

REPORTABLE DISEASES AND CONDITIONS

City and County of San Francisco

San Francisco Department of Public Health

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20 and §2800-2812.

§2500 (b) It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

§2500 (c) The Administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.

WHOM TO REPORT TO:

REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO COMMUNICABLE DISEASE CONTROL UNIT UNLESS OTHERWISE INDICATED

COMMUNICABLE DISEASE CONTROL UNIT PHONE: (415) 554-2830 FAX: (415) 554-2848 M-F 8AM TO 5PM CD URGENT REPORTS: After hours: call 415-554-2830, press "2" & follow the instructions on the voicemail to page the on-call MD.	HIV- New HIV cases must be called in to the REPORTING PHONE: (628) 217-6335 STD REPORTING PHONE: (628) 217-6653 FAX: (628) 217-6603	ANIMAL CARE & CONTROL ANIMAL BITES (MAMMALS Only) PHONE: (415) 554-9422 FAX: (415) 864-2866 ENVIRONMENTAL HEALTH SERVICES FOR PESTICIDE PHONE: (415) 252-3862 FAX: (415) 252-3818
COVID-19 REPORTING: Hospitalizations/deaths & POC testing by HCP Fax: (628) 217-7599 Secure Email: see other (CMR) side for instructions.	TUBERCULOSIS REPORTING PHONE: (628) 206-8524 FAX: (628) 206-4565	

DISEASE OR CONDITION/URGENCY REPORTING REQUIRMENTS [Title 17, CCR §2500 (h)(i)]

URGENCY REPORTING KEY:

📞 Report immediately by telephone

☎ Report by phone within one working day of identification

📠 Report by electronic transmission (FAX), phone or mail within one working day of identification **📧 Report within seven calendar days by FAX, phone or mail**

