

## CONFIDENTIAL MORBIDITY REPORT

**PLEASE NOTE:** Use this form for reporting lapses of consciousness or control, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).

### CONDITION BEING REPORTED ➔

<b>Patient Name - Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Ethnicity (check one)</b> <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown		
<b>Home Address: Number, Street</b>				<b>Apt./Unit No.</b>			
<b>City</b>			<b>State</b>	<b>ZIP Code</b>			
<b>Home Telephone Number</b>		<b>Cell Telephone Number</b>		<b>Work Telephone Number</b>			
<b>Email Address</b>				<b>Primary Language</b> <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____			
<b>Birth Date (mm/dd/yyyy)</b>	<b>Age</b>	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days	<b>Gender</b> <input type="checkbox"/> M to F Transgender <input type="checkbox"/> Male <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Female <input type="checkbox"/> Other: _____				
<b>Pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<b>Est. Delivery Date (mm/dd/yyyy)</b>		<b>Country of Birth</b> <input type="checkbox"/> Pacific Islander (check all that apply) <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> White <input type="checkbox"/> Other (specify): _____ <input type="checkbox"/> Unknown				
<b>Occupation or Job Title</b>			<b>Occupational or Exposure Setting (check all that apply):</b> <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> School <input type="checkbox"/> Other (specify): _____				
<b>Date of Onset (mm/dd/yyyy)</b>		<b>Date of First Specimen Collection (mm/dd/yyyy)</b>			<b>Date of Diagnosis (mm/dd/yyyy)</b>		
<b>Reporting Health Care Provider</b>		<b>Reporting Health Care Facility</b>			<b>REPORT TO:</b>  Solano County Public Health Communicable Disease Bureau 355 Tuolumne St., Suite 2500 Vallejo, CA 94590-5700 Phone (707) 553-5117 FAX (707) 553-5649  (Obtain additional forms from your local health department.)		
<b>Address: Number, Street</b>			<b>Suite/Unit No.</b>				
<b>City</b>		<b>State</b>	<b>ZIP Code</b>				
<b>Telephone Number</b>		<b>Fax Number</b>					
<b>Submitted by</b>			<b>Date Submitted (mm/dd/yyyy)</b>				

### DEPARTMENT OF MOTOR VEHICLES (DMV)

**California Driver License or Identification Card Number** (eight characters):

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode?: \_\_\_\_\_  
(mm/dd/yyyy)
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.  
 (a): \_\_\_\_\_ (b): \_\_\_\_\_ (c): \_\_\_\_\_ (d): \_\_\_\_\_ (e): \_\_\_\_\_ (f): \_\_\_\_\_  
(mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy) (mm/dd/yyyy)
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving?     Yes     No     Uncertain
4. Are additional lapses of consciousness likely to occur?     Yes     No     Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake?     Yes     No     Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease?     Yes     No     Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition?     Yes     No     Uncertain
8. Does this patient's condition represent a permanent driving disability?     Yes     No     Uncertain
9. Would you recommend a driving evaluation by DMV?     Yes     No     Uncertain

**Remarks:**

**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 jurisdiction 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)]**

- ⓪ ! = Report immediately by telephone (designated by a\* in regulations).
- † = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a● in regulations.)
- FAX ⓪ ⊗ = 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.

