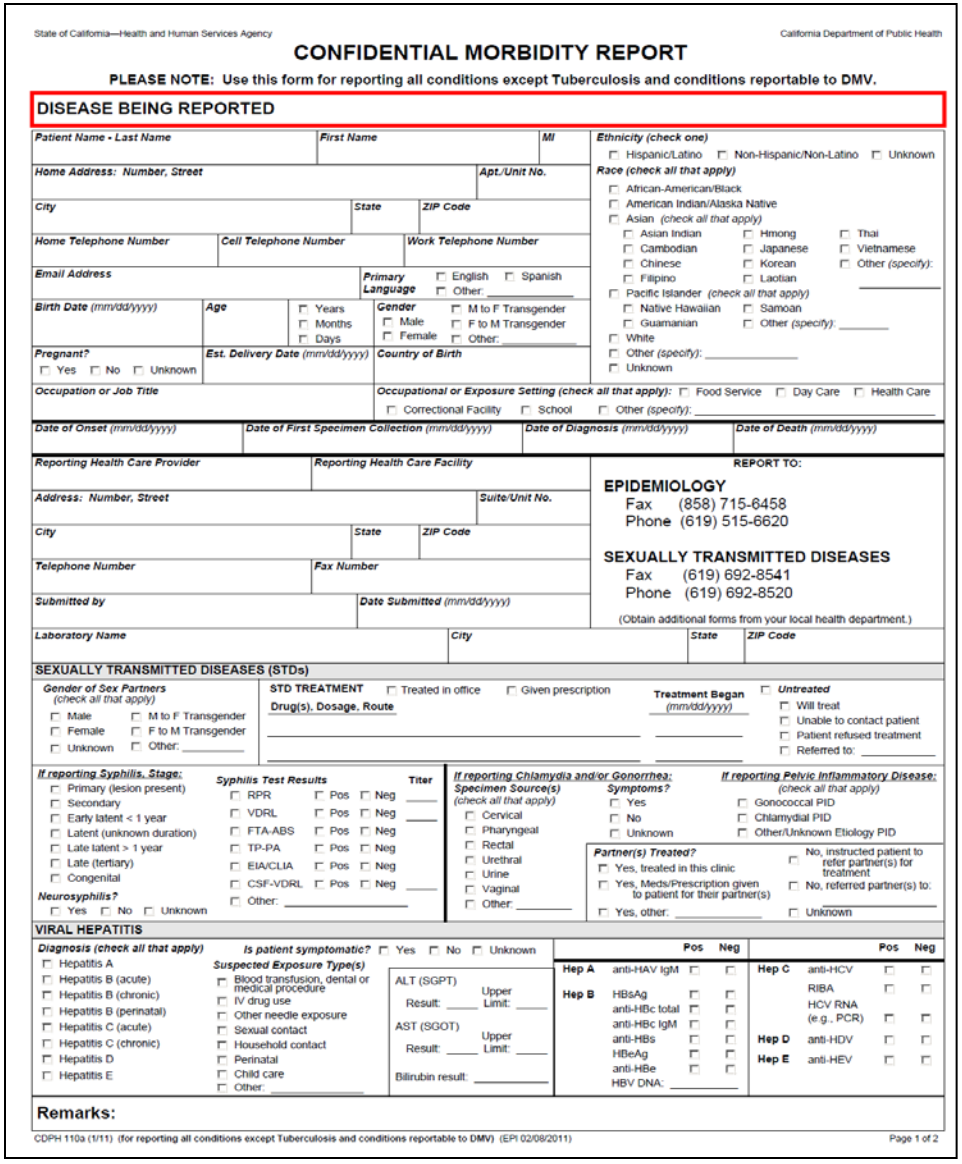
Symptoms?
- ☐ Yes
- ☐ No
- ☐ Unknown

If reporting Pelvic Inflammatory Disease:
(check all that apply)
- ☐ Gonococcal PID
- ☐ Chlamydial PID
- ☐ Other/Unknown Etiology PID

Partner(s) Treated?
- ☐ Yes, treated in this clinic
- ☐ Yes, Meds/Prescription given to patient for their partner(s)
- ☐ Yes, other: _____
- ☐ No, instructed patient to refer partner(s) for treatment
- ☐ No, referred partner(s) to: _____
- ☐ Unknown

New fields for partner treatment

Reminder: Disease Being Reported



State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI

Home Address: Number, Street | Apt./Unit No.

