



State of Nevada List of Reportable Diseases

Nevada Reportable Diseases

Acquired Immunodeficiency Syndrome (AIDS)*

Amebiasis

Animal bite from a rabies-susceptible species*

Anthrax*

Arsenic:

Exposures and Elevated Levels

Botulism*†

Brucellosis

Campylobacteriosis

CD4 lymphocyte counts <500/μL

Chancroid

Chikungunya virus disease

Chlamydia

Cholera

Coccidioidomycosis

Extraordinary occurrence of illness - Coronavirus
Disease 2019*†

Cryptosporidiosis

Dengue

Diphtheria†

Drowning‡

Ehrlichiosis/anaplasmosis

E. coli O157:H7

Encephalitis

Enterobacteriaceae, Extraordinary occurrence of
illness - Carbapenem-resistant (CRE), including
Carbapenem-resistant Enterobacter spp., Escherichia
coli and Klebsiella spp.

Exposures of Large Groups of People‡

Extraordinary occurrence of illness (e.g. Smallpox,
Dengue, SARS)*†

Giardiasis

Gonorrhea

Granuloma inguinale

Haemophilus Influenzae (invasive disease)

Hansen's Disease (leprosy)

Hantavirus

Hemolytic-uremic
syndrome (HUS)

Hepatitis A, B, C, delta, unspecified

HIV infection*

Influenza

Lead: Exposures and Elevated Levels

Legionellosis

Leptospirosis

Listeriosis

Lyme Disease

Lymphogranuloma venereum

Malaria

Measles (rubeola)†

Meningitis (specify type)

Meningococcal Disease*

Mercury: Exposures and Elevated Levels‡

Extraordinary occurrence of illness - Monkeypox*†

Mumps

Outbreaks of Communicable Disease*†

Outbreaks of Foodborne Disease*†

Pertussis

Plague*†

Poliomyelitis*†

Psittacosis

Q Fever

Rabies (human or animal)*†

Relapsing Fever

Respiratory Syncytial Virus (RSV)

Rotavirus

Rubella (including congenital)†

Saint Louis encephalitis virus (SLEV)

Salmonellosis

Severe Reaction to Immunization

Shigellosis

Spotted Fever Rickettsioses

Streptococcus pneumoniae (invasive)

Streptococcal toxic shock syndrome

Syphilis (including congenital)

Tetanus

Toxic Shock Syndrome

Trichinosis

Tuberculosis†

Latent Tuberculosis, report of positive TST/IGRA

Tularemia*

Typhoid Fever

Varicella (chicken pox)

Vancomycin intermediate Staphylococcus aureus (VISA) and
Vancomycin resistant Staphylococcus aureus

(VRSA) Infection Vibriosis, Non-Cholera

Viral Hemorrhagic Fever*

West Nile Virus

Yellow Fever

Yersiniosis

Zika virus disease

* Must be reported immediately

† Must be reported when suspect

‡ Reportable in Clark County Only

All cases, suspect cases, and carriers must be reported within 24 hours

Updated September 2022

State of Nevada

Confidential Morbidity Report Form Instructions



Disease Reporting

The Nevada Administrative Code (NAC) Chapter 441A requires reports of specified diseases, food borne illness outbreaks and extraordinary occurrences of illness be made to the local Health Authority. The purpose of disease reporting is to recognize trends in diseases of public health importance and to intervene in outbreaks or epidemic situations. Physicians, veterinarians, dentists, chiropractors, registered nurses, directors of medical facilities, medical laboratories, blood banks, school authorities, college administrators, directors of childcare facilities, nursing homes, and correctional institutions are required to report. Failure to report is a misdemeanor and may be subject to an administrative fine of \$1,000 for each violation.

HIPAA and Public Health Reporting

HIPAA laws were developed so as not to interfere with the ability of local public health authorities to collect information. According to 45 CFR 160.204(b): "Nothing in this part shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention."

