

MARYLAND CONFIDENTIAL MORBIDITY REPORT (DHMH 1140)

(For use by physicians and other health care providers, but not laboratories. Laboratories should use forms DHMH 1281 & DHMH 4492.)

STATE DATA BASE NUMBER
(Completed by Health Department)

SEND TO YOUR LOCAL HEALTH DEPARTMENT

NAME OF PATIENT - LAST		FIRST	M	DATE OF BIRTH MONTH DAY YEAR		AGE	SEX M <input type="checkbox"/> F <input type="checkbox"/>	ETHNICITY (Select independently of RACE) HISPANIC or LATINO: YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>	
TELEPHONE NUMBERS Home:		Workplace:		RACE (Select one or more. If multiracial, select all that apply) American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify):					
ADDRESS		UNIT#	CITY OR TOWN		STATE	ZIP CODE	COUNTY		
OCCUPATION OR CONTACT WITH VULNERABLE PERSONS (Check all that apply - include volunteers) <input type="checkbox"/> HEALTH CARE WORKER (Include any PATIENT CARE, ELDER CARE, "AIDES," etc.) <input type="checkbox"/> DAYCARE (Attendee or Worker) <input type="checkbox"/> PARENT of a child in DAYCARE <input type="checkbox"/> FOOD SERVICE WORKER <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> OTHER (SPECIFY):				WORKPLACE, SCHOOL, CHILD CARE FACILITY, ETC. (Include Name, Address, ZIP Code)					
DISEASE OR CONDITION				DATE OF ONSET MONTH DAY YEAR		ADMITTED YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE ADMITTED MONTH DAY YEAR		HOSPITAL
PATIENT HAS BEEN NOTIFIED OF THIS CONDITION YES <input type="checkbox"/> NO <input type="checkbox"/>									
CONDITION ACQUIRED IN MARYLAND YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> (IF NO, INTERSTATE <input type="checkbox"/> or INTERNATIONAL <input type="checkbox"/>)		SUSPECTED SOURCE OF INFECTION				DIED YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE DIED MONTH DAY YEAR		PREGNANT YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> WEEKS PREGNANT _____ DUE DATE _____
LABORATORY TESTS - VIRAL HEPATITIS POS NEG DATE HAV Antibody Total <input type="checkbox"/> <input type="checkbox"/> _____ HAV Antibody IgM <input type="checkbox"/> <input type="checkbox"/> _____ HBV surface Antigen <input type="checkbox"/> <input type="checkbox"/> _____ HBV e Antigen <input type="checkbox"/> <input type="checkbox"/> _____ HBV core Antibody Total <input type="checkbox"/> <input type="checkbox"/> _____ HBV core Antibody IgM <input type="checkbox"/> <input type="checkbox"/> _____		LABORATORY TESTS - VIRAL HEPATITIS POS NEG DATE HBV surface Antibody <input type="checkbox"/> <input type="checkbox"/> _____ HBV Viral DNA <input type="checkbox"/> <input type="checkbox"/> _____ HCV Antibody ELISA <input type="checkbox"/> <input type="checkbox"/> _____ HCV ELISA Signal/Cut Off Ratio _____ HCV Antibody RIBA <input type="checkbox"/> <input type="checkbox"/> _____ HCV RNA (eg., by PCR) <input type="checkbox"/> <input type="checkbox"/> _____		LABORATORY TESTS - VIRAL HEPATITIS HCV Viral Genotyping _____ DATE _____ ALT (SGPT) Level _____ DATE _____ ALT - Lab Normal Range: _____ to _____ AST (SGOT) Level _____ DATE _____ AST - Lab Normal Range: _____ to _____ NAME of LAB: _____		ADDITIONAL LAB RESULTS (SPECIMEN - TEST - RESULT - DATE - NAME of LAB) (Please attach copies of lab reports whenever possible)			
PERTINENT CLINICAL INFORMATION + OTHER COMMENTS									

HUMAN IMMUNODEFICIENCY VIRUS (HIV) and ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) - ADDITIONAL CASE INFORMATION

CONDITIONS	HIV LAB TESTS	DATE	RESULT
WEIGHT LOSS OR DIARRHEA <input type="checkbox"/>	CD4+ T-cells < 200 per microliter or < 14%		
SECONDARY INFECTIONS (PCP, TB, etc.) <input type="checkbox"/>	ELISA		
PERINATAL EXPOSURE OF NEWBORN <input type="checkbox"/>	WESTERN BLOT		
OTHER CONDITIONS ATTRIBUTED TO HIV INFECTION <input type="checkbox"/> (SPECIFY):	OTHER (SPECIFY):		
PHYSICIAN REQUESTS LOCAL HEALTH DEPARTMENT TO ASSIST WITH: NOTIFICATION TO PATIENT YES <input type="checkbox"/> NO <input type="checkbox"/> PARTNER SERVICES YES <input type="checkbox"/> NO <input type="checkbox"/>			

SEXUALLY TRANSMITTED DISEASE (STD) - ADDITIONAL CASE INFORMATION

SYPHILIS: PRIMARY <input type="checkbox"/> SECONDARY <input type="checkbox"/> EARLY LATENT (LESS THAN 1 YR) <input type="checkbox"/> CONGENITAL <input type="checkbox"/> OTHER STAGE <input type="checkbox"/> (SPECIFY):			
GONORRHEA: CERVICAL <input type="checkbox"/> URETHRAL <input type="checkbox"/> RECTAL <input type="checkbox"/> PHARYNGEAL <input type="checkbox"/> OPHTHALMIA NEONATORUM <input type="checkbox"/> PID <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY):			
CHLAMYDIA: CERVICAL <input type="checkbox"/> URETHRAL <input type="checkbox"/> RECTAL <input type="checkbox"/> PHARYNGEAL <input type="checkbox"/> PID <input type="checkbox"/> OTHER <input type="checkbox"/> (SPECIFY):			
OTHER STD (Specify):			
STD LABORATORY CONFIRMATION AND TREATMENT			
Specify STD Lab Test (e.g., RPR Titer, FTA - TPPA, Darkfield, Smear, Culture, NAAT, EIA, VDRL - CSF)		STD Treatment Given <input type="checkbox"/> (Specify date - drug - dosage below)	
No Treatment Given <input type="checkbox"/>			
DATE	TEST	RESULT	DOSAGE

TUBERCULOSIS (Suspect or Confirmed) - ADDITIONAL CASE INFORMATION

MAJOR SITE: PULMONARY <input type="checkbox"/> EXTRAPULMONARY <input type="checkbox"/> ATYPICAL <input type="checkbox"/> (SPECIFY)	ABNORMAL CHEST X-RAY: <input type="checkbox"/>
COMMENTS:	

REPORTED BY	ADDRESS	TELEPHONE NUMBER	DATE OF REPORT MONTH DAY YEAR
<input type="checkbox"/> Check here if completed by the Health Department			

NOTES: Your local health department may contact you following this initial report to request additional disease-specific information.
For more Confidential Morbidity Report forms or information about reporting, go to <http://www.edcp.org/html/reprtabl.html>.