

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

#### **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  
After-Hours 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://dph.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  
P. O. Box 11130  
Reno, Nevada 89520-0027  
https://www.nnpb.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)				<input type="checkbox"/> Check if completed by the Local Health Department		
	Person Reporting		Reporter Phone	Reporter Fax	Reporter Job Title		
Facility Type	Inpatient: <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____	Outpatient: <input type="checkbox"/> Private Office <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other _____		Screening Diagnostic Referral Agency: <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other _____		Other Facility: <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/> Yes	Prenatal Care <input type="checkbox"/> No <input type="checkbox"/> Yes	Pregnancy EDC		Ethnicity <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Expanded Ethnicity		
	Parent or Guardian Name		Birth Country and Arrival Date		Primary Language Spoken		
	Social Security Number		Occupation / Employer / School		Medical Records Number		
	Incarcerated <input type="checkbox"/> No <input type="checkbox"/> Yes	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Unknown					
Sexual Orientation: <input type="checkbox"/> Straight or Heterosexual <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Queer <input type="checkbox"/> Pansexual <input type="checkbox"/> Decline to answer <input type="checkbox"/> Other, specify: _____						Race(s) <input type="checkbox"/> White <input type="checkbox"/> Black: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown Expanded race: _____	
Morbidity Data	Disease or Condition		Date of Onset	Patient Notified of This Condition <input type="checkbox"/> Yes <input type="checkbox"/> No		Pertinent Clinical Information/Comments	
	Patient Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No Admit Date _____ Discharge Date: _____ Hospital: _____		Patient Died of This Illness <input type="checkbox"/> Yes <input type="checkbox"/> No Date: _____				
	Condition Acquired in Nevada <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If no, <input type="checkbox"/> Interstate <input type="checkbox"/> International		Diagnosis Date	Suspected Source	Symptoms		
	Was laboratory testing ordered? <i>If yes, attach the results or provide the laboratory name if the results are unavailable</i>			<input type="checkbox"/> No <input type="checkbox"/> Yes	Was the patient treated? <i>If yes, provide the treatment details (drug name, dosage, duration, dates etc.)</i>		<input type="checkbox"/> No <input type="checkbox"/> Yes
Hepatitis Laboratory Results	HAV Antibody Total	POS <input type="checkbox"/> NEG <input type="checkbox"/>	Date _____	HBV DNA	POS <input type="checkbox"/> NEG <input type="checkbox"/>	Date _____	HCV Genotype _____
	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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Evidence of receipt of HIV medical care other than laboratory test results (record additional evidence in comments) <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: <input type="checkbox"/> Health Dept. <input type="checkbox"/> Physician/provider <input type="checkbox"/> Patient <input type="checkbox"/> Unknown					
	TEST 1 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB					
	Test Brand Name/Manufacturer: _____ Point of care rapid test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Collection Date: _____					
	TEST 2 <input type="checkbox"/> HIV-1 IA <input type="checkbox"/> HIV-1/2 IA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 IA <input type="checkbox"/> HIV-2 WB			<b><u>Risk Exposure (select all that apply)</u></b> <b><u>Complete for HIV/AIDS or STI</u></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) _____		
	Test Brand Name/Manufacturer: _____ Point of care rapid test Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate 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)					
	Analyte results:	HIV-1 Ag: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive HIV-1 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive HIV-2 Ab: <input type="checkbox"/> Reactive <input type="checkbox"/> Nonreactive	<input type="checkbox"/> Not reportable due to high Ab level <input type="checkbox"/> Undifferentiated/Indeterminate <input type="checkbox"/> Undifferentiated/Indeterminate	Date: _____		
HIV Viral Load HIV Genotype	<b>Qualitative</b> Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Collection Date: _____		<b>Quantitative</b> Results <input type="checkbox"/> Detectable <input type="checkbox"/> 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	
	<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	<input type="checkbox"/> Chancre <input type="checkbox"/> Palmar/Plantar Rash <input type="checkbox"/> Condylomata Lata <input type="checkbox"/> Neurologic <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Cervical <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Ophthalmia Neonatorum <input type="checkbox"/> PID <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Cervical <input type="checkbox"/> Urethral <input type="checkbox"/> Rectal <input type="checkbox"/> Pharyngeal <input type="checkbox"/> PID <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Azithromycin 1g <input type="checkbox"/> L-A Bicillin 2.4 mu IM x # _____ (doses) <input type="checkbox"/> No Treatment Given <input type="checkbox"/> Ceftriaxone/Rocephin 500mg IM <input type="checkbox"/> Doxy 100 Mg BID x # _____ Days <input type="checkbox"/> 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) <input type="checkbox"/> Yes, I saw the sex partner(s) in my office <input type="checkbox"/> Yes, I gave medication for ___ (#) partners <input type="checkbox"/> Yes, I wrote a prescription for ___ (#) partner(s) Partner Name _____ DOB _____					
TB Disease and Latent TB Infection	<input type="checkbox"/> Tuberculosis Disease (suspected or confirmed) <input type="checkbox"/> TB Disease Site: _____		Chest X-ray/Imaging: (include last report) <input type="checkbox"/> Abnormal <input type="checkbox"/> Normal Date: _____			
	REASON for TB Testing: <input type="checkbox"/> Immigration/I-693; <input type="checkbox"/> TB symptoms; <input type="checkbox"/> Birth/Travel outside U.S. > 1 month; <input type="checkbox"/> Contact to infectious TB disease; <input type="checkbox"/> Employee screen; <input type="checkbox"/> Immunosuppression or planned; <input type="checkbox"/> Co-morbidity (diabetes, HIV, organ transplant, end-stage renal disease, cancer)					
	Symptoms <input type="checkbox"/> Cough > 3 weeks <input type="checkbox"/> Hemoptysis <input type="checkbox"/> Fever <input type="checkbox"/> Weight loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Abnormal Chest X-ray					
	Laboratory Results (include a copy of laboratory testing)				Treatment (include drug(s)/dose(s))	
	POS	NEG	Date	If Not Sputum, indicate source: _____		
TB Test, IGRA (QFT/TSPOT):	_____	_____	_____	POS	NEG	Date
TB Test, TST: _____ mm	_____	_____	_____	AFB Smear	_____	_____
				NAAT	_____	_____
				Culture	_____	_____
COVID-19	COVID-19 lab test type: <input type="checkbox"/> PCR <input type="checkbox"/> Antigen <input type="checkbox"/> Antibody	Vaccine Brand Name: _____ First Vaccine Date: _____				
	COVID Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No	Second Vaccine Date (if applicable): _____				

Completed reports can be faxed to the numbers listed on page 2 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.