

STATE
LOGO

Aggregate Natural Disaster Morbidity Report Form

For Active Surveillance in Facilities Serving Evacuees



Form v1.4
Rev.11/10/2007

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
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REPORTING PERSON/CONTACT:

PHONE	NAME
FAX	EMAIL

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	1 years
	65 years
	Pregnant females

Part II REPORTING PERIOD

START: _____ AM PM

END: _____ AM PM

MONTH DAY YEAR HOUR (CIRCLE)

TOTAL SHELTER POPULATION AT START:	TOTAL REFERRED TO HOSPITAL:
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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, bruise, fracture, vehicle collision)	_____
Poisoning / toxic exposure (e.g., CO)	_____
Violence / assault (e.g., sexual or other)	_____
Suicide / self-inflicted injury	_____
Injury–not specified above	_____
Neurological (e.g., altered mental status)	_____
Cold- or heat-related illness	_____
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)	_____
Respiratory illness – Total	_____
Cough	_____
Shortness of breath or difficulty breathing	_____
Wheezing in chest	_____
Lower respiratory infection, suspected	_____
Skin / soft tissue – Total	_____
Rash	_____
Infestation (e.g. Lice or scabies)	_____
Skin, soft tissue, or wound infection	_____

SYNDROME CATEGORY	TOTAL
Exacerbation of chronic disease – Total	_____
Cardiovascular disease (e.g., hypertension, coronary heart disease, congestive heart failure)	_____
Diabetes	_____
Immunocompromised (e.g. HIV, lupus)	_____
Respiratory (e.g., asthma, COPD, emphysema)	_____
Chronic illness–not specified above	_____
Mental Health – Total	_____
Affective symptoms (overly anxious/depressed)	_____
Drug / alcohol intoxication or withdrawal	_____
Psychological evaluation	_____
Suicidal thoughts or attempt	_____
Violent behavior / threatening violence	_____
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	_____
In labor	_____
Routine / follow-up care – Total	_____
Blood pressure check	_____
Blood sugar check	_____
Dressing change/wound care	_____
Medication refill	_____
Oral/dental problems	_____
Routine care–not specified above	_____
OTHER REASON FOR VISIT, specify:	_____