

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						
	Patient's Address			City	State	Zip	Current Gender	Male	Female					
	County of Residence		Home Telephone	Cellphone	Work Telephone		M to F Transgender							
	Ethnicity: Hispanic or Latino		Not Hispanic or Latino		Unknown		F to M Transgender							
	Occupation or Contact with Vulnerable Persons		Food Service Worker		Not Employed		Other							
	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		Pertinent Clinical Information/Comments								
				Yes No										
	Patient Hospitalized		Yes No	Patient Died of This Illness		Additional Lab Results (Specimen – Test – Result – Date – Name of Lab) Please attach copies of lab reports whenever possible.								
	Date Hospital		Yes No Date											
Patient Pregnant		Condition Acquired in Maryland		Suspected Source										
Yes No Unknown Not applicable		Yes No Unknown												
If yes, Due date (mm/dd/yyyy)		If no, Interstate International												
Weeks Pregnant														
HEPATITIS	Laboratory Results													
	HAV Antibody Total		POS NEG DATE	HBV surface Antibody		POS NEG DATE	HCV Genotype		DATE					
	HAV Antibody IgM			HBV DNA			ALT (SGPT) Level		DATE					
	HBV surface Antigen			HCV Antibody RIBA			ALT-Lab Normal Range		TO					
	HBV e Antigen			HCV RNA (e.g. by PCR)			AST (SGOT) Level		DATE					
	HBV core Antibody Total			HCV Antibody (ELISA)			AST-Lab Normal Range		TO					
	HBV core Antibody IgM			HCV Antibody (Rapid)			Name of Lab							
HIV and AIDS	HIV Lab Tests			Date	Result			Risk Exposure (Select all that apply)						
	HIV Diagnostic (Specify)							Complete for HIV/AIDS or STI						
	CD4+ T-cells							Sex with Male						
	HIV Viral Load							Sex with Female						
	HIV Genotype (Resistance)				Name of Testing Lab			Sex Partner has HIV or AIDS						
SEXUALLY TRANSMITTED INFECTION	Syphilis Stage		Syphilis Symptoms		Gonorrhea Site(s)		Chlamydia Site(s)		Other STI (specify)					
	Primary		Lesion		Cervical		Cervical		Sex Partner Injects Drugs Sex Partner is Male that has Sex with Males Injection Drug Use Perinatal Exposure of Newborn Other Exposure (specify)					
	Secondary		Palmar/Plantar Rash		Urethral		Urethral							
	Early Latent (<1 yr)		Condytomata Lata		Rectal		Rectal							
	Congenital		Neurologic		Pharyngeal		Pharyngeal							
	Other Stage (specify)		Other (specify)		Ophthalmia Neonatorum		PID							
					PID		Other (specify)							
	Specify STI Lab Test (e.g. RPR Titer, FTA-TPPA, Darkfield, Smear, Culture, NAAT, EIA, VDRL-CSF)					STI Treatment Given (Specify date – drug – dosage below)			No Treatment Given					
	DATE		TEST		RESULT		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		TST		mm		POS AFB Smear		POS Culture	
					NEG QFT						NEG AFB Smear		NEG Culture	
Symptoms: Cough >3 Weeks		Hemoptysis		Fever		Weight Loss		Fatigue		Abnormal Chest X-ray				
REPORTING SOURCE (REQUIRED)	Provider Name				Provider Telephone No.				Check here if completed by the Local Health Department		Date of Report			
	Facility/Organization (Name and Address)													

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.health.maryland.gov/Pages/what-to-report.aspx>

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