Instructions for Completing the Morbidity Report Form

Provider Information

Attending Physician/Phone/Fax

The physician primarily responsible for the care of this patient

Person Reporting/Phone/Fax

Provide if different than attending physician

Facility Name/Phone

List the locations for facilities with multiple locations.

Report Date

The date that this report is submitted

Patient Information

Sufficient information must be provided to allow the patient to be contacted. If insufficient information is provided, you will be contacted to provide that information. Attaching a patient face sheet to this report is an acceptable method of providing the patient demographic information.

Address/County/City/State/Zip

The home address of the patient, including the county

Date of Birth / Age

The patient's date of birth or age if birthdate is unknown.

Parent or Guardian Name

For patients under the age of 18, the name of the person(s) responsible for the patient

Phone

The home phone of the patient

Occupation / Employer / School

The occupation or employer of the patient, or the name of the school attended for students

Social Security Number

This information greatly assists in the investigation of cases, allowing easier access to laboratory and medical records.

Medical Record Number

A patient identifier unique to the facility or office

Gender / Sex Assigned at Birth

The current gender of the patient and the sex assigned at birth

Pregnant / Pregnancy EDC

The pregnancy status of the patient and their estimated date of confinement (projected delivery date)

Marital Status

The marital status of the patient

Race / Ethnicity

Race and ethnicity categories have been chosen to match those used by the Centers for Disease Control and Prevention.

Primary Language Spoken

Providing this information makes it easier to contact non-English-speaking patients and arrange for translators

Birth Country and Arrival Date

If the patient was not born in the United States, provide the patient's country of origin and date of arrival in the US.

Incarcerated

The incarceration status of the patient. If the patient is currently incarcerated, list the facility in the comments section

Disease Information

Disease or Condition Name

This form should be used for all legally reportable diseases in the state of Nevada

Onset Date

The date of the first symptom experienced by the patient

Diagnosis Date

The date that this disease was diagnosed. For reports of suspect illness, enter the date the illness was suspected.

Date Admitted/Discharged

For any patients admitted to a hospital, the date of admission and discharge (if the patient has been discharged)

Deceased / Date of Death

If the patient has died, list the date of death. If known, list the cause of death under comments.

Symptoms

All relevant symptoms

Laboratory Testing

If laboratory testing has been ordered, please attach the laboratory results to this form. If relevant tests are pending, list them in the comments section, as well as the name of the laboratory performing the testing

Treatment

Treatment information is necessary for the reporting of sexually transmitted diseases, and helpful in the investigation of other illnesses. If this field is left blank, you will be contacted to provide this information

Comments

Provide any additional information that may be useful in the investigation or to explain answers given elsewhere on this form.

Contact Information

Carson City Health & Human Services (Carson, Lyon, and Douglas Counties):

900 E. Long St.
Carson City, NV 89706
<http://gethealthycarsoncity.org>
Phone: (775) 887-2190
After-Hours Phone: (775) 887-2190
Confidential Fax (775) 887-2138

Nevada Division of Public and Behavioral Health (All other counties)

4150 Technology Way
Carson City, Nevada 89706
<http://dpbh.nv.gov>
Phone: (775) 684-5911 (24 Hours)
Confidential Fax: (775) 684-5999
After Hours Duty Officer: (775) 400-0333

Southern Nevada Health District (Clark County)

PO Box 3902
Las Vegas, NV 89127
<http://www.snhd.info>
Confidential Fax: (702) 759-1414
Epidemiology
Phone: (702) 759-1300 (24 hours)
Confidential Fax: (702) 759-1414
STDs, HIV, and AIDS
Phone: (702) 759-0727
Confidential Fax: (702) 759-1454
Tuberculosis
Phone: (702) 759-1015
Confidential Fax: (702) 759-1435

Washoe County Health District (Washoe County)

1001 E. Ninth St., Building B
P. O. Box 11130
Reno, Nevada 89520-0027
<http://www.washoecounty.us/health/>
Phone: (775) 328-2447 (24 hours)
Confidential Fax: (775) 328-3764

Nevada Rabies Control Contact

[Click this Link for Contact Sheet](#)

How to Report

Completed reports can be faxed to the numbers listed on the front of this form. Diseases requiring immediate investigation and/or prophylaxis (e.g., invasive meningococcal disease, plague) should be also reported by telephone to the appropriate health jurisdiction.

