HOW TO REPORT STDs WITH THE CMR

In California, health care providers who have diagnosed, or suspect the presence of, a sexually transmitted disease (STD) in their patient are legally required to report that information to the local health department.[1,2] The Confidentiality Morbidity Report (CMR) was developed by the California Department of Public Health (CDPH) to facilitate the reporting of communicable diseases, including STDs. An alternative way to report an illness is to utilize the provider portal in the California Reportable Disease Information Exchange (CalREDIE). To find out the status of provider portal or any other options for reporting in your local health jurisdiction please contact your local health department. By reporting STDs promptly and completely, you help limit the spread of STDs in California.

1 California Code of Regulations: Title 17, Division 1, Chapter 4, Subchapter 1, Article 1.
2 For a complete list of legally required reportable STDs, please see the back of the CMR; and consult with your local health department for any local reporting requirements.

STD Being Reported: If reporting multiple STDs for a patient, complete a separate CMR for each STD.

Patient Information: Provide all available information.

Date of First Specimen Collection: Provide date of specimen collection for this diagnosis.

Health Care Provider: Record name of diagnosing health care provider, facility where patient was seen, and individual completing CMR.

Gender of Sex Partner(s): Indicate gender of patient's sex partner(s) in the past 12 months.

Ethnicity and Race: Complete patient's ethnicity and race. Check all that apply.

Date of Diagnosis: Date lab report was received (or, if earlier, date of presumptive diagnosis).

Report to: Fax CMR to local health department.

Laboratory Name, City, State and ZIP: Indicate laboratory where specimen was processed.

STD Treatment: Indicate how patient was or will be treated. Include the drug(s) used, dosage and treatment date.

Syphilis Stage, Neurosyphilis and Test Results: Indicate stage of syphilis diagnosed AND whether patient has neurosyphilis. Check all laboratory tests performed and their results.

Chlamydia or Gonorrhea: Indicate source of positive specimen. Only check sites where patient tested positive.

Partner(s) Treated: Indicate how treatment of patient's sex partners was managed.

State of California—Health and Human Services Agency — California Department of Public Health

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | First Name | MI
Home Address: Number, Street | Apt./Unit No.
City | State | ZIP Code
Home Telephone Number | Cell Telephone Number | Work Telephone Number
Email Address | Primary Language ☐ English ☐ Spanish ☐ Other: _____
Date (mm/dd/yyyy) | Age ☐ Years ☐ Months ☐ Days | Gender ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other
Pregnant? ☐ Yes ☐ No ☐ Unknown | Est. Delivery Date (mm/dd/yyyy) | Country of Birth
Occupation or Job Title | Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other (specify): _____

Ethnicity (check one): ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply):
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian (check all that apply)
☐ Asian Indian ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Hmong ☐ Japanese ☐ Korean ☐ Laotian ☐ Thai ☐ Vietnamese ☐ Other (specify): _____
☐ Pacific Islander (check all that apply)
☐ Native Hawaiian ☐ Guamanian ☐ Samoan ☐ Other (specify): _____
☐ White
☐ Other (specify): _____
☐ Unknown

Date of Onset (mm/dd/yyyy) | Date of First Specimen Collection (mm/dd/yyyy) | Date of Diagnosis (mm/dd/yyyy)

Reporting Health Care Provider | Reporting Health Care Facility
Address: Number, Street | Suite/Unit No.
City | State | ZIP Code
Telephone Number | Fax Number
Submitted by | Date Submitted (mm/dd/yyyy)

REPORT TO:
Health Department Contact Info
(Obtain additional forms from your local health department.)

Name | City | State | ZIP Code

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply)
☐ Male ☐ Female ☐ Unknown ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | Treatment Began (mm/dd/yyyy)
☐ Untreated ☐ Will treat ☐ Unable to contact patient ☐ Patient refused treatment ☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present) ☐ Secondary ☐ Early latent < 1 year ☐ Latent (unknown duration) ☐ Late latent > 1 year ☐ Late (tertiary) ☐ Congenital

Syphilis Test Results | Titer
☐ RPR ☐ Pos ☐ Neg
☐ VDRL ☐ Pos ☐ Neg
☐ FTA-ABS ☐ Pos ☐ Neg
☐ TP-PA ☐ Pos ☐ Neg
☐ EIA/CLIA ☐ Pos ☐ Neg
☐ CSF-VDRL ☐ Pos ☐ Neg
☐ Other: _____

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) (check all that apply): ☐ Cervical ☐ Pharyngeal ☐ Rectal ☐ Urethral ☐ Urine ☐ Vaginal ☐ Other: _____
Symptoms? ☐ Yes ☐ No ☐ Unknown

If reporting Pelvic Inflammatory Disease: (check all that apply)
☐ Gonococcal PID ☐ Chlamydial PID ☐ Other/Unknown Etiology PID

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)		☐
Hep D	anti-HDV		☐
Hep E	anti-HEV		

Remarks

CDPH 110a (1… orting all conditions except Tuberculosis and conditions reportable to DMV) (EPI 1… Page 1 o…

STD Reporting Time Frames

Within 1 working day of identification: Syphilis, including suspected cases (i.e., presumption of syphilis based on presentation of signs and symptoms regardless of whether results of the laboratory tests are known).

Within 7 days of identification: Gonorrhea, chlamydia including lymphogranuloma venerum (LGV), pelvic inflammatory disease (PID), and chancroid.

Reporting of STDs does not require patient consent and is not subject to the requirements of the Health Insurance Portability and Accountability Act (HIPAA). HIPAA allows disclosure of this information to public health authorities for the "purpose of ... public health surveillance, public health investigations, and public health interventions..." 45 CFR §164.512(b)(1).

More Information

Local Health Department Contact Information:
cdph.ca.gov/HealthInfo/Documents/LHD_CD_Contact_Info.pdf

Reportable Diseases and Conditions:
cdph.ca.gov/HealthInfo/Pages/ReportableDiseases.aspx

CDPH STD Control Branch: std.ca.gov

CDPH California Department of PublicHealth