**REPORTABLE COMMUNICABLE DISEASES §2500(i)(1)**

<p>Acquired Immune Deficiency Syndrome (AIDS) (HIV infection only: see "Human Immunodeficiency Virus")</p> <p>FAX ⓪ ⊗ Amebiasis</p> <p>⓪ ! Anaplasmosis/Ehrlichiosis</p> <p>⓪ ! Anthrax</p> <p>⓪ ! Avian Influenza (human)</p> <p>FAX ⓪ ⊗ Babesiosis</p> <p>⓪ ! Botulism (Infant, Foodborne, Wound)</p> <p>⓪ ! Brucellosis</p> <p>FAX ⓪ ⊗ Campylobacteriosis</p> <p>Chancroid</p> <p>FAX ⓪ ⊗ Chickenpox (only hospitalizations and deaths)</p> <p>Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)</p> <p>⓪ ! Cholera</p> <p>⓪ ! Ciguatera Fish Poisoning</p> <p>Coccidioidomycosis</p> <p>FAX ⓪ ⊗ Colorado Tick Fever</p> <p>Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)</p> <p>FAX ⓪ ⊗ Cryptosporidiosis</p> <p>Cysticercosis or Taeniasis</p> <p>⓪ ! Dengue</p> <p>⓪ ! Diphtheria</p> <p>⓪ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)</p> <p>FAX ⓪ ⊗ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>⓪ ! <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli</i> O157</p> <p>† FAX ⓪ ⊗ Foodborne Disease</p> <p>Giardiasis</p> <p>Gonococcal Infections</p> <p>FAX ⓪ ⊗ <i>Haemophilus influenzae</i> invasive disease (report an incident less than 15 years of age)</p> <p>⓪ ! Hantavirus Infections</p> <p>⓪ ! Hemolytic Uremic Syndrome</p> <p>Hepatitis, Viral</p> <p>FAX ⓪ ⊗ Hepatitis A</p> <p>Hepatitis B (specify acute case or chronic)</p> <p>Hepatitis C (specify acute case or chronic)</p> <p>Hepatitis D (Delta)</p> <p>Hepatitis, other, acute</p> <p>Influenza deaths (report an incident of less than 18 years of age)</p> <p>Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)</p> <p>Legionellosis</p> <p>Leprosy (Hansen Disease)</p> <p>Leptospirosis</p> <p>FAX ⓪ ⊗ Listeriosis</p> <p>Lyme Disease</p> <p>FAX ⓪ ⊗ Malaria</p> <p>FAX ⓪ ⊗ Measles (Rubeola)</p> <p>FAX ⓪ ⊗ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic</p> <p>⓪ ! Meningococcal infections</p> <p>Mumps</p> <p>⓪ ! Paralytic Shellfish Poisoning</p> <p>Pelvic Inflammatory Disease (PID)</p> <p>FAX ⓪ ⊗ Pertussis (Whooping Cough)</p> <p>⓪ ! Plague, Human or Animal</p>	<p>FAX ⓪ ⊗ Poliovirus Infection</p> <p>FAX ⓪ ⊗ Psittacosis</p> <p>FAX ⓪ ⊗ Q Fever</p> <p>⓪ ! Rabies, Human or Animal</p> <p>FAX ⓪ ⊗ Relapsing Fever</p> <p>Rheumatic Fever, Acute</p> <p>Rocky Mountain Spotted Fever</p> <p>Rubella (German Measles)</p> <p>Rubella Syndrome, Congenital</p> <p>FAX ⓪ ⊗ Salmonellosis (Other than Typhoid Fever)</p> <p>⓪ ! Scombroid Fish Poisoning</p> <p>⓪ ! Severe Acute Respiratory Syndrome (SARS)</p> <p>⓪ ! Shiga toxin (detected in feces)</p> <p>FAX ⓪ ⊗ Shigellosis</p> <p>⓪ ! Smallpox (Variola)</p> <p>FAX ⓪ ⊗ <i>Staphylococcus aureus</i> infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, 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)</p> <p>FAX ⓪ ⊗ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)</p> <p>FAX ⓪ ⊗ Syphilis</p> <p>Tetanus</p> <p>Toxic Shock Syndrome</p> <p>FAX ⓪ ⊗ Trichinosis</p> <p>FAX ⓪ ⊗ Tuberculosis</p> <p>⓪ ! Tularemia</p> <p>FAX ⓪ ⊗ Typhoid Fever, Cases and Carriers</p> <p>Typhus Fever</p> <p>FAX ⓪ ⊗ <i>Vibrio</i> Infections</p> <p>⓪ ! Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)</p> <p>FAX ⓪ ⊗ Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)</p> <p>FAX ⓪ ⊗ West Nile Virus (WNV) Infection</p> <p>⓪ ! Yellow Fever</p> <p>FAX ⓪ ⊗ Yersiniosis</p> <p>⓪ ! OCCURRENCE of ANY UNUSUAL DISEASE</p> <p>⓪ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.</p>
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**HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20**

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and <http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx>

**REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800-2812 and §2593(b)**

Disorders Characterized by Lapses of Consciousness (§2800-2812)  
Pesticide-related illness or injury (known or suspected cases)\*\*  
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) § 2593\*\*\*

**LOCALLY REPORTABLE DISEASES (If Applicable):**

\* 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.ccrca.org](http://www.ccrca.org)