



# 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

Babesiosis

Botulism\*†

Brucellosis

Campylobacteriosis

*Candida auris*

CD4 lymphocyte counts <500/μL

Chancroid

Chikungunya virus disease

Chlamydia

Cholera

Coccidioidomycosis

Coronavirus disease 2019 (COVID-19)

~~Extraordinary occurrence of illness - Coronavirus Disease 2019 (COVID-19)\*†~~

Cryptosporidiosis

Cyclosporiasis (parasite)

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, any type)

Hansen's Disease (leprosy)

Hantavirus

Hemolytic-uremic syndrome (HUS)

Hepatitis A, B, C, delta, unspecified

Hepatitis C, negative results

HIV infection\*

HIV infection, negative results

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‡

Mpox (also known as 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

## State of Nevada

# Confidential Morbidity Report Form Instructions

Updated January 2024

### 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 constructed 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

#### **Source Information**

##### Provider Name/Phone Number

The physician primarily responsible for the care of this patient

##### Person Reporting/Phone/Fax

Provide if different than attending physician Facility/Organization

List the locations for facilities with multiple locations.

##### Report Date

The date that this report is submitted

##### Patient Demographic Data

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

#### **Morbidity Data**

##### 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://dphh.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

#### **Northern Nevada Public Health (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

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

<b>Initial Diagnostic HIV Tests</b>	Has this patient been informed of his/her HIV infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown				Evidence of receipt of HIV medical care other than laboratory test results (record additional evidence in comments) <input type="checkbox"/> Yes, documented <input type="checkbox"/> Yes, client self-report, only <input type="checkbox"/> Date of medical visit prescription __/__/____
	The patient's partners will be notified about their HIV exposure and counseled by: <input type="checkbox"/> Health Dept. <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown				
	TEST 1 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB				
	Test Brand Name/Manufacturer: _____		<input type="checkbox"/> Point of care rapid test		
	Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Collection Date: _____		
<b>HIV Type Diff</b>	HIV-1-2 Ag/Ab type-differentiating immunoassay (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)				<i>Risk Exposure (select all that apply)</i> <i>Complete for HIV/AIDS or STI</i> <input type="checkbox"/> Sex with Male <input type="checkbox"/> Sex with Female <input type="checkbox"/> Inject(ed) non-prescription drugs <input type="checkbox"/> Sex Partner has HIV or AIDS <input type="checkbox"/> Sex Partner Injects Drugs <input type="checkbox"/> Sex Partner is Male that has Sex with Males <input type="checkbox"/> Injection Drug Use <input type="checkbox"/> Perinatal Exposure of Newborn <input type="checkbox"/> Other Exposure (specify) _____
	Analyte results:	HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	
	<input type="checkbox"/> Not reportable due to high Ab level				
	<input type="checkbox"/> Undifferentiated/Indeterminate				
	<input type="checkbox"/> Undifferentiated/Indeterminate				
<b>HIV Viral Load HIV Genotype</b>	Qualitative Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Quantitative Results <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		
	Collection Date: _____		Copies/mL: _____		
	Collection Date: _____		Collection Date: _____		
HIV Genotype (Resistance)    Collection Date: _____    Interpretation: _____					
<b>Sexually Transmitted Infection (STI)</b>	Syphilis Stage	Syphilis Symptoms	Gonorrhea Specimen Site	Chlamydia Site(s)	STI Treatment
	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early Latent (<1 yr) <input type="checkbox"/> Latent <input type="checkbox"/> Congenital <input type="checkbox"/> Unknown	<input type="checkbox"/> Chancre <input type="checkbox"/> Palmar/Plantar Rash <input type="checkbox"/> Condylomata Lata <input type="checkbox"/> Neurologic <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Cervical <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Ophthalmia Neonatorum <input type="checkbox"/> PID <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Cervical <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> PID <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> L-A Bicillin 2.4 mu IM x # _____ (doses) <input type="checkbox"/> No Treatment Given <input type="checkbox"/> Ceftriaxone/Rocephin 500mg IM <input type="checkbox"/> Doxy 100 Mg BID x # _____ Days <input type="checkbox"/> 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)					
<input type="checkbox"/> Yes, I saw the sex partner(s) in my office <input type="checkbox"/> Yes, I gave medication for ___ (#) partners <input type="checkbox"/> Yes, I wrote a prescription for ___ (#) partner(s)					
Partner Name _____ DOB _____					
<b>TB Disease and LTBI</b>	<input type="checkbox"/> Tuberculosis Disease (suspected or confirmed)		<input type="checkbox"/> TB Disease Site: _____		Chest X-ray/Imaging: (include last report)
	<input type="checkbox"/> Latent TB Infection (LTBI)				<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal Date: _____
	Symptoms <input type="checkbox"/> Cough > 3 weeks <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Abnormal Chest X-ray				
	Laboratory Results (include a copy of laboratory testing)				
TB Test, IGRA		POS	NEG	Date	Treatment (include drug(s)/dose(s)) <input type="checkbox"/> No treatment started <input type="checkbox"/> LTBI treatment, Date started _____ <input type="checkbox"/> TB Disease treatment, Date started _____
TB Test, TST: ___ mm					
AFB Smear		POS	NEG	Date	
NAAT					
Culture					
<b>COVID-19</b>	<input type="checkbox"/> COVID-19	lab test type: <input type="checkbox"/> PCR <input type="checkbox"/> Antigen <input type="checkbox"/> Antibody		Vaccine Details:	
	COVID-19 Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		Vaccine Date: _____		

**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-19) (702) 759-1414