

## State of Nevada List of Reportable Diseases

### Nevada Reportable Diseases

Amebiasis	Legionellosis
Animal bite from a rabies-susceptible species*	Leptospirosis
Anthrax*	Listeriosis
Arsenic: Exposures and Elevated Levels	Lyme Disease
Babesiosis	Lymphogranuloma venereum
Botulism*†	Malaria
Brucellosis	Measles (rubeola)†
Campylobacteriosis	Meningitis (specify type)
<i>Candida auris</i>	Meningococcal Disease*
Carbapenem-resistant Enterobacteriales (CRE), including <i>Enterobacter</i> spp., <i>Escherichia coli</i> and <i>Klebsiella</i> spp.	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)
Exposures of Large Groups of People‡	Salmonellosis
Extraordinary occurrence of illness*†	Severe Reaction to Immunization
Giardiasis	Shigellosis
Gonorrhea	Spotted Fever Rickettsioses
Granuloma inguinale	Streptococcus pneumoniae (invasive)
<i>Haemophilus influenzae</i> (invasive, any type)	Streptococcal toxic shock syndrome
Hansen's Disease (leprosy)	Syphilis (including congenital)
Hantavirus	Tetanus
Hemolytic-uremic syndrome (HUS)	Toxic Shock Syndrome
Hepatitis A, B, C, delta, unspecified	Trichinosis
Hepatitis C, negative results	Tuberculosis†
Human Immunodeficiency virus infection (HIV)*	Tuberculosis, Latent Infection (LTBI)
HIV Stage 3 (formerly known as Acquired Immunodeficiency Syndrome [AIDS])*	Tularemia*
HIV, negative results	Typhoid Fever
Influenza	Varicella (chicken pox)
Lead: Exposures and Elevated Levels	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

### 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

#### **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 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

#### **Northern Nevada Public Health (Washoe County)**

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

#### **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

#### **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: <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 _____					
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 <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					
	Social Security Number		Occupation / Employer / School		Medical Records Number					
	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								
Sexual Orientation: <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Pansexual <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other, specify: _____										
Morbidity Data	Disease or Condition		Date of Onset	Patient Notified of This Condition <input type="checkbox"/> Yes <input type="checkbox"/> No		Pertinent Clinical Information/Comments				
	Patient Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient Died of This Illness <input type="checkbox"/> Yes <input type="checkbox"/> No							
	Admit Date _____ Discharge Date: _____		Date: _____							
	Hospital: _____									
Condition Acquired in Nevada <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Diagnosis Date	Suspected Source	Symptoms						
If no, <input type="checkbox"/> Interstate <input type="checkbox"/> International										
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							
Hepatitis Laboratory Results	HAV Antibody Total	POS	NEG	Date	HBV DNA	POS	NEG	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)		
Initial Diagnostic HIV Tests	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 or 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: _____ Point of care rapid test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> 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)			<b>Risk Exposure (select all that apply)</b> <u>Complete for HIV/AIDS or STI</u> <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	<input type="checkbox"/> Not reportable due to high Ab level		Date: _____
	HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	<input type="checkbox"/> Undifferentiated/Indeterminate			
	HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	<input type="checkbox"/> Undifferentiated/Indeterminate			
HIV Viral Load HIV Genotype	<b>Qualitative</b> Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Collection Date: _____		<b>Quantitative</b> Results <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable 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	<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		
TB Disease and Latent TB Infection	<input type="checkbox"/> Tuberculosis Disease (suspected or confirmed) <input type="checkbox"/> TB Disease Site: _____ <input type="checkbox"/> Latent TB Infection (LTBI) Diagnosis _____			Chest X-ray/Imaging: (include last report) <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal Date: _____	
	REASON for TB Testing: <input type="checkbox"/> Immigration/I-693; <input type="checkbox"/> TB symptoms; <input type="checkbox"/> Birth/Travel outside U.S. > 1 month; <input type="checkbox"/> Contact to infectious TB disease; <input type="checkbox"/> Employee screen; <input type="checkbox"/> Immunosuppression or planned; <input type="checkbox"/> Co-morbidity (diabetes, HIV, organ transplant, end-stage renal disease, cancer)				
	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)			Treatment (include drug(s)/dose(s))	
	POS	NEG	Date	<input type="checkbox"/> No treatment started <input type="checkbox"/> LTBI treatment: _____ Date started _____ <input type="checkbox"/> TB Disease treatment: _____ Date started _____	
TB Test, IGRA (QFT/TSPOT):	_____	_____	_____	If Not Sputum, indicate source: _____ POS NEG Date AFB Smear _____ NAAT _____ Culture _____	
TB Test, TST: _____ mm	_____	_____	_____		
COVID-19	COVID-19 lab test type: <input type="checkbox"/> PCR <input type="checkbox"/> Antigen <input type="checkbox"/> Antibody	Vaccine Brand Name: _____			
	COVID Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No	First Vaccine Date: _____ Second Vaccine Date (if applicable): _____			

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