MAIL THE TOP TWO COPIES TO YOUR LOCAL HEALTH DEPARTMENT

VIRGINIA DEPARTMENT OF HEALTH
Confidential Morbidity Report

Patient's Name (Last, First, Middle Initial):

SSN: _____-_____-_____

Home #: ( ) _____-_____

Work #: ( ) _____-_____

Patient's Address (Street, City or Town, State, Zip Code):

City or County of Residence

Date of Birth: (mm/dd/yyyy) | Age: | Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Unknown | Hispanic: ☐ Yes ☐ No | Sex: ☐ F ☐ M

DISEASE OR CONDITION:

Pregnant: ☐ Yes ☐ No ☐ Unknown

Death: ☐ Yes ☐ No

Death Date:

Date of Onset:

Date of Diagnosis:

Influenza: (Report # and type only. No patient identification)

Number of Cases: Type, if Known:

Physician's Name: Phone #: ( ) _____-_____

Address:

Hospital Admission: ☐ Yes ☐ No Hospital Name:

Date of Admission: Medical Record Number:

Laboratory Information and Results

Source of Specimen:

Date Collected:

Laboratory Test(s) and Finding(s):

Name/Address of Lab:

CLIA Number:

Other Information

Comments: (e.g., Risk situation [food handling, patient care, day care], Treatment [including dates], Immunization status [including dates], Signs/Symptoms, Exposure, Outbreak-associated, etc.)

Name, Address, and Phone Number of Person Completing this Form:

Date Reported:

Check here if you need more of these forms, or call your local health department. (Be sure your address is complete.) ☐

For Health Department Use

Date Received:

VEDSS Patient ID:

Please complete as much of this form as possible

Form Epi-1, 10/2011