<ul style="list-style-type: none"> 📧 Anaplasmosis 📧 Animal bites (mammals only) <i>to Animal Care</i> ☎ Anthrax*, human or animal 📞 Babesiosis ☎ Botulism* (Infant, Foodborne, Wound, Other) 📧 Brucellosis, animal (except infections due to <i>Brucella canis</i>) ☎ Brucellosis*, human 📞 Campylobacteriosis -- Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (Report w/in 30 days to California Cancer Registry) 📧 Chancroid <i>to STD Reporting</i> 📞 Chickenpox (Varicella) (outbreaks, hospitalizations and deaths) 📞 Chikungunya Virus Infection ☎ Cholera ☎ Ciguatera Fish Poisoning 📧 Coccidioidomycosis 📞 Coronavirus Disease 2019 (COVID-19), ONLY hospitalizations/deaths, POC testing by HCP 📧 Creutzfeld-Jakob Disease (CJD) 📞 Cryptosporidiosis 📧 Cyclosporiasis 📧 Cysticercosis 📞 Dengue Virus Infection ☎ Diphtheria 📧 Disorders Characterized by Lapses of Consciousness ☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning) 📧 Ehrlichiosis 📞 Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic ☎ <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli O157</i> ☎ Flavivirus infection of undetermined species ☎ Foodborne illness (2 or more cases from different households) 📧 Giardiasis 📧 Gonococcal infections (including disseminated) <i>to STD Reporting</i> 	<ul style="list-style-type: none"> 📞 <i>Haemophilus influenzae</i>, invasive disease, all serotypes (report an incident in persons less than five years of age) 📞 Hantavirus infections ☎ Hemolytic Uremic Syndrome 📞 Hepatitis A, acute infection 📧 Hepatitis B (specify acute, chronic or perinatal) 📧 Hepatitis C (specify acute, chronic or perinatal) 📧 Hepatitis D (Delta) (specify acute or chronic) 📧 Hepatitis E, acute infection ☎ Human Immunodeficiency Virus (HIV), acute infection 📧 Human Immunodeficiency Virus (HIV), infection, any stage <i>to HIV Reporting</i> 📧 Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS) <i>to HIV reporting</i> 📧 Influenza-associated deaths in laboratory-confirmed cases less than 18 years of age ☎ Influenza, due to novel strains (human) 📧 Legionellosis 📧 Leprosy (Hansen Disease) 📧 Leptospirosis 📞 Listeriosis 📧 Lyme Disease 📞 Malaria ☎ Measles (Rubeola) 📞 Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic ☎ Meningococcal infections ☎ Middle East Respiratory Syndrome (MERS) 📧 Mumps ☎ Novel Coronavirus Infection ☎ Novel Virus Infection with Pandemic Potential ☎ Paralytic Shellfish Poisoning 📞 Paratyphoid Fever -- Parkinson's Disease, Report w/in 90 days to California Parkinson's Disease Registry (CPDR) 📞 Pertussis (Whooping Cough) 📧 Pesticide-related illness or injury (known or suspected cases) <i>to Environmental Health Services</i> 	<ul style="list-style-type: none"> ☎ Plague*, human or animal 📞 Poliovirus infection 📞 Psittacosis 📞 Q Fever ☎ Rabies, human or animal 📞 Relapsing Fever 📧 Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age 📧 Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses 📧 Rocky Mountain Spotted Fever 📧 Rubella (German Measles) 📧 Rubella Syndrome, Congenital 📞 Salmonellosis (other than Typhoid Fever) ☎ Scombroid Fish Poisoning ☎ Shiga toxin (detected in feces) 📞 Shigellosis ☎ Smallpox* (Variola) 📞 Syphilis (all stages, including congenital) <i>to STD Reporting</i> 📧 Taeniasis 📧 Tetanus 📧 Transmissible Spongiform Encephalopathies (TSE) 📞 Trichinosis 📞 Tuberculosis <i>to Tuberculosis Reporting</i> 📧 Tularemia, animal ☎ Tularemia*, human 📞 Typhoid Fever (cases and carriers) 📞 Vibrio infections ☎ Viral Hemorrhagic Fevers*, human or animal (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses) 📞 West Nile Virus (WNV) Infection 📞 Yellow Fever 📞 Yersiniosis 📞 Zika Virus Infection ☎ OCCURRENCE OF ANY UNUSUAL DISEASE ☎ OUTBREAKS OF ANY DISEASE (including diseases not listed in §2500). Specify if institutional and/or open community.
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For updates go to <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Public-Health-Reporting.aspx>

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name		First Name /Middle Name (or initial)			Ethnicity (✓one)																																																																														
		DOB	Age			Hispanic/Latino <input type="checkbox"/> Unknown																																																																													
Email address		MONTH	DAY	YEAR		Non-Hispanic/Non-Latino																																																																													
Address: Number, Street				Apt./Unit Number																																																																															
City /Town		State	ZIP Code	Country of Birth																																																																															
Phone Number		Gender (Please Check One)		Pregnant? Y N UNK																																																																															
Area Code	Primary Phone Number	Male	Genderqueer/Gender Non-Binary	Estimated Delivery Date:																																																																															
		Female	Not Listed (Specify): _____																																																																																
Area Code	Secondary Phone Number	Trans Male	Patient's Occupation/Setting	DD	MM	YY																																																																													
		Trans Female	Food service Day care Health care School																																																																																
		Unknown	Correctional facility Other _____																																																																																
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Other: _____																																																																																			
Unknown																																																																																			

DATE OF ONSET		Reporting Health Care Provider			Medical Record Number			Report all non-STD, non-TB, non-HIV to: Communicable Disease Control/SFDPH 25 Van Ness Ave, Suite 500, SF CA 94102 CD Phone: (415) 554-2830 CD Fax: (415) 554-2848 COVID-19 Fax: (628)217-7599 Use: CDPH_SF COVID CMR Email: include 'SECURE' in subject line: send to cdcontrol@sfdph.org STD Fax: (628) 217-6603 TB Fax: (628) 206-4565 HIV: Phone reports only: (628) 217-6335		
Month Day Year		Reporting Health Care Facility								
DATE DIAGNOSED		Address								
Month Day Year		City			State					
DATE OF DEATH		Telephone Number			Fax					
Month Day Year		() ()			() ()					
		Submitted by			Date Submitted					
					Month/Day/Year					

