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 0157: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 constructed 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.

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.

State of Nevada
Confidential Morbidity Report Form

Nevada Department of Health and Human Services | Carson City Health & Human Services | Southern Nevada Health District | Washoe County Health District – Enhancing Quality of Life

Source

Provider Name	Provider Telephone #		Report Date
Facility/Organization (Name and Address)			☐ Check if completed by the Local Health Department
Person Reporting	Reporter Phone	Reporter Fax	Reporter Job Title

Facility Type

Inpatient:	Outpatient:	Screening Diagnostic Referral Agency:	Other Facility:
Hospital	Private Office ☐ Adult HIV Clinic	CTS STD Clinic	Emergency Room ☐ Laboratory
Other_____	Other_____	Other_____	☐ Corrections ☐ Other_____

Patient Demographic Data

Patient Name (Last)	(First) (MI)	Date of Birth	Age	Sex assigned at birth Female Male
Patient Address	(City)	(State)	(Zip)	Current Gender Female M to F Transgender ☐ Male F to M Transgender ☐Unknown Refused to answer ☐ 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	Race(s) ☐ White ☐ Black: ☐ Asian ☐ American Indian Pacific Islander Other ☐ Unknown
Social Security Number	Occupation / Employer / School	Medical Records Number	
Incarcerated No Yes	Marital Status Single ☐ Married Widowed Separated Divorced Unknown		
Sexual Orientation: Straight or Heterosexual ☐ Lesbian or Gay Bisexual Queer Pansexual Decline to answer Other, specify:			Expanded race: _____

Morbidity Data

Disease or Condition Date of Onset	Patient Notified of This Condition Yes No	Pertinent Clinical Information/Comments
Patient Hospitalized Yes No Admit Date 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 ☐ Yes		Was the patient treated? *If yes, provide the treatment details (drug name, dosage, duration, dates etc.)* No Yes	

Hepatitis Laboratory Results

	POS	NEG	Date
HAV Antibody Total			_____
HAV Antibody IgM	☐	☐	_____
HBV Surface Antigen	☐	☐	_____
HBV e Antigen	☐	☐	_____
HBV Core Antibody Total	☐	☐	_____
HBV core Antibody IgM	☐	☐	_____
HBV Surface Antibody	☐	☐	_____

	POS	NEG	Date
HBV DNA			_____
HCV Antibody RIBA	☐	☐	_____
HCV RNA (e.g. by PCR)	☐	☐	_____
HCV Antibody (ELISA)	☐	☐	_____
HCV Antibody (Rapid)	☐	☐	_____
HDV Antibody	☐	☐	_____
HDV Rapid	☐	☐	_____

	Date / Range
HCV Genotype	_____
ALT (SGPT) Level	_____
Alt-Lab Normal Range	_____
AST (SGOT) Level	_____
AST-Lab Normal Range	_____
Name of Lab	

Patient Name (Last) (First) MI)

Initial Diagnostic HIV Tests

Has this patient been informed of his/her HIV infection? Yes No Unknown

The patient's partners will be notified about their HIV exposure and counseled by:
Health Dept. Physician/provider Patient Unknown

TEST 1 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

Results Positive Negative ndeterminate Collection Date: _

TEST 2 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

Results Positive Negative Indeterminate Collection Date: _

Evidence of receipt of HIV medical care other than laboratory test results
☐Yes, documented
☐ Yes, client self-report, only
☐ Date of medical visit or prescription

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:				Date:
	HIV-1 Ag: Reactive	Nonreactive	Not reportable due to high Ab level	
	HIV-1 Ab: Reactive	Nonreactive	Undifferentiated/Indeterminate	
	HIV-2 Ab: Reactive	Nonreactive	Undifferentiated/Indeterminate	

HIV Viral Load HIV Genotype

Qualitative
Results Positive Negative Indeterminate
Collection Date: _

Quantitative
Results Detectable Undetectable
Copies/mL: _____
Collection Date:

HIV Genotype (Resistance) Collection Date: Interpretation: _____

Risk Exposure (select all that apply)
Complete for HIV/AIDS or STI
Sex with Male
☐ Sex with Female
☐ Inject(ed) non-prescription drugs
☐ Sex Partner has HIV or AIDS
☐ Sex Partner Injects Drugs
☐ Sex Partner is Male that has Sex with Males
☐ Injection Drug Use
☐ Perinatal Exposure of Newborn
☐ Other Exposure (specify)
_____

Sexually Transmitted Infection (STI)

Syphilis Stage	Syphilis Symptoms	Gonorrhea Specimen Site	Chlamydia Site(s)	STI Treatment
☐ Primary	Chancre	Cervical	Cervical	Azithromycin 1g
☐ Secondary	Palmar/Plantar Rash	Urethral	☐ Urethral	☐L-A Bicillin 2.4 mu IM
☐ Early Latent (<1 yr)	Condylomata Lata	Rectal	Rectal	x #_ (doses)
☐ Latent	Neurologic	Pharyngeal	Pharyngeal	No Treatment Given
☐ Congenital	Other (specify)	Ophthalmia Neonatorum	PID	☐Ceftriaxone/Rocephin 500mg IM
☐ Unknown	_____	☐ PID	Other (specify)	☐ Doxy 100 Mg BID
		☐ Other (specify) _____	_____	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) ☐ TB Disease Site:
☐ Latent TB Infection (LTBI) _____

Chest X-ray/Imaging: (include last report)
Abnormal ormal Date: _____

Symptoms Cough > 3 weeks Hemoptysis Fever Weight loss Fatigue Abnormal Chest X-ray

Laboratory Results (include a copy of laboratory testing)

		POS	NEG	Date
TB Test, IGRA		_____	_____	_____
TB Test, TST: _	mm	_____	_____	_____

If *Not* Sputum, indicate source:_

	POS	NEG	Date
AFB Smear	_____	_____	_____
NAAT	_____	_____	_____
Culture	_____	_____	_____

Treatment (include drug(s)/dose(s))
No treatment started
LTBI treatment,
Date started
TB Disease treatment,
Date started

COVID-19

COVID-19 lab test type: PCR Antigen ☐ Antibody

COVID Vaccine Yes No

Vaccine Brand Name:

First Vaccine Date:
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

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