

REPORTABLE DISEASES AND CONDITIONS

City and County of San Francisco

San Francisco Department of Public Health

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20 and §2800-2812.

§2500 (b) It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

§2500 (c) The Administrator of each health facility, clinic or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.

WHOM TO REPORT TO:

REPORT OUTBREAKS, DISEASES, AND CONDITIONS TO COMMUNICABLE DISEASE CONTROL UNIT UNLESS OTHERWISE INDICATED

COMMUNICABLE DISEASE CONTROL UNIT PHONE: (415) 554-2830 FAX: (415) 554-2848 M-F 8AM TO 5PM CD URGENT REPORTS: After hours: call 415-554-2830, press "2" & follow the instructions on the voicemail to page the on-call MD.	HIV- New HIV cases must be called in to the REPORTING PHONE: (628) 217-6335 STD REPORTING PHONE: (628) 217-6653 FAX: (628) 217-6603	ANIMAL CARE & CONTROL ANIMAL BITES (MAMMALS Only) PHONE: (415) 554-9422 FAX: (415) 864-2866 ENVIRONMENTAL HEALTH SERVICES FOR PESTICIDE PHONE: (415) 252-3862 FAX: (415) 252-3818
COVID-19 REPORTING: Hospitalizations/deaths & POC testing by HCP Fax: (628) 217-7599 Secure Email: see other (CMR) side for instructions.	TUBERCULOSIS REPORTING PHONE: (628) 206-8524 FAX: (628) 206-4565	

DISEASE OR CONDITION/URGENCY REPORTING REQUIRMENTS [Title 17, CCR §2500 (h)(i)]

URGENCY REPORTING KEY: **📞** Report immediately by telephone **☎** Report by phone within one working day of identification
📠 Report by electronic transmission (FAX), phone or mail within one working day of identification **📧** Report within seven calendar days by FAX, phone or mail

