



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 O157: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‡
- 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
- 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 October 2021

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

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.

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 _____ 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	Discharge Date	Symptoms/Suspected Source					
	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	NEG	Date	HBV DNA	POS	NEG	Date	HCV Genotype	Date / Range
	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 <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: _____ <input type="checkbox"/> 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 Test Brand Name/Manufacturer: _____ <input type="checkbox"/> 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	<input type="checkbox"/> Not reportable due to high Ab level	Date: _____	
HIV Viral Load HIV Genotype	Qualitative		Quantitative		
	Results <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate		Results <input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable		
	Collection Date: _____		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"/> Chancere <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 LTBI	<input type="checkbox"/> Tuberculosis Disease (suspected or confirmed) <input type="checkbox"/> TB Disease Site: _____		Chest X-ray/Imaging: (include last report)		
	<input type="checkbox"/> Latent TB Infection (LTBI)		<input type="checkbox"/> Abnormal <input type="checkbox"/> Normal Date: _____		
	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))
TB Test, IGRA	POS _____	NEG _____	Date _____	<input type="checkbox"/> No treatment started <input type="checkbox"/> LTBI treatment, Date started <input type="checkbox"/> TB Disease treatment, Date started	
TB Test, TST: _____ mm	_____	_____	_____		
AFB Smear	POS _____	NEG _____	Date _____		
NAAT	_____	_____	_____		
Culture	_____	_____	_____		
COVID-19	<input type="checkbox"/> COVID-19	lab test type: <input type="checkbox"/> PCR <input type="checkbox"/> Antigen <input type="checkbox"/> Antibody	Vaccine Brand Name: _____		
	COVID Vaccine <input type="checkbox"/> Yes <input type="checkbox"/> No		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