CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except HIV/AIDS, STIs, Tuberculosis, and conditions reportable to DMV.
For all HIV/AIDS reporting, call (805) 652-3313.

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***	☐ Year ☐ Months ☐ Days

Current Gender Identity (check one)
- ☐ Male
- ☐ Female
- ☐ Trans male/transman
- ☐ Trans female/transwoman
- ☐ Genderqueer or non-binary
- ☐ Identity not listed (specify)_____
- ☐ Declined to answer

Sex Assigned at Birth (check one)
- ☐ Male
- ☐ Female
- ☐ Declined to answer

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

Race (check all that apply)
- ☐ African-American/Black
- ☐ American Indian/Alaskan 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

Sexual Orientation (check one)
☐ Heterosexual or straight ☐ Bisexual ☐ Gay, lesbian, or same gender loving ☐ Orientation not listed (specify)_____
☐ Questioning/Unsure/Client doesn't know ☐ Declined to answer

Patient Pregnant?	***Partner Pregnant?***	***Country of Birth***
☐ Yes, Est. Delivery Date: _____ ☐ No ☐ Unknown	☐ Yes, Est. Delivery Date: _____ ☐ No ☐ Unknown	

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)*

REPORT TO:

VENTURA COUNTY PUBLIC HEALTH
A Department of Ventura County Health Care Agency

Communicable Disease Program
Phone: (805) 981-5201
Fax: (805) 981-5200
Email: vcph-id@ventura.org

Laboratory Name	***City***	***State***	***ZIP Code***

VIRAL HEPATITIS

Diagnosis (check all that apply) ***Is patient symptomatic?*** ☐ Yes ☐ No ☐ Unknown

- ☐ Hepatitis A
- ☐ Hepatitis B (acute)
- ☐ Hepatitis B (chronic)
- ☐ Hepatitis B (perinatal)
- ☐ Hepatitis C (acute)
- ☐ Hepatitis C (chronic)
- ☐ Hepatitis C (perinatal)
- ☐ Hepatitis D (acute)
- ☐ Hepatitis D (chronic)
- ☐ Hepatitis E

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: