



# 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.

Updated

### 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.

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 Name (Last) (First) (MI)		Date of Birth	Age	Sex assigned at birth Female Male				
Patient Demographic Data	Patient Address		(City)	(State)	(Zip)	Current Gender Female M to F Transgender <input type="checkbox"/> Male F to M Transgender <input type="checkbox"/> Unknown Refused to answer <input type="checkbox"/> Additional gender identity (specify) _____			
	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 <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 Expanded race: _____			
	Disease or Condition		Date of Onset	Patient Notified of This Condition Yes No		Pertinent Clinical Information/Comments			
Patient Hospitalized Admit Date		Yes No Hospital:	Patient Died of This Illness Yes No Date:						
Condition Acquired in Nevada Yes No Unknown If no, Interstate International		Diagnosis Date	Discharge Date	Symptoms/Suspected Source					
Was laboratory testing ordered? If yes, attach the results or provide the laboratory name if the results are unavailable			No <input type="checkbox"/> 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		<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? Yes No Unknown			Evidence of receipt of HIV medical care other than laboratory test results <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: Health Dept. Physician/provider Patient Unknown								
	<b>TEST 1</b>	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		Collection Date: _		
	<b>TEST 2</b>	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		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) Complete for HIV/AIDS or STI</b> <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: 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	<b>Qualitative</b>			<b>Quantitative</b>					
	Results	Positive	Negative	Indeterminate	Results	Detectable	Undetectable		
	Collection Date: _			Copies/mL: _____					
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	Chancere 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)					
	<input type="checkbox"/> Latent TB Infection (LTBI)			Abnormal    ormal 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	If Not Sputum, indicate source: _			No treatment started		
TB Test, TST: _ mm	_____	_____	_____	POS	NEG	Date	LTBI treatment, Date started		
				AFB Smear	_____	_____	TB Disease treatment, Date started		
				NAAT	_____	_____			
				Culture	_____	_____			
COVID-19	COVID-19	lab test type: PCR	Antigen	<input type="checkbox"/> 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