MARYLAND CONFIDENTIAL MORBIDITY REPORT (DHMH 1140)

STATE DATA BASE NUMBER
(Completed by Health Department)

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

When completed, send form to Baltimore City Health Department: 1001 E. Fayette St, Baltimore, MD 21202

NAME OF PATIENT – LAST **FIRST** **M**

DATE OF BIRTH MONTH / DAY / YEAR

AGE

SEX M ☐ F ☐

ETHNICITY (Select independently of RACE)
HISPANIC or LATINO: YES ☐ NO ☐ UNKNOWN ☐

TELEPHONE NUMBERS
Home: Workplace:

RACE (Select one or more. If multiracial, select all that apply)
American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐
Hawaiian/Pacific Islander ☐ White ☐ Unknown ☐
Other (Specify):

ADDRESS **UNIT#** **CITY OR TOWN** **STATE** **ZIP CODE** **COUNTY**

OCCUPATION OR CONTACT WITH VULNERABLE PERSONS
(Check all that apply - include volunteers)
☐ HEALTH CARE WORKER (Include any PATIENT CARE, ELDER CARE, "AIDES," etc.)
☐ DAYCARE (Attendee or Worker)
☐ PARENT of a child in DAYCARE
☐ FOOD SERVICE WORKER
☐ NOT EMPLOYED
☐ OTHER (SPECIFY):

WORKPLACE, SCHOOL, CHILD CARE FACILITY, ETC. (Include Name, Address, ZIP Code)

DISEASE OR CONDITION
PATIENT HAS BEEN NOTIFIED OF THIS CONDITION YES ☐ NO ☐

DATE OF ONSET MONTH / DAY / YEAR

ADMITTED YES ☐ NO ☐

DATE ADMITTED MONTH / DAY / YEAR

HOSPITAL

CONDITION ACQUIRED IN MARYLAND
YES ☐ NO ☐ UNKNOWN ☐
(IF NO, INTERSTATE ☐ or INTERNATIONAL ☐)

SUSPECTED SOURCE OF INFECTION

DIED YES ☐ NO ☐

DATE DIED MONTH / DAY / YEAR

PREGNANT
YES ☐ NO ☐ UNKNOWN ☐ NOT APPLICABLE ☐
WEEKS PREGNANT _____ DUE DATE _____

LABORATORY TESTS - VIRAL HEPATITIS

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

LABORATORY TESTS - VIRAL HEPATITIS

	POS	NEG	DATE
HBV surface Antibody	☐	☐	
HBV Viral DNA	☐	☐	
HCV Antibody ELISA	☐	☐	
HCV ELISA Signal/Cut Off Ratio			
HCV Antibody RIBA	☐	☐	
HCV RNA (eg., by PCR)	☐	☐	

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 ☐	CD4+ T-cells < 200 per microliter or < 14%		
SECONDARY INFECTIONS (PCP, TB, etc.) ☐	ELISA		
PERINATAL EXPOSURE OF NEWBORN ☐	WESTERN BLOT		
OTHER CONDITIONS ATTRIBUTED TO HIV INFECTION ☐ (SPECIFY):	OTHER (SPECIFY):		

PHYSICIAN REQUESTS LOCAL HEALTH DEPARTMENT TO ASSIST WITH: NOTIFICATION TO PATIENT YES ☐ NO ☐ PARTNER SERVICES YES ☐ NO ☐

SEXUALLY TRANSMITTED INFECTION (STI) – ADDITIONAL CASE INFORMATION

SYPHILIS: PRIMARY ☐ SECONDARY ☐ EARLY LATENT (LESS THAN 1 YR) ☐ CONGENITAL ☐ OTHER STAGE ☐ SPECIFY):

GONORRHEA: CERVICAL ☐ URETHRAL ☐ RECTAL ☐ PHARYNGEAL ☐ OPHTHALMIA NEONATORUM ☐ PID ☐ OTHER ☐ SPECIFY):

CHLAMYDIA: CERVICAL ☐ URETHRAL ☐ RECTAL ☐ PHARYNGEAL ☐ PID ☐ OTHER ☐ SPECIFY):

OTHER STI (Specify):

STI LABORATORY CONFIRMATION AND TREATMENT (IF POSITIVE, TREATMENT SECTION REQUIRED)

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

TUBERCULOSIS (Suspect or Confirmed) – ADDITIONAL CASE INFORMATION

MAJOR SITE: PULMONARY ☐ EXTRAPULMONARY ☐ ATYPICAL ☐ (SPECIFY) **ABNORMAL CHEST X-RAY:** ☐

COMMENTS:

REPORTED BY	ADDRESS	TELEPHONE NUMBER	DATE OF REPORT MONTH / DAY / YEAR
☐ 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.
To print blank report forms or get more information about reporting, go to http://ideha.dhmh.maryland.gov/SitePages/what-to-report.aspx.