<ul style="list-style-type: none"> 📧 Anaplasmosis 📧 Animal bites (mammals only) <i>to Animal Care</i> 📞 Anthrax*, human or animal 📞 Babesiosis 📞 Botulism* (Infant, Foodborne, Wound, Other) 📧 Brucellosis, animal (except infections due to <i>Brucella canis</i>) 📞 Brucellosis*, human 📞 Campylobacteriosis -- Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (Report w/in 30 days to California Cancer Registry) 📧 Chancroid <i>to STD Reporting</i> 📞 Chickenpox (Varicella) (outbreaks, hospitalizations and deaths) 📞 Chikungunya Virus Infection 📞 Cholera 📞 Ciguatera Fish Poisoning 📧 Coccidioidomycosis 📞 Coronavirus Disease 2019 (COVID-19), ONLY hospitalizations/deaths, POC testing by HCP 📧 Creutzfeld-Jakob Disease (CJD) 📞 Cryptosporidiosis 📧 Cyclosporiasis 📧 Cysticercosis 📞 Dengue Virus Infection 📞 Diphtheria 📧 Disorders Characterized by Lapses of Consciousness 📞 Domoic Acid Poisoning (Amnesic Shellfish Poisoning) 📧 Ehrlichiosis 📞 Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic 📞 <i>Escherichia coli</i>: shiga toxin producing (STEC) including <i>E. coli O157</i> 📞 Flavivirus infection of undetermined species 📞 Foodborne illness (2 or more cases from different households) 📧 Giardiasis 📧 Gonococcal infections (including disseminated) <i>to STD Reporting</i> 	<ul style="list-style-type: none"> 📞 <i>Haemophilus influenzae</i>, invasive disease, all serotypes (report an incident in persons less than five years of age) 📞 Hantavirus infections 📞 Hemolytic Uremic Syndrome 📞 Hepatitis A, acute infection 📧 Hepatitis B (specify acute, chronic or perinatal) 📧 Hepatitis C (specify acute, chronic or perinatal) 📧 Hepatitis D (Delta) (specify acute or chronic) 📧 Hepatitis E, acute infection 📞 Human Immunodeficiency Virus (HIV), acute infection 📧 Human Immunodeficiency Virus (HIV), infection, any stage <i>to HIV Reporting</i> 📧 Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS) <i>to HIV reporting</i> 📧 Influenza-associated deaths in laboratory-confirmed cases less than 18 years of age 📞 Influenza, due to novel strains (human) 📧 Legionellosis 📧 Leprosy (Hansen Disease) 📧 Leptospirosis 📞 Listeriosis 📧 Lyme Disease 📞 Malaria 📞 Measles (Rubeola) 📞 Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic 📞 Meningococcal infections 📞 Middle East Respiratory Syndrome (MERS) 📧 Mumps 📞 Novel Coronavirus Infection 📞 Novel Virus Infection with Pandemic Potential 📞 Paralytic Shellfish Poisoning 📞 Paratyphoid Fever -- Parkinson's Disease, Report w/in 90 days to California Parkinson's Disease Registry (CPDR) 📞 Pertussis (Whooping Cough) 📧 Pesticide-related illness or injury (known or suspected cases) <i>to Environmental Health Services</i> 	<ul style="list-style-type: none"> 📞 Plague*, human or animal 📞 Poliovirus infection 📞 Psittacosis 📞 Q Fever 📞 Rabies, human or animal 📞 Relapsing Fever 📧 Respiratory Syncytial Virus-associated deaths in laboratory-confirmed cases less than five years of age 📧 Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses 📧 Rocky Mountain Spotted Fever 📧 Rubella (German Measles) 📧 Rubella Syndrome, Congenital 📞 Salmonellosis (other than Typhoid Fever) 📞 Scombroid Fish Poisoning 📞 Shiga toxin (detected in feces) 📞 Shigellosis 📞 Smallpox* (Variola) 📞 Syphilis (all stages, including congenital) <i>to STD Reporting</i> 📧 Taeniasis 📧 Tetanus 📧 Transmissible Spongiform Encephalopathies (TSE) 📞 Trichinosis 📞 Tuberculosis <i>to Tuberculosis Reporting</i> 📧 Tularemia, animal 📞 Tularemia*, human 📞 Typhoid Fever (cases and carriers) 📞 Vibrio infections 📞 Viral Hemorrhagic Fevers*, human or animal (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses) 📞 West Nile Virus (WNV) Infection 📞 Yellow Fever 📞 Yersiniosis 📞 Zika Virus Infection 📞 OCCURRENCE OF ANY UNUSUAL DISEASE 📞 OUTBREAKS OF ANY DISEASE (including diseases not listed in §2500). Specify if institutional and/or open community.
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For updates go to <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Public-Health-Reporting.aspx>

CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED: _____

Patient's Last Name		First Name /Middle Name (or initial)			Ethnicity (✓one)	
		DOB	Age			Hispanic/Latino <input type="checkbox"/> Unknown
Email address		MONTH	DAY	YEAR		Non-Hispanic/Non-Latino <input type="checkbox"/>
Address: Number, Street				Apt./Unit Number		
City /Town		State	ZIP Code		Country of Birth	
Phone Number		Gender (Please Check One)		Pregnant? Y N UNK		
Area Code	Primary Phone Number	Male <input type="checkbox"/>	Genderqueer/Gender Non-Binary <input type="checkbox"/>	Estimated Delivery Date:		
		Female <input type="checkbox"/>	Not Listed (Specify): _____			
Area Code	Secondary Phone Number	Trans Male <input type="checkbox"/>	Patient's Occupation/Setting	DD	MM	YY
		Trans Female <input type="checkbox"/>	Food service <input type="checkbox"/> Day care <input type="checkbox"/> Health care <input type="checkbox"/> School <input type="checkbox"/>			
		Unknown <input type="checkbox"/>	Correctional facility <input type="checkbox"/> Other _____			
						Hawaiian <input type="checkbox"/> Other _____
						Native American/Alaskan Native <input type="checkbox"/>
						White <input type="checkbox"/>
						Other: _____
						Unknown <input type="checkbox"/>

