FAX TO YOUR LOCAL HEALTH DEPARTMENT

VIRGINIA DEPARTMENT OF HEALTH
Confidential Morbidity Report

Patient's Name (Last, First, Middle Initial):	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 Island White Unknown Other (specify):	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: Address:	Phone: ( )
Hospital Admission: ☐ Yes ☐ No Date of Admission	Hospital Name: Medical Record Number:

Laboratory Information and Results

Source of Specimen:	Date Collected:
Laboratory Test and Findings:	
Name/Address of Lab: CLIA Number:	

Other Information

Comments(e.g., Risk situation [Food handling, patient care, day care], Treatment [including dates], Immunization status [indlucing dates], Signs/Symptoms, Exposure, Outbreak Associated, etc.)

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

For Health Department Use

	Date Received:
	NEDSS Patient ID:

Please complete as much of this form as possible Form EPI-1, 10/07