

State of Nevada List of Reportable Diseases

Unless otherwise specified, all conditions must be reported during the regular business hours of the health authority on the first working day following the identification of the case or suspected case.

Nevada Reportable Diseases §

Amebiasis
Animal bite from a rabies-susceptible animal**
Anthrax*†
Any infection or disease related to an act of intentional transmission or biological terrorism*†
 Arsenic: Exposures and Elevated Levels‡
 Babesiosis
Botulism*†
Brucellosis**
 Campylobacteriosis
Candida auris
 Chancroid
 Chikungunya virus disease
 Chlamydia
Cholera**
 Coccidioidomycosis
 Coronavirus disease 2019 (COVID-19)
 Cryptosporidiosis
 Cyclosporiasis
 Dengue
Diphtheria†**
 Drowning‡
 Ehrlichiosis/anaplasmosis
 Encephalitis
 Enterobacteriaceae, Carbapenem-resistant (CRE), including *Enterobacter* spp., *Escherichia coli* and *Klebsiella* spp.
 Exposures of Large Groups of People‡
Extraordinary occurrence of illness*†
 Giardiasis
 Gonorrhea
 Granuloma inguinale
Haemophilus influenzae (invasive, any type)**
 Hansen's Disease (leprosy)
 Hantavirus
 Hemolytic-uremic syndrome (HUS)
Hepatitis A**
 Hepatitis B, acute and chronic
 Hepatitis C, perinatal, acute, and chronic
 Hepatitis C, negative results¶
 Hepatitis Delta
Hepatitis E**
 Hepatitis, unspecified
 Human Immunodeficiency virus infection (HIV)
 HIV: Stage 3 (formerly known as Acquired Immunodeficiency Syndrome [AIDS])
 HIV: negative results¶
 Influenza associated with a hospitalization
Influenza associated with a death**
Influenza of a pandemic risk strain*†
 Influenza of a strain that is novel or untypable
 Lead: Exposures and Elevated Levels‡
 Lead: All blood lead level test results in a child under 18 years of age¶
 Legionellosis
 Leptospirosis
 Listeriosis
 Lyme Disease
 Lymphogranuloma venereum
 Malaria
Measles (rubeola)*† (single case concerning for possible outbreak)
 Meningitis
Meningococcal Disease*†
 Mercury: Exposures and Elevated Levels‡
 Mpox (also known as monkeypox)
Mumps**
Outbreaks and Suspected Outbreaks*†
Outbreaks of Foodborne Disease*†
Pertussis†**
Plague*†
Poliovirus infection*†
 Psittacosis
 Q Fever
Rabies (human*† or animal)**
 Relapsing Fever
 Respiratory Syncytial Virus (RSV)
 Rotavirus
Rubella (including congenital)†**
 Saint Louis encephalitis virus (SLEV)
 Salmonellosis
Severe Acute Respiratory Syndrome (SARS)*†
 Severe Reaction to Immunization
 Shiga toxin-producing *Escherichia coli* (STEC, e.g., *E. coli* O157:H7)
 Shigellosis
Smallpox (variola)*†
 Spotted Fever Rickettsioses
Staphylococcus aureus, vancomycin intermediate (VISA) and vancomycin resistant (VRSA) infection
 Streptococcus pneumoniae (invasive)
 Streptococcus, group A (invasive)‡
 Syphilis (including congenital)
 Tetanus
 Toxic Shock Syndrome, streptococcal and other
 Trichinosis
Tuberculosis†**
 Tuberculosis, Latent Infection (LTBI)**
Tularemia*†
Typhoid Fever**
 Varicella (chicken pox)
 Vibriosis, Non-Cholera
Viral Hemorrhagic Fever*†
 West Nile Virus
 Yellow Fever
 Yersiniosis
 Zika virus disease

* Must be reported immediately

** Must be reported within 24 hours

*** Must be reported within 5 days

† Must be reported when suspect

‡ Reportable in Clark County only

¶ Reporting of negative test results should occur through Electronic Laboratory Reporting (ELR). If ELR is not available, the CMR form on page 3 of this document can be used.

