State of Nevada
List of Reportable Diseases

Nevada Reportable Diseases

Amebiasis
Animal bite from a rabies-susceptible species*
Anthrax*
Arsenic
Exposures and Elevated Levels
Babesiosis
Botulism*†
Brucellosis
Campylobacteriosis
Candida auris
CD4 lymphocyte counts <500/µL
Chancroid
Chikungunya virus disease
Chlamydia
Cholera
Coccidioidomycosis
Coronavirus disease 2019 (COVID-19)
Cryptosporidiosis
Cyclosporiasis (parasite)
Dengue
Diphtheria†
Drowning‡
Ehrlichiosis/anaplasmosis
E. coli 0157: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*†
Giardiasis
Gonorrhea
Granuloma inguinale
Haemophilus influenzae (invasive, any type)
Hansen's Disease (leprosy)
Hantavirus
Hemolytic-uremic syndrome (HUS)
Hepatitis A, B, C, delta, unspecified
Hepatitis C, negative results
Human Immunodeficiency virus infection (HIV)*
HIV Stage 3 (*formerly known as Acquired Immunodeficiency Syndrome [AIDS]*)*
HIV, negative results
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‡
Mpox (also known as monkeypox)
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
Varicella (chicken pox)
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

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 constructed 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

Source Information

Provider Name/Phone Number
The physician primarily responsible for the care of this patient

Person Reporting/Phone/Fax
Provide if different than attending physician

Facility/Organization
List the locations for facilities with multiple locations.

Report Date
The date that this report is submitted

Patient Demographic Data
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

Morbidity Data

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

Northern Nevada Public Health (Washoe County)
1001 E. Ninth St., Building B
P. O. Box 11130
Reno, Nevada 89520-0027
https://www.nnph.org/
Phone: (775) 328-2447 (24 hours)
Confidential Fax: (775) 328-3764

Central Nevada Health District (Fallon, Churchill, Mineral, Eureka, and Pershing County)
485 West B. St.
Fallon, NV 89406
https://www.centralnevadahd.org/
Phone: (775) 866-7535 (24 hours)
Confidential Fax: (877) 513-3442

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 also be reported by telephone to the appropriate health jurisdiction.

State of Nevada
Confidential Morbidity Report Form

Source

Provider Name	Provider Telephone #		Report Date
Facility/Organization (Name and Address)			☐ Check if completed by the Local Health Department
Person Reporting	Reporter Phone	Reporter Fax	Reporter Job Title

Facility Type

Inpatient:	Outpatient:	Screening Diagnostic Referral Agency:	Other Facility:
☐ Hospital ☐ Other_____	☐ Private Office ☐Adult HIV Clinic ☐ Other_____	☐ CTS ☐ STD Clinic ☐ Other_____	☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Other_____

Patient Demographic Data

Patient Name (Last)	(First) (MI)	Date of Birth	Age	Sex assigned at birth ☐ Female ☐ Male
Patient Address	(City)	(State)	(Zip)	Current Gender ☐ Female ☐ M to F Transgender ☐ Male ☐ F to M Transgender ☐ Unknown ☐ Refused to answer ☐ Additional gender identity (specify)_
County of Residence	Home Phone	Cell Phone		

Pregnant ☐ No ☐ Yes	Prenatal Care ☐ No ☐ Yes	Pregnancy EDC	Ethnicity ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown ☐ Expanded Ethnicity_____

Parent or Guardian Name	Birth Country and Arrival Date	Primary Language Spoken	Race(s) ☐ White ☐ Black: ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other ☐ Unknown Expanded race:_____
Social Security Number	Occupation / Employer / School	Medical Records Number	

Incarcerated ☐ No ☐ Yes	Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Unknown

Sexual Orientation:
☐ Straight or Heterosexual ☐ Lesbian or Gay ☐ Bisexual ☐ Queer ☐ Pansexual ☐ Decline to answer
☐ Other, specify:

Morbidity Data

Disease or Condition	Date of Onset	Patient Notified of This Condition ☐ Yes ☐ No	Pertinent Clinical Information/Comments
Patient Hospitalized ☐ Yes ☐ No Admit Date Discharge Date: Hospital:		Patient Died of This Illness ☐ Yes ☐ No Date:	

Condition Acquired in Nevada ☐ Yes ☐ No ☐ Unknown If no, ☐ Interstate ☐ International	Diagnosis Date	Suspected Source	Symptoms

Was laboratory testing ordered? *If yes, attach the results or provide the laboratory name if the results are unavailable* ☐ No ☐ Yes	Was the patient treated? *If yes, provide the treatment details (drug name, dosage, duration, dates etc.)* ☐ No ☐ Yes

Hepatitis Laboratory Results

	POS	NEG	Date
HAV Antibody Total	☐	☐	
HAV Antibody IgM	☐	☐	
HBV Surface Antigen	☐	☐	
HBV e Antigen	☐	☐	
HBV Core Antibody Total	☐	☐	
HBV core Antibody IgM	☐	☐	
HBV Surface Antibody	☐	☐	