State of Nevada

Confidential Morbidity Report Form



Nevada Department of
Health and Human Services



WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

Source	Provider Name		Provider Telephone #		Report Date	
	Facility/Organization (Name and Address)				☐ Check if completed by the Local Health Department	
	Person Reporting		Reporter Phone	Reporter Fax	Reporter Job Title	
Facility Type	Inpatient: Hospital Other _____		Outpatient: Private Office ☐ Adult HIV Clinic Other _____		Screening Diagnostic Referral Agency: CTS STD Clinic Other _____	
					Other Facility: Emergency Room ☐ Laboratory ☐ Corrections ☐ Other _____	
Patient Demographic Data	Patient Name (Last)		(First)	(MI)	Date of Birth	Age
	Patient Address		(City)		(State)	(Zip)
	County of Residence		Home Phone		Cell Phone	
	Pregnant No Yes	Prenatal Care No Yes	Pregnancy EDC		Ethnicity	Hispanic/Latino Non-Hispanic/Latino Unknown
	Parent or Guardian Name		Birth Country and Arrival Date		Primary Language Spoken	
	Social Security Number		Occupation / Employer / School		Medical Records Number	
	Incarcerated No Yes	Marital Status Single ☐ Married Widowed Separated Divorced Unknown				
	Sexual Orientation: Straight or Heterosexual ☐ Lesbian or Gay Bisexual Queer Pansexual Decline to answer Other, specify: _____					Race(s) ☐ White ☐ Black: ☐ Asian ☐ American Indian Pacific Islander Other ☐ Unknown Expanded race: _____
Morbidity Data	Disease or Condition		Date of Onset		Patient Notified of This Condition Yes No	
	Patient Hospitalized Yes No Admit Date Hospital:		Patient Died of This Illness Yes No Date:		Pertinent Clinical Information/Comments	
	Condition Acquired in Nevada Yes No Unknown If no, Interstate International		Diagnosis Date	Discharge Date		
	Was laboratory testing ordered? If yes, attach the results or provide the laboratory name if the results are unavailable ☐ Yes No				Was the patient treated? If yes, provide the treatment details (drug name, dosage, duration, dates etc.) No Yes	
Hepatitis Laboratory Results	POS NEG Date		POS NEG Date		Date / Range	
	HAV Antibody Total		HBV DNA		HCV Genotype	
	HAV Antibody IgM ☐ ☐		HCV Antibody RIBA ☐ ☐		ALT (SGPT) Level	
	HBV Surface Antigen ☐ ☐		HCV RNA (e.g. by PCR) ☐ ☐		Alt-Lab Normal Range	
	HBV e Antigen ☐ ☐		HCV Antibody (ELISA) ☐ ☐		AST (SGOT) Level	
	HBV Core Antibody Total ☐ ☐		HCV Antibody (Rapid) ☐ ☐		AST-Lab Normal Range	
	HBV core Antibody IgM ☐ ☐		HDV Antibody ☐ ☐		Name of Lab	
	HBV Surface Antibody ☐ ☐		HDV Rapid ☐ ☐			

