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.)

SEND TO YOUR LOCAL HEALTH DEPARTMENT

STATE DATA BASE NUMBER
(Completed by Health Department)

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

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.