

# REPORTABLE DISEASES AND CONDITIONS

City and County of San Francisco San Francisco Department of Public Health

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641-2643 and §2800-2812 §2500(b).

Every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, must 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.

## WHO TO REPORT TO

REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO COMMUNICABLE DISEASE CONTROL UNIT UNLESS OTHERWISE INDICATED

<b>COMMUNICABLE DISEASE CONTROL UNIT</b> <b>PHONE: (415) 554-2830</b> <b>FAX: (415) 554-2848 M-F 8AM to 5PM</b>  For urgent reports after hours, follow the prompts to page the on-call MD	<b>AIDS OFFICE</b> <b>PHONE: (415) 554-9050</b>	<b>ANIMAL BITES (mammals only)</b> <b>PHONE: (415) 554-9422 FAX: (415) 864-2866</b>
	<b>STD CLINIC</b> <b>PHONE: (415) 487-5555 FAX: (415) 431-4628</b>	<b>ENVIRONMENTAL HEALTH SERVICES</b> <b>PHONE: (415) 252-3862 FAX: (415) 252-3818</b>
	<b>TUBERCULOSIS CLINIC</b> <b>PHONE: (415) 206-8524 FAX: (415) 206-4565</b>	

## DISEASE OR CONDITION / URGENCY REPORTING REQUIREMENTS

### URGENCY REPORTING KEY

▲ Report immediately by telephone    1 Report within one working day of identification    7 Report within seven calendar days by FAX, phone or mail

7 Acquired Immune Deficiency Syndrome (AIDS) <i>to AIDS Office</i> 7 Alzheimer's Diseases and Related Conditions 1 Amebiasis 7 Animal bites (mammals only) <i>to Animal Care and Control</i> ▲ Anthrax* ▲ Avian Influenza (human) 1 Babesiosis ▲ Botulism* (Infant, Foodborne, Wound) ▲ Brucellosis* 1 Campylobacteriosis 7 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) 7 Chancroid <i>to STD Clinic</i> 1 Chickenpox (only hospitalizations and deaths) 7 Chlamydial infections <i>to STD Clinic</i> ▲ Cholera ▲ Ciguatera Fish Poisoning 7 Coccidioidomycosis 1 Colorado Tick Fever 1 Conjunctivitis, Acute Infectious of the Newborn (specify etiology) 7 Creutzfeldt-Jakob Disease (CJD) 1 Cryptosporidiosis 7 Cysticercosis ▲ Dengue ▲ Diarrhea of the Newborn, outbreaks ▲ Diphtheria 7 Disorders Characterized by Lapses of Consciousness ▲ Domoic Acid Poisoning (Amnesic Shellfish Poisoning) 7 Ehrlichiosis 1 Encephalitis, infectious (specify etiology) ▲ <i>Escherichia coli</i> shiga toxin producing (STEC) including <i>E. coli</i> O157 ▲ Foodborne illness	7 Giardiasis 7 Gonococcal infections <i>to STD Clinic</i> 1 <i>Haemophilus influenzae</i> invasive disease (less than 15 years of age) ▲ Hantavirus infections ▲ Hemolytic Uremic Syndrome 7 Hepatitis, viral 1 Hepatitis A 7 Hepatitis B (specify acute case or chronic) 7 Hepatitis C (specify acute case or chronic) 7 Hepatitis D (Delta) 7 Hepatitis, other acute 7 Human Immunodeficiency Virus (HIV) <i>to AIDS Office</i> 7 Influenza deaths (less than 18 years of age) 7 Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome) 7 Legionellosis 7 Leprosy (Hansen Disease) 7 Leptospirosis 1 Listeriosis 7 Lyme Disease 7 Lymphogranuloma Venereum (LGV) <i>to STD Clinic</i> 1 Malaria 1 Measles (Rubeola) 1 Meningitis (specify etiology) ▲ Meningococcal infections 7 Mumps ▲ Paralytic Shellfish Poisoning 7 Pelvic Inflammatory Disease (PID) <i>to STD Clinic</i> 1 Pertussis (Whooping Cough) 7 Pesticide-related illness or injury (known or suspected cases) <i>to Environmental Health Services</i> ▲ Plague (human or animal)* 1 Poliomyelitis, Paralytic 1 Psittacosis 1 Q Fever ▲ Rabies (human or animal) 1 Relapsing Fever	7 Rheumatic Fever, Acute 7 Rocky Mountain Spotted Fever 7 Rubella (German Measles) 7 Rubella Congenital Syndrome 1 Salmonellosis (other than Typhoid Fever) ▲ Scombroid Fish Poisoning ▲ Severe Acute Respiratory Syndrome (SARS) ▲ Shiga toxin (detected in feces) 1 Shigellosis ▲ Smallpox (Variola)* ▲ <i>Staphylococcus aureus</i> infections, severe (ICU/death) in a previously healthy person 1 Streptococcal infections, outbreaks of any type and individual cases in food handlers and dairy workers only 1 Syphilis <i>to STD Clinic</i> 7 Taeniasis 7 Tetanus 7 Toxic Shock Syndrome 7 Toxoplasmosis 7 Transmissible Spongiform Encephalopathies (TSE) 1 Trichinosis 1 Tuberculosis <i>to Tuberculosis Clinic</i> ▲ Tularemia* 1 Typhoid Fever (cases and carriers) 7 Typhus Fever 1 <i>Vibrio</i> infections ▲ Viral Hemorrhagic Fevers* (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses) 1 Water-associated disease (e.g. Swimmer's Itch and Hot Tub Rash) 1 West Nile Virus ▲ Yellow Fever 1 Yersiniosis ▲ ANY UNUSUAL DISEASES ▲ NEW DISEASE OR SYNDROME NOT PREVIOUSLY RECOGNIZED ▲ OUTBREAKS OF ANY DISEASE
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\*Potential Bioterrorism Agents

