

**Utah County Health Department**

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# MORBIDITY CARD

# CONFIDENTIAL CASE REPORT

Last Name:		First Name:		MI:
Address:		City:		State:
County:	Zip:	Date of birth:	Age:	
Phone #1:	Phone #2:	Phone #3:		
Gender: <i>(check one)</i> <input type="checkbox"/> M <input type="checkbox"/> F	Race: <i>(check all that apply)</i> <input type="checkbox"/> White <input type="checkbox"/> Black/Af. Am <input type="checkbox"/> American Indian <input type="checkbox"/> Unknown <input type="checkbox"/> Asian <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnicity: <i>(check one)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Not Hispanic <input type="checkbox"/> Unknown	

## CLINICAL INFORMATION

Name of disease/condition: \_\_\_\_\_ Date of symptom onset: \_\_\_\_\_

Clinician name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medication: \_\_\_\_\_ Date of treatment: \_\_\_\_\_

Y  N  U Has patient been vaccinated against this disease (if applicable)? If yes, date(s) of vaccine: \_\_\_\_\_

Y  N  U Was patient hospitalized? Hospital: \_\_\_\_\_ Admit date: \_\_\_\_\_

Y  N  U Is patient pregnant? EDC: \_\_\_\_\_

Y  N  U Did patient die? Date of death: \_\_\_\_\_

## LABORATORY INFORMATION

Test name	Laboratory	Date collected	Value	Results
Not necessary to complete this section if lab is attached				

## NOTES

## REPORTING

Name of the reporter:	Phone:	Date reported:
Agency/Clinic name:		