MARYLAND CONFIDENTIAL MORBIDITY REPORT (DHMH 1140)

STATE DATA BASE NUMBER

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

SEND TO YOUR LOCAL HEALTH DEPARTMENT

DEMOGRAPHIC DATA PATIENT INFORMATION

Patient's Name (Last) (First) (M.I.) | Date of Birth | Age

Sex at Birth ☐ Male ☐ Female

Current Gender ☐ Male ☐ Female
☐ M to F Transgender
☐ F to M Transgender
☐ Other

Patient's Address | City | State | Zip

County of Residence | Home Telephone | Cellphone | Work Telephone

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Occupation or Contact with Vulnerable Persons ☐ Food Service Worker ☐ Not Employed
☐ Health Care Worker ☐ Daycare ☐ Parent of Daycare Child ☐ Other (Specify): _____

Workplace, School, Child Care Facility, Etc. (Include Name, Address, Zipcode)

Race:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hawaiian or Pacific Islander
☐ White
☐ Unknown
☐ Other (specify): _____

MORBIDITY DATA

Disease or Condition | Date of Onset

Patient Notified of this Condition ☐ Yes ☐ No

Pertinent Clinical Information/Comments

Patient Hospitalized ☐ Yes ☐ No
Date | Hospital

Patient Died of This Illness ☐ Yes ☐ No Date _____

Patient Pregnant
☐ Yes ☐ No ☐ Unknown ☐ Not applicable
If yes, Due date (mm/dd/yyyy) _____
Weeks Pregnant _____

Condition Acquired in Maryland ☐ Yes ☐ No ☐ Unknown
If no, ☐ Interstate ☐ International
Suspected Source

Additional Lab Results (Specimen – Test – Result – Date – Name of Lab) Please attach copies of lab reports whenever possible.

HEPATITIS

Laboratory Results

	POS	NEG	DATE
HAV Antibody Total	☐	☐	
HAV Antibody IgM	☐	☐	
HBV surface Antigen	☐	☐	
HBV e Antigen	☐	☐	
HBV core Antibody Total	☐	☐	
HBV core Antibody IgM	☐	☐	

	POS	NEG	DATE
HBV surface Antibody	☐	☐	
HBV DNA	☐	☐	
HCV Antibody RIBA	☐	☐	
HCV RNA (e.g. by PCR)	☐	☐	
HCV Antibody ELISA	☐	☐	
HCV ELISA s/co Ratio			

HCV Genotype _____ DATE _____
ALT (SGPT) Level _____ DATE _____
ALT–Lab Normal Range _____ TO _____
AST (SGOT) Level _____ DATE _____
AST–Lab Normal Range _____ TO _____
Name of Lab _____

HIV and AIDS

HIV Lab Tests	Date	Result
HIV Diagnostic (Specify)		
CD4+ T-cells		
HIV Viral Load		
HIV Genotype (Resistance)		Name of Testing Lab

Risk Exposure (Select all that apply)
Complete for HIV/AIDS or STI
☐ Sex with Male
☐ Sex with Female
☐ Sex Partner has HIV or AIDS
☐ Sex Partner Injects Drugs
☐ Sex Partner is Male that has Sex with Males
☐ Injection Drug Use
☐ Perinatal Exposure of Newborn
☐ Other Exposure (specify) _____

SEXUALLY TRANSMITTED INFECTION

Syphilis Stage	Syphilis Symptoms	Gonorrhea Site(s)	Chlamydia Site(s)	Other STI (specify)
☐ Primary	☐ Lesion	☐ Cervical	☐ Cervical	
☐ Secondary	☐ Palmar/Plantar Rash	☐ Urethral	☐ Urethral	
☐ Early Latent (<1 yr)	☐ Condylomata Lata	☐ Rectal	☐ Rectal	
☐ Congenital	☐ Neurologic	☐ Pharyngeal	☐ Pharyngeal	
☐ Other Stage (specify) _____	☐ Other (specify) _____	☐ Ophthalmia Neonatorum	☐ PID	
		☐ PID	☐ Other (specify) _____	
		☐ Other (specify) _____		

Specify STI Lab Test (e.g. RPR Titer, FTA-TPPA, Darkfield, Smear, Culture, NAAT, EIA, VDRL-CSF)

DATE	TEST	RESULT

STI Treatment Given ☐ (Specify date – drug – dosage below) ☐ No Treatment Given

DATE	DRUG	DOSAGE

Did you provide treatment for any of this patient's partners? (Check all that apply)
☐ Yes, I saw the sex partner(s) in my office ☐ Yes, I gave medication for __ (#) partner(s) ☐ Yes, I wrote a prescription for __(#) partner(s)

TB and OTHER MYCOBACT.

☐ Tuberculosis (Suspect or Confirmed) ☐ Non TB: Atypical (Specify) _____

Major Site: ☐ Pulmonary ☐ Extrapulmonary Site: _____
☐ POS QFT ☐ NEG QFT
☐ TST _____ mm
☐ POS AFB Smear ☐ NEG AFB Smear
☐ POS Culture ☐ NEG Culture

Symptoms: ☐ Cough >3 Weeks ☐ Hemoptysis ☐ Fever ☐ Weight Loss ☐ Fatigue ☐ Abnormal Chest X-ray

REPORTING SOURCE (REQUIRED)

Provider Name | Provider Telephone No.

Facility/Organization (Name and Address)

Check here if completed by the Local Health Department ☐

Date of Report

NOTES: Your local health department may contact you following this initial report to request additional disease-specific information.
To print blank report forms or get more information about reporting, go to http://phpa.dhmh.maryland.gov/SitePages/what-to-report.aspx