# 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 <input style="width:95%" type="text"/>	Social Security Number <input style="width:15%" type="text"/> - <input style="width:15%" type="text"/> - <input style="width:15%" type="text"/>	Ethnicity (✓ one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
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First Name/Middle Name (or initial) <input style="width:95%" type="text"/>	Birth Date Month Day Year <input style="width:15%" type="text"/> / <input style="width:15%" type="text"/> / <input style="width:15%" type="text"/>	Age <input style="width:15%" type="text"/>
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Address: Number, Street <input style="width:95%" type="text"/>	Apt./Unit Number <input style="width:95%" type="text"/>
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City/Town <input style="width:95%" type="text"/>	State <input style="width:15%" type="text"/>	ZIP Code <input style="width:15%" type="text"/>	Country of Birth <input style="width:95%" type="text"/>
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Area Code <input style="width:15%" type="text"/>	Home Telephone <input style="width:15%" type="text"/>	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> Unk	Estimated Delivery Date Month Day Year <input style="width:15%" type="text"/> / <input style="width:15%" type="text"/> / <input style="width:15%" type="text"/>
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Area Code <input style="width:15%" type="text"/>	Work Telephone <input style="width:15%" type="text"/>	Patient's Occupation/Setting <input type="checkbox"/> Food service <input type="checkbox"/> Day care <input type="checkbox"/> Correctional facility <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/> Other _____	Race (✓ one) <input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (✓ one) <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other _____ <input type="checkbox"/> Native American/Alaskan Native <input type="checkbox"/> White: _____ <input type="checkbox"/> Other: _____
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**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**  
  
206-4565  
(PH): (415) 554-9050  
(Obtain additional forms from your local health department.)

**SEXUALLY TRANSMITTED DISEASES (STD)**

**Syphilis**  
 Primary (lesion present)  Late latent > 1 year  
 Secondary  Late (tertiary)  
 Early latent < 1 year  Congenital  
 Latent (unknown duration)

**Neurosyphilis**

**Chlamydia** Site:  
 Gonorrhea  Pharyngeal  Cervical/Vaginal  
 Chancroid  Rectal  Urine  
 PID  Urethral  Other: \_\_\_\_\_

**Syphilis Test Results**  
 RPR Titer: \_\_\_\_\_  
 VDRL Titer: \_\_\_\_\_  
 FTA/MHA:  Pos  Neg  
 CSF-VDRL:  Pos  Neg  
 Other: \_\_\_\_\_

**Gender of Sex Partners last 12 months:**  
 Male  Transgender (M to F)  
 Female  Transgender (F to M)  
 Unknown  Refused

**VIRAL HEPATITIS**

	Pos	Neg	Pend	Not Done
<input type="checkbox"/> <b>Hep A</b> anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Hep B</b>				
<input type="checkbox"/> <b>Acute</b> HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Chronic</b> anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Hep C</b> anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Acute</b> PCR-HCV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Chronic</b>				
<input type="checkbox"/> <b>Hep D (Delta)</b> anti-Delta	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> <b>Other:</b> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**STD TREATMENT INFORMATION**

**Treated** (Drugs, Dosage, Route ): \_\_\_\_\_ Date Treatment Initiated Month Day Year  
 **Untreated**  
 Will treat  
 Unable to contact patient  
 Refused treatment  
 Referred to: \_\_\_\_\_

**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  
Results: \_\_\_\_\_ mm  Pending  Not Done

**Chest X-Ray**  
Date Performed Month Day Year  
 Normal  Pending  Not done  
 Cavitory  Abnormal/Noncavitory

**Bacteriology**  
Date Specimen Collected Month Day Year  
Source \_\_\_\_\_  
Smear:  Pos  Neg  Pending  Not done  
Culture:  Pos  Neg  Pending  Not done  
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 \_\_\_\_\_