Syphilis				Test Results: Other: _____																																																																			
Primary (lesion present)		RPR Titer: _____		VIRAL HEPATITIS <table style="width: 100%; border: none;"> <tr> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> <td style="width: 15%;"></td> </tr> <tr> <td>Hep A</td> <td>anti-HAV IgM</td> <td>Pos</td> <td>Neg</td> <td>Pend</td> <td>Not Done</td> </tr> <tr> <td>Hep B</td> <td>HBsAg</td> <td colspan="4"></td> </tr> <tr> <td>Acute</td> <td>anti-HBc</td> <td colspan="4"></td> </tr> <tr> <td>Chronic</td> <td>anti-HBc IgM</td> <td colspan="4"></td> </tr> <tr> <td></td> <td>anti-HBs</td> <td colspan="4"></td> </tr> <tr> <td>Hep C</td> <td>anti-HCV</td> <td colspan="4"></td> </tr> <tr> <td>Acute</td> <td>PCR-HCV</td> <td colspan="4"></td> </tr> <tr> <td>Chronic</td> <td></td> <td colspan="4"></td> </tr> <tr> <td>Hep D (Delta)</td> <td>anti-Delta</td> <td colspan="4"></td> </tr> <tr> <td></td> <td>Other: _____</td> <td colspan="4"></td> </tr> </table>								Hep A	anti-HAV IgM	Pos	Neg	Pend	Not Done	Hep B	HBsAg					Acute	anti-HBc					Chronic	anti-HBc IgM						anti-HBs					Hep C	anti-HCV					Acute	PCR-HCV					Chronic						Hep D (Delta)	anti-Delta						Other: _____				
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Secondary		Late latent > 1 year		VDRL Titer: _____																																																																			
Early latent <1year Latent (unknown duration)		Late (tertiary)		CSF-VDRL Pos Neg																																																																			
Neurosyphilis Y N UNK		Congenital		TP-PA Pos Neg																																																																			
Ocular Syphilis Y N UNK		EIA/CLIA		Pos Neg																																																																			
Gonorrhea Disseminated gonococcal infection (DGI)				Gender(s) of Sex Partners last 12 months																																																																			
Specimen Source				Please check all that apply:																																																																			
Chlamydia		Pharyngeal Urine		Male		Female																																																																	
LGV (Suspect)		Rectal Vaginal		Trans Male		Trans Female																																																																	
Urethral/Cervical		Other: _____		Unknown Genderqueer/Gender Non-Binary																																																																			
STD TREATMENT INFORMATION On PrEP for HIV prevention Y N UNK				Treated in office Given prescription																																																																			
Treated (Drugs, Dosage, Route)				Unable to contact patient																																																																			
Month Day Year				Refused treatment																																																																			
				Referred to: _____																																																																			
				Suspected Exposure Type																																																																			
Blood transfusion		Other needle exposure		Sexual contact		Household contact																																																																	
Child care				Other: _____																																																																			

TUBERCULOSIS (TB)		TB Testing			Bacteriology/Pathology			TB TREATMENT INFORMATION		
Status		IGRA Month Day Year			Accession number _____			Current Treatment		
Active Disease LTBI		PPD/TST			Month Day Year			I INH RIF PZA		
Confirmed		Date Performed			Date Specimen Collected			EMB h Other: _____		
Suspected		Results: _____			Source: _____			Date Treatment Initiated		
Site(s)		Month Day Year			Smear: Pos Neg Pending			Month Day Year		
Pulmonary		Chest X-Ray			Culture: Pos Neg Pending					
Extra-Pulmonary		Date Performed			Pathology suggests TB					
NAAT/PCR		Normal Attach all results to CMR			Other test(s) _____			Untreated		
Positive		Cavitary Abnormal/Noncavitary						Will treat		
Negative								Unable to contact patient		
RIF resistance detected								Refused treatment		
RIF resistance NOT detected								Referred to: _____		

REMARKS