

State of Nevada List of Reportable Diseases

Nevada Reportable Diseases

Amebiasis	Legionellosis
Animal bite from a rabies-susceptible species*	Leptospirosis
Anthrax*	Listeriosis
Arsenic	Lyme Disease
Exposures and Elevated Levels	Lymphogranuloma venereum
Babesiosis	Malaria
Botulism*†	Measles (rubeola)†
Brucellosis	Meningitis (specify type)
Campylobacteriosis	Meningococcal Disease*
<i>Candida auris</i>	Mercury: Exposures and Elevated Levels‡
CD4 lymphocyte counts <500/μL	Mpox (also known as monkeypox)
Chancroid	Mumps
Chikungunya virus disease	Outbreaks of Communicable Disease*†
Chlamydia	Outbreaks of Foodborne Disease*†
Cholera	Pertussis
Coccidioidomycosis	Plague*†
Coronavirus disease 2019 (COVID-19)	Poliomyelitis†
Cryptosporidiosis	Psittacosis
Cyclosporiasis (parasite)	Q Fever
Dengue	Rabies (human or animal)*†
Diphtheria†	Relapsing Fever
Drowning‡	Respiratory Syncytial Virus (RSV)
Ehrlichiosis/anaplasmosis	Rotavirus
E. coli O157:H7	Rubella (including congenital)†
Encephalitis	Saint Louis encephalitis virus (SLEV)
Enterobacteriaceae, Extraordinary occurrence of illness - Carbapenem-resistant (CRE), including Carbapenem-resistant Enterobacter spp., Escherichia coli and Klebsiella spp.	Salmonellosis
Exposures of Large Groups of People‡	Severe Reaction to Immunization
Extraordinary occurrence of illness*†	Shigellosis
Giardiasis	Spotted Fever Rickettsioses
Gonorrhea	Streptococcus pneumoniae (invasive)
Granuloma inguinale	Streptococcal toxic shock syndrome
Haemophilus influenzae (invasive, any type)	Syphilis (including congenital)
Hansen's Disease (leprosy)	Tetanus
Hantavirus	Toxic Shock Syndrome
Hemolytic-uremic syndrome (HUS)	Trichinosis
Hepatitis A, B, C, delta, unspecified	Tuberculosis†
Hepatitis C, negative results	Latent Tuberculosis, report of positive TST/IGRA
Human Immunodeficiency virus infection (HIV)*	Tularemia*
HIV Stage 3 (formerly known as Acquired Immunodeficiency Syndrome [AIDS])*	Typhoid Fever
HIV, negative results	Varicella (chicken pox)
Influenza	Vancomycin intermediate Staphylococcus aureus (VISA) and Vancomycin resistant Staphylococcus aureus (VRSA) Infection
Lead: Exposures and Elevated Levels	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

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://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

Northern Nevada Public Health (Washoe County)

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

Central Nevada Health District (Churchill, Mineral, Eureka, and Pershing County)

485 West B. St.
Fallon, NV 89406
<https://www.centralnevadahd.org/>
Phone: (775) 866-7535 (24 hours)
Confidential Fax: (877) 513-3442

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 also be reported by telephone to the appropriate health jurisdiction.



State of Nevada Confidential Morbidity Report Form

Source	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	
Facility Type	Inpatient: Hospital Other _____	Outpatient: Private Office <input type="checkbox"/> Adult HIV Clinic Other _____		Screening Diagnostic Referral Agency: CTS STD Clinic Other _____		Other Facility: Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> 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 <input type="checkbox"/> Married Widowed Separated Divorced Unknown				
Sexual Orientation: Straight or Heterosexual <input type="checkbox"/> Lesbian or Gay Bisexual Queer Pansexual Decline to answer Other, specify: _____					Race(s) <input type="checkbox"/> White <input type="checkbox"/> Black: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian Pacific Islander Other <input type="checkbox"/> Unknown	
Morbidity Data	Disease or Condition		Date of Onset		Patient Notified of This Condition Yes No	
	Patient Hospitalized Admit Date Discharge 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	Suspected Source		
	Was laboratory testing ordered? <i>If yes, attach the results or provide the laboratory name if the results are unavailable</i>			No <input type="checkbox"/> Yes <input type="checkbox"/>	Was the patient treated? <i>If yes, provide the treatment details (drug name, dosage, duration, dates etc.)</i>	
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 (record additional evidence in comments) <input type="checkbox"/> Yes, documented <input type="checkbox"/> 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						
Results	Positive	Negative	Indeterminate	Collection Date: _			Risk Exposure (select all that apply) <u>Complete for HIV/AIDS or STI</u>		
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:	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)		
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		
	<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	Chancre Palmar/Plantar Rash Condylomata Lata Neurologic Other (specify) _____		Cervical Urethral Rectal Pharyngeal Ophthalmia Neonatorum <input type="checkbox"/> PID <input type="checkbox"/> Other (specify) _____	Cervical <input type="checkbox"/> Urethral Rectal Pharyngeal PID Other (specify) _____		Azithromycin 1g <input type="checkbox"/> L-A Bicillin 2.4 mu IM x # _____ (doses) No Treatment Given <input type="checkbox"/> Ceftriaxone/Rocephin 500mg IM <input type="checkbox"/> 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) <input type="checkbox"/> TB Disease Site: _____			Chest X-ray/Imaging: (include last report) Abnormal Normal Date: _____					
	<input type="checkbox"/> Latent TB Infection (LTBI)								
	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))		
		POS	NEG	Date	If Not Sputum, indicate source: _____		No treatment started LTBI treatment, Date started TB Disease treatment, Date started		
TB Test, IGRA	_____	_____	_____	_____	POS	NEG	Date		
TB Test, TST: _ mm	_____	_____	_____	_____	AFB Smear	_____	_____		
					NAAT	_____	_____		
					Culture	_____	_____		
COVID-19	COVID-19	lab test type:	PCR	Antigen	<input type="checkbox"/> Antibody		Vaccine Brand Name: _____		
	COVID Vaccine	Yes	No			First Vaccine Date: _____ Second Vaccine Date (if applicable): _____			

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