Natural Disaster Morbidity Surveillance Summary Report Form

For Reporting Purposes

Form v1.9
Rev.09/29/2009

Submit completed form daily to _____via email (xxxxxxx@xxxxx.xxx), phone (xxx/xxx.xxxx) or fax (xxx/xxx.xxxx)

Part I FACILITY INFORMATION

LOCATION:

STATE | ZIPCODE | NAME OF FACILITY

REPORTING PERSON/CONTACT:

PHONE | NAME

FAX | EMAIL

Part II REPORTING PERIOD

START: _____ AM PM

END: MONTH DAY YEAR _____ HOUR (CIRCLE) AM PM

TOTAL SHELTER POPULATION AT START:	#

Part III PERSONS SEEN OR TREATED

TOTAL SEEN OR TREATED DURING CURRENT REPORTING PERIOD:		#
RACE / ETHNICITY	White	#
	Black/African American	#
	Hispanic or Latino	#
	Asian	#
	Unknown	#
AGE	≤ 1 years	#
	≥ 65 years	#
	Pregnant females	#
TOTAL REFERRED TO HOSPITAL:		#

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
WORKERS/VOLUNTEERS - TOTAL	__ __ __
INJURY - TOTAL	__ __ __
Fall, slip, trip (from height or same level)	__ __ __
Motor vehicle crash	__ __ __
Carbon monoxide exposure	__ __ __
Violence/assault	__ __ __
Injury - not specified above	__ __ __
DERMATOLOGIC/SKIN - TOTAL	__ __ __
Rash	__ __ __
Infection	__ __ __
Infestation (e.g., lice or scabies)	__ __ __
GASTROINTESTINAL ILLNESS - TOTAL	__ __ __
Diarrhea - bloody	__ __ __
Diarrhea - watery	__ __ __
Nausea or vomiting	__ __ __
OB/GYN – TOTAL	__ __ __
GYN condition not associated with pregnancy or post-partum period	__ __ __
In labor	__ __ __
Pregnancy complication	__ __ __
Routine pregnancy check-up	__ __ __
RESPIRATORY ILLNESS - TOTAL	__ __ __
Congestion, runny nose, sinusitis	__ __ __
Cough	__ __ __
Pneumonia, suspected	__ __ __
Shortness of breath or difficulty breathing	__ __ __
Wheezing in chest	__ __ __
INFLUENZA-LIKE-ILLNESS (ILI) - TOTAL	__ __ __

SYNDROME CATEGORY	TOTAL
OTHER ILLNESS - TOTAL	__ __ __
Dehydration	__ __ __
Fever (≥100° F or 37.8° C)	__ __ __
Meningitis/encephalitis, suspected	__ __ __
Neurological	__ __ __
Pain	__ __ __
Other illness – not specified above	__ __ __
EXACERBATION OF CHRONIC DISEASE - TOTAL	__ __ __
Cardiovascular disease (e.g., hypertension, CHF)	__ __ __
Diabetes	__ __ __
Immunocompromised (e.g., HIV, lupus)	__ __ __
Neurological (e.g., seizure, stroke)	__ __ __
Respiratory (e.g., Asthma, COPD)	__ __ __
MENTAL HEALTH - TOTAL	__ __ __
Agitated behavior	__ __ __
Anxiety or stress	__ __ __
Depressed mood	__ __ __
Drug/alcohol intoxication or withdrawal	__ __ __
Previous mental health diagnosis	__ __ __
Psychotic symptoms (i.e. paranoia)	__ __ __
Suicidal thoughts or ideation	__ __ __
ROUTINE/FOLLOW-UP - TOTAL	__ __ __
Medication refill	__ __ __
Blood sugar check	__ __ __
Blood pressure check	__ __ __
Vaccination	__ __ __
Wound care	__ __ __
OTHER REASON FOR VISIT, not listed above	__ __ __