Aggregate Morbidity Report Form*

Part I. General Information
1. Disaster Name: _____
2. Reporting Start Date: ___/___/___ Time: _____
3. Reporting End Date: ___/___/___ Time: _____
4. City: _____ State _____
5. Shelter Name: _____

Part II. Number of Client-Related Interactions

Tally (卌 卌 卌)	Total (#)
7. **Total Client-related Contacts (includes CMIST):**	
7b. **Total of Health-related Client Visits: (fill part III)**	

Part III. Demographics (for Health-related Visits Only)

		Tally (卌 卌 卌)	Total (#)
Sex	Male		
	Female		
Age	≤ 2		
	3 to 18		
	19 to 64		
	≥ 65		

Functional/Access Needs: mark each individual need based on C-MIST model per 24 hours

	Tally (卌 卌 卌)	Total (#)
Communication		
Maintenance of Health		
Independence		
Safety and Security		
Transportation		

Part IV. Reason for Visit: for each client visit, tick ALL reason(s) for visits.

	Tally (卌 卌 卌)	Total (#)		Tally (卌 卌 卌)	Total (#)
Injury			**Behavioral/Mental Health**		
Bite (includes *ALL* bites)			Agitated/disruptive/psychotic		
Burn (thermal or chemical)			Anxiety/stress/depressed mood		
Cut/laceration/puncture			Suicidal/homicidal thoughts		
Foreign body (e.g., splinter)			Substance addiction/withdrawal		
Fall/slip/trip			Other mental health		
Hit by or against object			**Exacerbation of Chronic Illness**		
Use of machinery/tools/equip.			Asthma		
Assault			Obstructive pulmonary disease		
Carbon Monoxide (CO) exposure			Cardiovascular (HTN, CHF, CHD)		
Poisoning, non-CO			Chronic muscle or joint pain		
Other injury			Diabetes		
Illness/Symptoms			Neurological (seizure, stroke, dementia)		
Fever (>100.4°F or 38°C)			Previous mental health diagnosis		
Conjunctivitis/eye irritation			Other chronic illness		
Dehydration			**Health Care Maintenance**		
Heat stress/heat exhaustion			Blood pressure check		
Hypothermia/cold-environment			Blood sugar check		
Oral health			Pregnancy/post-partum care		
Pain: chest, angina, cardiac arrest			Dressing change/wound care		
Pain: muscle or joint pain			Immunization/vaccination		
Pain: head, ears, eyes, nose, throat			Medical refill (please mark one tick for *each* med refill)		
Pain: other, not specified above			Other health maintenance		
Gastrointestinal (GI): diarrhea					
GI: nausea/vomiting					

	Tally (卌 卌 卌)	Total (#)
Part V. Disposition		
Provided Red Cross care		
Referred to…		
Hospital		
Physician/dentist/clinic		
Pharmacist		
Other (e.g., DMH)		
Refused Red Cross care		

(continuing Part IV left column)

	Tally (卌 卌 卌)	Total (#)
GI: other (constipation, GERD)		
Genitourinary (GU)		
Skin (includes *ALL* skin conditions)		
Allergic reaction		
Respiratory (include *ALL* resp.)		
Influenza-like-illness (ILI)		
Neurological, new onset		
Other illness/symptoms		

*Complete one form per service location per 24 hours. Submit by 4pm local time.

Print name: _____ Contact information: _____

Aggregate Morbidity Report Form*

Basic Instructions

Purpose: Use this form to report on all clients medically seen in your shelter over the last 24 hours.

Procedure:

PART I: Fill out the top portion of this form with disaster name, report date and timeframe (24hr period), city, state, and name of shelter.

PART II:
- o Total Client-related Contacts = **mark EACH CONTACT** in the 24hr reporting period.
- o Total Number of Health-Related Client Visits = **mark EACH VISIT** in the 24hr reporting period for each time client health care was given (e.g., multiple blood sugar checks = mark a tick for each visit)

PART III: Mark one tick for sex (male or female) and for age category, for each **Health–related Visit**
- o The total number for sex (male + female) and for combined age categories at the end of the 24hr reporting period should equal the **total number of health-related client visits (7b)**.

PART IV: Mark one tick for each complaint for the *current* health visit.
- o For example, if a client has diabetes and receives a regular blood sugar check, only mark Blood sugar check. Do not mark diabetes unless the client is currently having symptoms consistent with an exacerbation of diabetes.
- o IMPORTANT: For medication refill, mark one tick for EACH medication supplied

Part V: Mark client disposition for each health-related visit.
- o Tick **provided Red Cross care** for clients treated and released (back into shelter or community) as well as those referred, if care was given prior to referral.

Functional/Access Needs: Mark each identified individual need based on the C-MIST model ONCE per 24 hour period.

Print your name and provide contact information on the bottom of the form

Submit by 4pm local time

Thank you!