§ Any condition identified by the CDC as nationally notifiable is also notifiable in Nevada per [NAC 441A](#)

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
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://dphh.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
Reno, Nevada 89512
<https://www.nnpd.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)				☐ 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 ☐ Expanded Ethnicity _____					
	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 _____ 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			
					Symptoms					
Hepatitis Laboratory Results	Was laboratory testing ordered? If yes, attach the results or provide the laboratory name if the results are unavailable ☐ No ☐ Yes				Was the patient treated? If yes, provide the treatment details (drug name, dosage, duration, dates etc.) ☐ No ☐ Yes					
Hepatitis Laboratory Results	HAV Antibody Total	POS	NEG	Date	HBV DNA	POS	NEG	Date	HCV Genotype	Date / Range
	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) ☐ 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 Results ☐ Positive ☐ Negative ☐ Indeterminate Collection Date: _____				Risk Exposure (select all that apply) <u>Complete for HIV/AIDS or STI</u> ☐ Sex with Male ☐ Sex with Female ☐ Inject(ed) non-prescription drugs ☐ Sex Partner has HIV or AIDS ☐ Sex Partner Injects Drugs ☐ Sex Partner is Male that has Sex with Males ☐ Injection Drug Use ☐ Perinatal Exposure of Newborn ☐ Other Exposure (specify) _____																													
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 HIV-1 Ab: ☐ Reactive ☐ Nonreactive HIV-2 Ab: ☐ Reactive ☐ Nonreactive	☐ Not reportable due to high Ab level ☐ Undifferentiated/Indeterminate ☐ Undifferentiated/Indeterminate	Date: _____																														
HIV Viral Load HIV Genotype	Qualitative Results ☐ Positive ☐ Negative ☐ Indeterminate Collection Date: _____		Quantitative Results ☐ Detectable ☐ 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																													
	☐ 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 Latent TB Infection	☐ Tuberculosis Disease (suspected or confirmed) ☐ TB Disease Site: _____ Chest X-ray/Imaging: (include last report) ☐ Latent TB Infection (LTBI) Diagnosis _____ ☐ Abnormal ☐ Normal Date: _____																																	
	REASON for TB Testing: ☐ Immigration/I-693; ☐ TB symptoms; ☐ Birth/Travel outside U.S. > 1 month; ☐ Contact to infectious TB disease; ☐ Employee screen; ☐ Immunosuppression or planned; ☐ Co-morbidity (diabetes, HIV, organ transplant, end-stage renal disease, cancer)																																	
	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))																													
	<table border="0"> <tr> <td></td><td>POS</td><td>NEG</td><td>Date</td><td></td></tr> <tr> <td>TB Test, IGRA (QFT/TSPOT):</td><td>_____</td><td>_____</td><td>_____</td><td>If Not Sputum, indicate source: _____</td></tr> <tr> <td>TB Test, TST: _____ mm</td><td>_____</td><td>_____</td><td>_____</td><td>POS NEG Date</td></tr> <tr> <td></td><td></td><td></td><td></td><td>AFB Smear _____</td></tr> <tr> <td></td><td></td><td></td><td></td><td>NAAT _____</td></tr> <tr> <td></td><td></td><td></td><td></td><td>Culture _____</td></tr> </table>					POS	NEG	Date		TB Test, IGRA (QFT/TSPOT):	_____	_____	_____	If Not Sputum, indicate source: _____	TB Test, TST: _____ mm	_____	_____	_____	POS NEG Date					AFB Smear _____					NAAT _____					Culture _____
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				AFB Smear _____																														
				NAAT _____																														
				Culture _____																														
COVID-19	COVID-19	lab test type: ☐ PCR ☐ Antigen ☐ Antibody		Vaccine Brand Name: _____ First Vaccine Date: _____ Second Vaccine Date (if applicable): _____																														
	COVID Vaccine ☐ Yes ☐ No																																	

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