

# MORBIDITY CARD

# CONFIDENTIAL CASE REPORT

Last Name:		First Name:		Date of Birth:		Age:	
Address:				City:		State:	Zip:
County:			Phone #1:		Phone #2:		
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		
Disease:					Date of Onset:		
Laboratory Results/Serotype:			Specimen Source:		Date of Lab Test:		
Name of Laboratory:					Phone:		
Name of Attending Physician:					Phone:		
Hospitalized? <input type="checkbox"/> Y <input type="checkbox"/> N		Where?			Date Hospitalized:		
Pregnant? <input type="checkbox"/> Y <input type="checkbox"/> N		EDC:					
Died? <input type="checkbox"/> Y <input type="checkbox"/> N		Cause of Death:			Date Expired:		
Food Handler? <input type="checkbox"/> Y <input type="checkbox"/> N		Where?					
Health Care Provider? <input type="checkbox"/> Y <input type="checkbox"/> N		Where?			Position/Title:		
Day Care Center? <input type="checkbox"/> Y <input type="checkbox"/> N		Address/Phone:			Attend or Employed?		
Treatment & Dosage Given:					Date:		
Notes:							
*Name of Person Reporting:					*Date Reported:		
Agency:					*Phone:		

A completed form may be mailed, faxed, or emailed to our confidential site.

The information may also be called in. A detailed message may be left on our confidential voice mail.

**Phone with confidential voice mail**

Lisa Guerra 851-7037

or

Darcy Knight 851-7057

or

Jennifer Stoker 851-7023

**Fax**

801-343-8151

or

801-851-7539

**Email**

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or

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or

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