State of Delaware Health and Human Services Agency- Delaware Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

DISEASE BEING REPORTED

Patient Name-*Last Name, First Name*

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
☐Filipino ☐Laotian☐ Other(*specify*): _____
☐Pacific Islander (*Check all that apply*)
☐ Native Hawaiian ☐Samoan ☐Guamanian
☐ Other(*specify*)_____
☐White
☐Other(*specify*)_____
☐Unknown

Home Address: *Number, Street* | ***Apt./Unit No.***

City | ***County*** ☐New Castle ☐Kent ☐Sussex | ***State*** | ***Zip Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐English ☐Spanish ☐Hattian-Creole ☐Other: _____

Gender
☐Male ☐Female ☐M to F Transgender
☐F to M Transgender☐Other: _____

Birthdate*(mm/dd/yyyy)* | ***Age*** | ☐**Years** ☐**Months** ☐**Days** | ***Country of Birth*** | ***Pregnant?*** ☐Yes☐ No ☐Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)*

Occupation or Student's School

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)*

Specimen Type | ***Lab Test Type*** | ***Vaccination Status (if applicable)*** ☐Up to date ☐Not up to date ☐Not vaccinated ☐Not available ☐Exempt (medical/religious) | ***Vaccination Date*** *(mm/dd/yyyy)*

Diagnostic Result | ***Reporting Health Care Provider*** | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***Zip Code*** | ***Telephone Number***

Fax Number | ***Submitted By*** | ***Submit Date*** *(dd/mm/yyyy)*

Laboratory Name | ***City*** | ***State*** | ***Zip Code***

Was Patient Hospitalized? ☐Yes ☐No ☐Unknown | ***Date Admitted*** *(mm/dd/yyyy)* | ***Date Discharged*** *(mm/dd/yyyy)* | ***Name of Hospital***

Patient Medical Record Number | ***Was the client treated?*** ☐Yes ☐No ☐Unknown | ***Treatment Date*** *(mm/dd/yyyy)* | ***Treatment Description***

Primary Care Provider | ***Primary Care Provider Telephone***

Reason Test was Conducted? ☐Infection ☐Screening ☐Other_____

Was Specimen submitted to DPH Laboratory? ☐Yes ☐No ☐Unknown

Is Isolate Resistant to Any Antimicrobial Agent? * ☐Yes ☐No ☐Unknown

***If Yes fax susceptibility test to 302-622-4149 or email to reportdisease@delaware.gov**

Remarks:(Include details on location of specimen for courier pickup, if appropriate)

