GUAM DEPARTMENT OF PUBLIC HEALTH AND SOCIAL SERVICES
BUREAU OF COMMUNICABLE DISEASE CONTROL
MORBIDITY REPORT: EPIDEMIOLOGIST

***Date of Report** (mm/dd/yyyy): ____ / ____ / _____*

DISEASE		**SPECIMEN SITE**		☐ *Suspected* ☐ *Confirmed*

PATIENT INFORMATION AND DEMOGRAPHICS

Patient Name *(Last Name, First Name) – Include parent/guardian's name if patient is <18yrs of age*

DOB **Age:** **Sex:** ☐ Male ☐ Female ☐ Other ☐ Unknown *If female, currently pregnant?* ☐ *Yes* ☐ *No* ☐ *Unknown*

Ethnicity		**Status***	

Residential Address **Village**

Home Telephone **Cell Phone** **E-mail Address**

Employer	**Occupation**	**Insurance** ☐ Private ☐ Public ☐ Uninsured

SYMPTOMS AND TREATMENT

Symptom status ☐ *Symptomatic* ☐ *Asymptomatic* ☐ *Unknown* *If symptomatic, date of onset: ____ / ____ / _____*

	YES	NO	UNK	SPECIFY
Fever >100.4ºF (38ºC)	☐	☐	☐	
Sore Throat	☐	☐	☐	
Cough	☐	☐	☐	
Chills	☐	☐	☐	
Nausea or vomiting	☐	☐	☐	
Diarrhea	☐	☐	☐	
Other	☐	☐	☐	

Treatment		**Treatment Date**	
Number of partners		**Number of partners treated**	

REPORTER INFORMATION

Reporting Facility	**Physician**
Reported By	**Contact Information**

***STATUS CODE**: C – Civilian, M – Military, D – Military Dependent, N – Medical Referral, T – Tourist/Visitor, U – Unknown*

10 GCA §3302 REQUIRES REPORTING OF ALL INFECTIOUS DISEASES

PLEASE COMPLETE THIS FORM AND SUBMIT TO DPHSS

Fax Reports 24 hour 671-300-5566 or 671-734-1475

Email: dphss.surveillance@dphss.guam.gov

Notes

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