DATE OF ONSET		Reporting Health Care Provider		Medical Record Number		Report all non-STD, non-TB, non-HIV to: Communicable Disease Control/SFDPH 25 Van Ness Ave, Suite 500, SF CA 94102 CD Phone: (415) 554-2830 CD Fax: (415) 554-2848 COVID-19 Fax: (628)217-7599 Use: CDPH_SF COVID CMR Email: include 'SECURE' in subject line: send to cdcontrol@sfdph.org STD Fax: (628) 217-6603 TB Fax: (628) 206-4565 HIV: Phone reports only: (628) 217-6335	
Month Day Year		Reporting Health Care Facility					
DATE DIAGNOSED		Address					
Month Day Year		City		State			
DATE OF DEATH		Telephone Number		Fax			
Month Day Year		() ()		() ()			
		Submitted by		Date Submitted			
				(Month/Day/Year)			

Syphilis				Test Results: Other: _____																																																													
Primary (lesion present)		RPR Titer: _____		VIRAL HEPATITIS <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">Hep A</td> <td style="width: 45%;">anti-HAV IgM</td> <td style="width: 10%;">Pos</td> <td style="width: 10%;">Neg</td> <td style="width: 10%;">Pend</td> <td style="width: 10%;">Not Done</td> </tr> <tr> <td>Hep B</td> <td>HBsAg</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Acute</td> <td>anti-HBc</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Chronic</td> <td>anti-HBc IgM</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>anti-HBs</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hep C</td> <td>anti-HCV</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Acute</td> <td>PCR-HCV</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Chronic</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Hep D (Delta)</td> <td>anti-Delta</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td colspan="2">Other: _____</td> <td colspan="4"></td> </tr> </table>		Hep A	anti-HAV IgM	Pos	Neg	Pend	Not Done	Hep B	HBsAg					Acute	anti-HBc					Chronic	anti-HBc IgM						anti-HBs					Hep C	anti-HCV					Acute	PCR-HCV					Chronic						Hep D (Delta)	anti-Delta					Other: _____					
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Secondary		Late latent > 1 year		VDRL Titer: _____																																																													
Early latent <1year Latent (unknown duration)		Late (tertiary)		CSF-VDRL Pos Neg																																																													
Neurosyphilis Y N UNK		Congenital		TP-PA Pos Neg																																																													
		Ocular Syphilis Y N UNK		EIA/CLIA Pos Neg																																																													
Gonorrhea				Disseminated gonococcal infection (DGI)																																																													
Specimen Source				Gender(s) of Sex Partners last 12 months																																																													
Chlamydia		Pharyngeal Urine		Please check all that apply:																																																													
LGV (Suspect)		Rectal Vaginal		Male <input type="checkbox"/> Female <input type="checkbox"/> Trans Male <input type="checkbox"/> Trans Female <input type="checkbox"/>																																																													
		Urethral/Cervical Other: _____		Unknown <input type="checkbox"/> Genderqueer/Gender Non-Binary <input type="checkbox"/>																																																													

STD TREATMENT INFORMATION			Bacteriology/Pathology			TB TREATMENT INFORMATION		
On PrEP for HIV prevention Y N UNK			Accession number _____			Current Treatment		
Treated (Drugs, Dosage, Route)			Date Specimen Collected			I INH RIF PZA		
Month Day Year			Month Day Year			EMB h Other: _____		
Treated in office Given prescription			Source: _____			Date Treatment Initiated		
Unable to contact patient			Smear: Pos Neg Pending			Month Day Year		
Refused treatment			Culture: Pos Neg Pending					
Referred to: _____			Pathology suggests TB					
			Other test(s) _____					
						Untreated		
						Will treat		
						Unable to contact patient		
						Refused treatment		
						Referred to: _____		

REMARKS