NOTIFIABLE DISEASES

■ACQD. IMM. DEF. SYND. (AIDS) (S) ■AMOEBIASIS ■ANTHRAX (T)
■ARBOVIRUSES ■BABESIOSIS ■BOTULISM (T) ■BRUCELLOSIS
■CALIFORNIA SEROGROUP VIRUSES
■CAMPYLOBACTERIOSIS
■CARBAPENEM-RESISTANT ORGANISMS (CRO)
■CHANCROID(S)■CHIKUNGUNYA■CHLAMYDIA(S)
■CHOLERA(TOXIGENIC VIBRIO CHOLERAE 01 OR 0139) (T)
■COCCODIOIDOMYCOSIS ■COVID-19 (T)
■CREUTZFELDT-JAKOB DISEASE (T)
■CRYPTOSPORIDIOSIS■CYCLOSPORIASIS
■CYTOMEGALOVIRUS (NEONATAL ONLY)■DENGUE FEVER (T)
■DIPHTHERIA (T) ■EASTERN EQUINE ENCEPHALITIS
■ENTERHEMORRHAGIC E. COLI INCLUDING BUT NOT LIMITED TO E.COLI 0157:H7 (T)
■EHRLICHIOSIS ■ENCEPHALITIS
■FOODBORNE DISEASE OUTBREAKS (T)
■GIARDIASIS ■GLANDERS (T) ■GONORRHEA (S)
■GRANULOMA INGUINALE (S) ■GUILLAIN-BARRE
■HANSEN'S DISEASE (LEPROSY) ■HANTAVIRUS INFECTION (T)
■HAEMOPHILUS INFLUENZAE INVASIVE ■HEMOLYTIC UREMIC SYNDROME (HUS) (T)
■HEPATITIS A(T)■HEPATITIS B(S)■HEPATITIS C■HEPATITIS OTHER
■UNSPECIFIED HERPES (CONGENITAL) (S) ■HERPES (GENITAL) (N)
■HISTOPLASMOSIS ■HUMAN IMMUNODEFICIENCY VIRUS (HIV)
■HUMAN PAPILLOMAVIRUS (S)■INFLUENZA
■INFLUENZA ASSOC. INFANT MORTALITY (T)
■KAWASAKI SYNDROME ■LEAD POISONING ■LEGIONELLOSIS
■LEPTOSPIROSIS■LISTERIOSIS ■LYME DISEASE
■LYMPHOGRANULOMA VENEREUM (S) ■MALARIA
■MEASLES (T) ■MELIODOSIS
■MENINGITIS (ALL TYPES OTHER THAN MENINGOCOCCAL)
■MENINGOCOCCAL INFECTIONS (ALL TYPES) (T)
■MONKEY POX(T) ■MUMPS (T) ■NOROVIRUS
■NOSOCOMIAL DISEASE OUTBREAK (T)
■PELVIC INFLAMMATORY DISEASE (N. GONORRHEA, C. TRACHOMATIS, OR UNSPECIFIED) (S)
■PERTUSSIS (T) ■PLAGUE(T) ■POLIOMYELITIS (T)
■POWASSAN ■PSITTACOSIS
■Q FEVER ■RABIES (MAN, ANIMAL) (T)
■REYE SYNDROME ■RHEUMATIC FEVER ■RICIN TOXIN
■RICKETTSIAL DISEASE ■ROCKY MOUNTAIN SPOTTED FEVER
■RUBELLA (T) ■RUBELLA (CONGENITAL) (T) ■SALMONELLOSIS
■SEVERE ACUTE RESPIRATORY SYNDROME (SARS) ■MERS-CoV
■SHIGATOXIN PRODUCTION ■SHIGELLOSIS ■SILICOSIS
■SMALLPOX(T) ■ST. LOUIS ENCEPHALITIS VIRUS
■STAPHYLOCOCCAL ENTEROTOXIN
■STREPTOCOCCAL DISEASE (INVASIVE GROUP A OR B)
■STREPTOCOCCUS PNEUMONIAE, INVASIVE (SENSITIVE AND RESISTANT)
■SYPHILIS (S) ■TETANUS (T)
■TOXIC SHOCK SYNDROME (STREPTOCOCCAL OR STAPHYLOCOCCAL) ■TOXOPLASMOSIS ■TRICHINOSIS
■TUBERCULOSIS (T) ■TULAREMIA (T) ■TYPHOID FEVER (T)
■TYPHUS FEVER (ENDEMIC FLEA BORNE, LOUSE BORNE, TICK BORNE) ■VACCINE ADVERSE REACTIONS
■VARICELLA (CHICKENPOX) ■VIBRIO, NON-CHOLERA
■VIRAL HEMORAGIC FEVERS (T)■WEST NILE VIRUS
■WESTERN EQUINE ENCEPHALITIS
■WATERBORNE DISEASE OUTBREAKS (T)
■YELLOW FEVER (T) ■YERSINIOSIS

DRUG RESISTANT ORGANISMS REQUIRED TO BE REPORTED

■ENTEROCOCCUS SPECIES, VANCOMYCIN RESISTANT
■ENTEROBACTERIACEAE, CARBAPENEM-RESISTANT (INVASIVE OR URINE ONLY)
■ESBL RESISTANCE (EXTENDED- SPECTRUM ß-LACTAMASES)
■STAPHYLOCOCCUS AUREUS, METHICILLIN RESISTANT (MRSA)
■STAPHYLOCOCCUS AUREUS, VANCOMYCIN INTERMEDIATE OR RESISTANT (VISA, VRSA)
■STREPTOCOCCUS PNEUMONIAE, INVASIVE (SENSITIVE AND RESISTANT)

(T) report by rapid means (telephone, fax or other electronic means)

(N) report in number only when so requested
For all diseases not marked by (T) or (N):

(S) sexually transmitted disease,

report required within 24 hours

Others - report required within 48 hours

Delaware Office of Infectious Disease Epidemiology
Email reportdisease@delaware.gov
24/7 Emergency Contact Number 1-888-295-5156
FAX 302-622-4149

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 56 DOVER DE

POSTAGE WILL BE PAID BY ADDRESSEE

DELAWARE DIVISION OF PUBLIC HEALTH
BUREAU OF EPIDEMIOLOGY
JESSE COOPER BUILDING
417 FEDERAL ST
DOVER, DE 19901-3636