MORBIDITY REPORT FORM

Houston Department of Health and Human Services
8000 North Stadium Drive Houston, Texas 77054
832-393-5080
Fax: (832) 393-5232 [*Do NOT fax HIV/AIDS-related patient information*]

Reported By : ______________________ Date : __________
Case Number :

PATIENT DEMOGRAPHIC DATA

Last Name : __________ FirstName & MI : __________
DOB : __________ Age : __________ Sex : ______
Race/Ethnicity : SocSecNumber :

Address : __________
City, Zipcode : Home Phone : ( ) --

Occupation/Work Place : __________ Tel: ( ) --
School/Day Care Center : __________ Tel: ( ) --
Parent/Contact Person : Tel: ( ) --

DISEASE DATA

Date of Onset:__________

REPORTABLE DISEASE/ORGANISM: __________
Species/serotype : __________

Source of Specimen	Date of Collection	Diagnostic test and Result	Source of Specimen	Date of Collection	Diagnostic test and Result
Specific Viral Hepatitis Studies		Anti-HAV IgM _____ Anti-HAV Total _____	Anti-HBc IgM ___ Anti-HBc Total ___ Anti-HBs ___ HbsAg ___ HbeAg ___	Anti-HCV ___ HCV RIBA ___ HCV RNA by PCR ___	AST/SGOT ___ ALT/SGPT ___

HOSPITAL or CLINIC DATA

Hospital/Clinic : __________
Medical RecNumber : __________
Date Admitted : __________
Date Discharged : __________
Date Expired :

Attending Physician : __________
Address : __________
____
Pager/Phone : __________
Other Physician :

Comments/patient history/risk factors:

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Investigator: __________

FOR OFFICIAL USE ONLY

FILENO:	RPTBY :	HSA:	INTRV :	STATUS :
KMAP :	CENTRCT:	DX :	OCCUP:	

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