City | State | ZIP Code

Home Telephone Number | Cell Telephone Number | Work Telephone Number

Email Address | Primary Language ☐ English ☐ Spanish ☐ Other: _____

Birth Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth

Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply):
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian (check all that apply)
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other (specify): _____
☐ Filipino ☐ Laotian
☐ Pacific Islander (check all that apply)
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other (specify): _____
☐ White
☐ Other (specify): _____
☐ Unknown

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy) | Date of Death (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility

Address: Number, Street | Suite/Unit No.

City | State | ZIP Code

Telephone Number | Fax Number

Submitted by | Date Submitted (mm/dd/yyyy)

Laboratory Name | City | State | ZIP Code

REPORT TO:

EPIDEMIOLOGY
Fax (858) 715-6458
Phone (619) 515-6620

SEXUALLY TRANSMITTED DISEASES
Fax (619) 692-8541
Phone (619) 692-8520

(Obtain additional forms from your local health department.)

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply): ☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route _____ Treatment Began (mm/dd/yyyy) _____
☐ Untreated ☐ Will treat ☐ Unable to contact patient ☐ Patient refused treatment ☐ Referred to: _____

If reporting Syphilis, Stage: ☐ Primary (lesion present) ☐ Secondary ☐ Early latent < 1 year ☐ Latent (unknown duration) ☐ Late latent > 1 year ☐ Late (tertiary) ☐ Congenital
Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | Titer
☐ RPR ☐ Pos ☐ Neg
☐ VDRL ☐ Pos ☐ Neg
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg
☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) (check all that apply): ☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other: _____
Symptoms? ☐ Yes ☐ No ☐ Unknown
Partner(s) Treated? ☐ Yes, treated in this clinic ☐ Yes, Meds/Prescription given to patient for their partner(s) ☐ Yes, other: _____ ☐ No, instructed patient to refer partner(s) for treatment ☐ No, referred partner(s) to: _____ ☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply) ☐ Gonococcal PID ☐ Chlamydial PID ☐ Other/Unknown Etiology PID

VIRAL HEPATITIS

Diagnosis (check all that apply): ☐ Hepatitis A ☐ Hepatitis B (acute) ☐ Hepatitis B (chronic) ☐ Hepatitis B (perinatal) ☐ Hepatitis C (acute) ☐ Hepatitis C (chronic) ☐ Hepatitis D ☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s): ☐ Blood transfusion, dental or medical procedure ☐ IV drug use ☐ Other needle exposure ☐ Sexual contact ☐ Household contact ☐ Perinatal ☐ Child care ☐ Other: _____

ALT (SGPT) Result: ____ Upper Limit: ____
AST (SGOT) Result: ____ Upper Limit: ____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

CDPH 110a (1/11) (for reporting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 02/08/2011) — Page 1 of 2

Remember to <u>enter the disease being reported</u> at the top of the form. This field is now highlighted in red.

Fill out a separate CMR for <u>each</u> disease reported.

Available on the County website at
http://www.sdcounty.ca.gov/hhsa/programs/phs/documents/CMRa.pdf

STD Reporting Information

- STD Reporting Time Frames
  - Report syphilis cases, including suspected cases, within 1 working day of identification
    - Suspected cases: a presumption of syphilis based on presentation of signs and symptoms, lab result pending
  - Report the following within 7 days of identification:
    - Chancroid
    - Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)
    - Gonococcal Infections
    - Pelvic Inflammatory Disease (PID)
- More Information on Disease Reporting
  - For more information about the reporting of STDs in San Diego County, please call (619) 692-8501.
  - For information about reporting other diseases, please call (619) 515-6620.