	Patient Name (Last)	(First)	MI)							
Initial Diagnostic HIV Tests	Has this patient been informed of his/her HIV infection? Yes No Unknown				Evidence of receipt of HIV medical care other than laboratory test results ☐ Yes, documented ☐ Yes, client self-report, only ☐ Date of medical visit or prescription					
	The patient's partners will be notified about their HIV exposure and counseled by: Health Dept. Physician/provider Patient Unknown									
	TEST 1	HIV-1 IA	HIV-1/2 IA	HIV-1/2 Ag/Ab			HIV-1 WB	HIV-1 IFA	HIV-2 IA	HIV-2 WB
	Test Brand Name/Manufacturer: _____						Point of care rapid test			
	Results	Positive	Negative	Indeterminate			Collection Date: _			
	TEST 2	HIV-1 IA	HIV-1/2 IA	HIV-1/2 Ag/Ab	HIV-1 WB	HIV-1 IFA	HIV-2 IA	HIV-2 WB		
	Test Brand Name/Manufacturer: _				Point of care rapid test		Risk Exposure (select all that apply) <u>Complete for HIV/AIDS or STI</u>			
	Results	Positive	Negative	Indeterminate	Collection Date: _					
HIV Type Diff	HIV-1-2 Ag/Ab type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)									
	Analyte results:	HIV-1 Ag: Reactive	Nonreactive	Not reportable due to high Ab level		Date:				
		HIV-1 Ab: Reactive	Nonreactive	Undifferentiated/Indeterminate						
		HIV-2 Ab: Reactive	Nonreactive	Undifferentiated/Indeterminate						
HIV Viral Load HIV Genotype	Qualitative			Quantitative						
	Results	Positive	Negative	Indeterminate	Results	Detectable	Undetectable			
	Collection Date: _			Copies/mL: _____ Collection Date: _____						
	HIV Genotype (Resistance)			Collection Date: _____	Interpretation: _____					
Sexually Transmitted Infection (STI)	Syphilis Stage		Syphilis Symptoms		Gonorrhea Specimen Site		Chlamydia Site(s)	STI Treatment		
	☐ Primary ☐ Secondary ☐ Early Latent (<1 yr) ☐ Latent ☐ Congenital ☐ Unknown		Chancre Palmar/Plantar Rash Condylomata Lata Neurologic Other (specify) _____		Cervical Urethral Rectal Pharyngeal Ophthalmia Neonatorum ☐ PID ☐ Other (specify) _____		Cervical ☐ Urethral Rectal Pharyngeal PID Other (specify) _____	Azithromycin 1g ☐ L-A Bicillin 2.4 mu IM x # _____ (doses) No Treatment Given ☐ Ceftriaxone/Rocephin 500mg IM ☐ Doxy 100 Mg BID x # _____ Days Other: _____		
	Specify STI Lab Test (e.g. RPR Titer, FTA-TPPA, Darkfield, Smear, Culture, NAAT, EIA, VDRL-CSF)									
	Date	Test	Result							
	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 ____ (#) partners Yes, I wrote a prescription for ____ (#) partner(s)									
	Partner Name _____ DOB _____									
	TB Disease and LTBI	Tuberculosis Disease (suspected or confirmed) ☐ TB Disease Site: _____				Chest X-ray/Imaging: (include last report)				
☐ Latent TB Infection (LTBI)				Abnormal Normal Date: _____						
Symptoms		Cough > 3 weeks	Hemoptysis	Fever	Weight loss	Fatigue	Abnormal Chest X-ray			
Laboratory Results (include a copy of laboratory testing)						Treatment (include drug(s)/dose(s))				
TB Test, IGRA			POS	NEG	Date	No treatment started				
TB Test, TST: _ mm			_____	_____	_____	LTBI treatment, Date started				
			AFB Smear	_____	_____	TB Disease treatment, Date started				
			NAAT	_____	_____					
			Culture	_____	_____					
COVID-19	COVID-19	lab test type:	PCR	Antigen	☐ Antibody	Vaccine Brand Name:	First Vaccine Date:			
	COVID Vaccine	Yes	No				Second Vaccine Date (if applicable):			

Fax completed forms to:

Carson City, Lyon, Douglas: (775) 887-2138
 Washoe County: (775) 328-3764
 All Other Areas: (775) 684-5999

Clark County: HIV (702) 759-1454
 TB (702) 759-1435
 General (and COVID) (702) 759-1414