STATE LOGO

Form v1.0
Rev.06/13/2006

Aggregate Hurricane Morbidity Report Form

For Active Surveillance in Facilities Serving Evacuees

Submit completed form daily to CONTACT via email (xxx@xxx.xxx), phone (XXX/XXX-XXXX) or fax (XXX/XXX-XXXX).

Part I FACILITY INFORMATION

LOCATION:

STATE ____ ZIPCODE ____ NAME OF FACILITY ____

REPORTING PERSON/CONTACT:

PHONE ____ NAME ____

FAX ____ EMAIL ____

Part II REPORTING PERIOD

START: MONTH ____ DAY ____ YEAR ____ HOUR ____ AM PM (CIRCLE)

END: MONTH ____ DAY ____ YEAR ____ HOUR ____ AM PM (CIRCLE)

TOTAL SHELTER POPULATION AT START: ____

Part III PERSONS SEEN OR TREATED

TOTAL SEEN OR TREATED DURING CURRENT REPORTING PERIOD:		
RACE / ETHNICITY	White	
	Black/African American	
	Hispanic or Latino	
	Asian	
	Other	
AGE	≤ 2 years	
	≥ 65 years	
	Pregnant females	
TOTAL REFERRED TO HOSPITAL:		

Part IV TREATED PATIENTS

▶ Use categories that best describe patients' **current** reasons for seeking care. Complete the **Total** patient tallies for each syndrome category in the column to the right. Be as specific as possible. A single patient may be counted more than once.

SYNDROME CATEGORY	TOTAL
Acute neurological symptoms (e.g., altered mental status)	___ ___ ___
Cold- or heat-related illness or dehydration	___ ___ ___
Conjunctivitis / eye irritation	___ ___ ___
Fever (i.e., >100.4° F or 38° C)	___ ___ ___
Gastrointestinal illness – Total	___ ___ ___
Watery diarrhea	___ ___ ___
Bloody diarrhea	___ ___ ___
Nausea / vomiting	___ ___ ___
Gastrointestinal illness–*not specified above*	___ ___ ___
Jaundice/viral hepatitis, suspected	___ ___ ___
Meningitis/encephalitis, suspected (e.g., fever, stiff neck, headache, altered mental status)	___ ___ ___
Obstetrics/gynecology – Total	___ ___ ___
Routine pregnancy check-up	___ ___ ___
Complication of pregnancy (e.g., bleeding, abdominal pain, fluid leakage)	___ ___ ___
GYN condition not associated with pregnancy or post-partum period	___ ___ ___
Respiratory illness – Total	___ ___ ___
Cough	___ ___ ___
Shortness of breath or difficulty breathing	___ ___ ___
Wheezing in chest	___ ___ ___
Lower respiratory infection, suspected	___ ___ ___
Skin / soft tissue – Total	___ ___ ___
Generalized rash (e.g., chickenpox, measles)	___ ___ ___
Localized rash (e.g., dermatitis, eczema)	___ ___ ___
Lice or scabies	___ ___ ___
Skin, soft tissue, or wound infection	___ ___ ___

SYNDROME CATEGORY	TOTAL
Routine / follow-up care – Total	___ ___ ___
Blood pressure check	___ ___ ___
Blood sugar check	___ ___ ___
Dressing change/wound care	___ ___ ___
Medication refill	___ ___ ___
Routine care–*not specified above*	___ ___ ___
Exacerbation of chronic illness – Total	___ ___ ___
Cardiovascular disease (e.g., hypertension, coronary heart disease, congestive heart failure)	___ ___ ___
Cerebrovascular disease / stroke	___ ___ ___
Chronic pain / arthritis	___ ___ ___
Diabetes	___ ___ ___
Chronic respiratory disease (e.g., asthma, COPD, emphysema)	___ ___ ___
Chronic illness–*not specified above*	___ ___ ___
Injury – Total	___ ___ ___
Violence / assault (e.g., sexual or other)	___ ___ ___
Suicide / self-inflicted injury	___ ___ ___
Unintentional injury (e.g., fall, burn, bite/sting, cut, bruise, fracture)	___ ___ ___
Poisoning / toxic exposure (e.g., CO)	___ ___ ___
Injury–*not specified above*	___ ___ ___
Mental Health – Total	___ ___ ___
Anxiety / depression	___ ___ ___
Disoriented to person, place, or time	___ ___ ___
Drug / alcohol intoxication or withdrawal	___ ___ ___
Violent behavior / threatening violence	___ ___ ___
Unable to care for self or dependents	___ ___ ___
OTHER REASON FOR VISIT, specify:	___ ___ ___