STATE LOGO

Form v1.6
Rev.11/10/2007

Aggregate Natural Disaster Morbidity Report Form

For Reporting Purposes

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: AM PM

END: AM PM

MONTH DAY YEAR HOUR (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	
	Unknown	
AGE	≤ 1 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
Injury – Total	__ __ __
Unintentional injury (e.g., fall, burn, bite/sting, cut, foreign body, vehicle collision, poison-not CO)	__ __ __
CO poisoning	__ __ __
Violence / assault (e.g., sexual or other)	__ __ __
Suicide / self-inflicted injury	__ __ __
Cold- or heat-related illness	__ __ __
Injury–*not specified above*	__ __ __
Gastrointestinal illness – Total	__ __ __
Nausea / vomiting	__ __ __
Bloody diarrhea	__ __ __
Watery diarrhea	__ __ __
Respiratory Illness – Total	__ __ __
Cough	__ __ __
Pneumonia, suspected	__ __ __
Shortness of breath or difficulty breathing	__ __ __
Wheezing in chest	__ __ __
Dermatologic Illness - Total	__ __ __
Rash	__ __ __
Infection	__ __ __
Infestation (e.g., lice or scabies)	__ __ __
Other Illness - Total	__ __ __
Fever (i.e., >100.4° F or 38° C)	__ __ __
Jaundice/viral hepatitis, suspected	__ __ __
Meningitis/encephalitis, suspected	__ __ __
Other illness – *not specified above*	__ __ __

Management of chronic disease – Total	__ __ __
Cardiovascular disease	__ __ __
Diabetes	__ __ __
Immunocompromised	__ __ __
Respiratory	__ __ __
Seizure	__ __ __
Mental Health – Total	__ __ __
Affective symptoms	__ __ __
Drug / alcohol intoxication or withdrawal	__ __ __
Psychological evaluation	__ __ __
Suicidal thoughts or ideation	__ __ __
Violent behavior / threatening violence	__ __ __
Obstetrics/gynecology – Total	__ __ __
Complication of pregnancy	__ __ __
GYN condition not associated with pregnancy or post-partum period	__ __ __
In labor	__ __ __
Routine pregnancy check-up	__ __ __
Routine / follow-up care – Total	__ __ __
Blood pressure check	__ __ __
Blood sugar check	__ __ __
Wound care	__ __ __
Medication refill	__ __ __
Vaccination	__ __ __
OTHER REASON FOR VISIT, not listed above	__ __ __

SYNDROME CATEGORY	TOTAL