	POS	NEG	Date
HBV DNA	☐	☐	
HCV Antibody RIBA	☐	☐	
HCV RNA (e.g. by PCR)	☐	☐	
HCV Antibody (ELISA)	☐	☐	
HCV Antibody (Rapid)	☐	☐	
HDV Antibody	☐	☐	
HDV Rapid	☐	☐	

	Date / Range
HCV Genotype	_____
ALT (SGPT) Level	_____
Alt-Lab Normal Range	_____
AST (SGOT) Level	_____
AST-Lab Normal Range	_____
Name of Lab	

Patient Name (Last) (First) MI)

Initial Diagnostic HIV Tests

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown

The patient's partners will be notified about their HIV exposure and counseleund by:
☐ Health Dept. ☐ Physician/provider ☐ Patient ☐ Unknown

TEST 1 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer: _____ Point of care rapid test
Results ☐ Positive ☐ Negative ☐ Indeterminate Collection Date: _

TEST 2 ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer: _ Point of care rapid test
Results ☐ Positive ☐ Negative ☐ Indeterminate Collection Date: _

Evidence of receipt of HIV medical care other than laboratory test results (record additional evidence in comments)
☐ Yes, documented
☐ Yes, client self-report, only
Date of medical visit or prescription

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:				Date:
	HIV-1 Ag: ☐ Reactive	☐ Nonreactive	☐ Not reportable due to high Ab level	
	HIV-1 Ab: ☐ Reactive	☐ Nonreactive	☐ Undifferentiated/Indeterminate	
	HIV-2 Ab: ☐ Reactive	☐ Nonreactive	☐ Undifferentiated/Indeterminate	

HIV Viral Load HIV Genotype

Qualitative
Results ☐ Positive ☐ Negative ☐ Indeterminate
Collection Date: _____

Quantitative
Results ☐ Detectable ☐ Undetectable
Copies/mL: _____
Collection Date: _____

HIV Genotype (Resistance) Collection Date: Interpretation: _____

Risk Exposure (select all that apply)
Complete for HIV/AIDS or STI
☐ Sex with Male
☐ Sex with Female
☐ Inject(ed) non-prescription drugs
☐ Sex Partner has HIV or AIDS
☐ Sex Partner Injects Drugs
☐ Sex Partner is Male that has Sex with Males
☐ Injection Drug Use
☐ Perinatal Exposure of Newborn
☐ Other Exposure (specify)
_____

Sexually Transmitted Infection (STI)

Syphilis Stage	Syphilis Symptoms	Gonorrhea Specimen Site	Chlamydia Site(s)	STI Treatment
☐ Primary	☐ Chancre	☐ Cervical	☐ Cervical	☐ Azithromycin 1g
☐ Secondary	☐ Palmar/Plantar Rash	☐ Urethral	☐ Urethral	☐ L-A Bicillin 2.4 mu IM
☐ Early Latent (<1 yr)	☐ Condylomata Lata	☐ Rectal	☐ Rectal	x #_ (doses)
☐ Latent	☐ Neurologic	☐ Pharyngeal	☐ Pharyngeal	☐ No Treatment Given
☐ Congenital	☐ Other (specify)	☐ Ophthalmia Neonatorum	☐ PID	☐ Ceftriaxone/Rocephin 500mg IM
☐ Unknown	_____	☐ PID	☐ Other (specify)	☐ Doxy 100 Mg BID
		☐ Other (specify) _____	_____	x #_____Days
				☐ 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)

☐ Yes, I saw the sex partner(s) in my office ☐ Yes, I gave medication for___ (#) partners ☐ Yes, I wrote a prescription for __ (#) partner(s)

Partner Name_____ DOB_____

TB Disease and LTBI .

☐ Tuberculosis Disease (suspected or confirmed) ☐ TB Disease Site: _____
☐ Latent TB Infection (LTBI)

Chest X-ray/Imaging: (include last report)
☐ Abnormal ☐ Normal Date:_____

Symptoms ☐ Cough > 3 weeks ☐ Hemoptysis ☐ Fever ☐ Weight loss ☐ Fatigue ☐ Abnormal Chest X-ray

Laboratory Results (include a copy of laboratory testing)

		POS	NEG	Date
TB Test, IGRA				
TB Test, TST: _	mm			

If *Not* Sputum, indicate source:_

	POS	NEG	Date
AFB Smear			
NAAT			
Culture			

Treatment (include drug(s)/dose(s))
☐ No treatment started
☐ LTBI treatment, Date started
☐ TB Disease treatment, Date started

COVID - 19

☐ COVID-19 lab test type: ☐ PCR ☐ Antigen ☐ Antibody
COVID Vaccine ☐ Yes ☐ No

Vaccine Brand Name: First Vaccine Date:
Second Vaccine Date (if applicable):

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