



Natural Disaster Morbidity Surveillance Summary Report Form

For Reporting Purposes

Form v2.1
Rev.4/6/2015

Submit completed form daily to the Kentucky Dept. for Public Health via fax at **502-696-5852**..

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:	AM PM
MONTH	DAY
YEAR	HOUR (CIRCLE)
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
<p>▶ 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.</p>

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	_____