Natural Disaster Morbidity Surveillance Individual Form

For Active Surveillance with Medical Staff

Form v1.9
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Part I: VISIT INFORMATION	Name of Facility	City	State	Date of Visit	Time of Visit
				/ /	AM PM

Part II: PATIENT INFORMATION	Unique Identifier/Medical Record Number	Age ☐ <1yrs	Gender	Pregnant	If yes, due date
		yrs	☐ Male ☐ Female	☐ Yes ☐ No/NA	/ /

Race/Ethnicity ☐ White ☐ Black/African American ☐ Hispanic or Latino ☐ Asian ☐ Unknown

Did reason for visit occur as a result of work (paid or volunteer) involving disaster response or rebuilding efforts? ☐ Yes ☐ No/NA

If Yes, occupation/response role

Activity at time of injury/illness

Part III: REASON FOR VISIT (Please check all categories related to patient's current reason for seeking care)

TYPE OF INJURY

- ☐ Abrasion, laceration, cut
- ☐ Avulsion, amputation
- ☐ Concussion, head injury
- ☐ Fracture
- ☐ Sprain/strain

MECHANISM OF INJURY

- ☐ Bite/sting, *specify*:
  - ☐ Insect
  - ☐ Snake
  - ☐ Other *specify* _____
- ☐ Burn, *specify*:
  - ☐ Chemical
  - ☐ Fire, hot object or substance
  - ☐ Sun exposure
- ☐ Cold/heat exposure, *specify*:
  - ☐ Cold (e.g., hypothermia)
  - ☐ Heat (e.g., stress, hyperthermia)
- ☐ Electric shock
- ☐ Fall, slip, trip, *specify*:
  - ☐ From height
  - ☐ Same level
- ☐ Foreign body (e.g., glass shard)
- ☐ Hit by or against an object
- ☐ Motor vehicle crash, *specify:*
  - ☐ Driver/occupant
  - ☐ Pedestrian/bicyclist
- ☐ Non-fatal drowning, submersion
- ☐ Poisoning, *specify:*
  - ☐ Carbon monoxide exposure
  - ☐ Inhalation of fumes, dust, other gas
  - ☐ Ingestion *specify* _____
- ☐ Use of machinery, tools, or equipment
- ☐ Violence/assault, *specify:*
  - ☐ Self-inflicted injury/suicide attempt
  - ☐ Sexual assault
  - ☐ Other assault *specify* _____

ACUTE ILLNESS/SYMPTOMS

- ☐ Conjunctivitis/eye irritation
- ☐ Dehydration
- ☐ Dermatologic/skin, *specify:*
  - ☐ Rash
  - ☐ Infection
  - ☐ Infestation (e.g., lice, scabies)
- ☐ Fever (≥100°F or 37.8°C)
- ☐ Gastrointestinal, *specify:*
  - ☐ Diarrhea
    - ☐ Bloody
    - ☐ Watery
  - ☐ Nausea or vomiting
- ☐ Jaundice
- ☐ Meningitis/encephalitis
- ☐ Neurological (e.g., altered mental status, confused/disoriented, syncope)
- ☐ Obstetrics/Gynecology, *specify*:
  - ☐ GYN condition not associated with pregnancy or post-partum
  - ☐ In labor
  - ☐ Pregnancy complication (e.g., bleeding, fluid leakage)
  - ☐ Routine pregnancy check-up
- ☐ Pain, *specify:*
  - ☐ Abdominal pain or stomachache
  - ☐ Chest pain, angina, cardiac arrest
  - ☐ Ear pain or earache
  - ☐ Headache or migraine
  - ☐ Muscle or joint pain (e.g., back, hip)
  - ☐ Oral/dental pain
- ☐ Respiratory, *specify:*
  - ☐ Congestion, runny nose, sinusitis
  - ☐ Cough, *specify:*
    - ☐ Dry
    - ☐ Productive
    - ☐ With blood
  - ☐ Pneumonia, suspected
  - ☐ Shortness of breath/difficulty breathing
  - ☐ Wheezing in chest
- ☐ Sore throat

EXACERBATION OF CHRONIC DISEASE

- ☐ Cardiovascular, *specify*:
  - ☐ Hypertension
  - ☐ Congestive heart failure
- ☐ Diabetes
- ☐ Immunocompromised (e.g., HIV, lupus)
- ☐ Neurological, *specify*:
  - ☐ Seizure
  - ☐ Stroke
- ☐ Respiratory, *specify*:
  - ☐ Asthma
  - ☐ COPD

MENTAL HEALTH

- ☐ Agitated behavior (i.e. violent behavior/threatening violence)
- ☐ Anxiety or stress
- ☐ Depressed mood
- ☐ Drug/alcohol intoxication or withdrawal
- ☐ Previous mental health diagnosis (i.e. PTSD)
- ☐ Psychotic symptoms (i.e. paranoia)
- ☐ Suicidal thoughts or ideation

ROUTINE/FOLLOW-UP

- ☐ Medication refill
  If yes, how many medications? _____
- ☐ Blood sugar check
- ☐ Blood pressure check
- ☐ Vaccination
- ☐ Wound care

OTHER

Part IV: DISPOSITION

- ☐ Discharge to self care
- ☐ Refer to other care (e.g., clinic or physician)
- ☐ Admit/refer to hospital
- ☐ Left before being seen
- ☐ Deceased

☐ **Influenza-like-illness (ILI)** – Fever (temperature of 100°F [37.8°C] or greater) AND a cough *or* a sore throat in the absence of a KNOWN cause other than influenza