CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting lapses of consciousness, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).

CONDITION 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: _____

Birth 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***

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, Samoan, Guamanian, Other *(specify)*: _____
White
Other *(specify)*: _____
Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): Food Service | Day Care | Health Care | Correctional Facility | School | Other *(specify)*: _____

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:

County of Santa Cruz
Communicable Disease Unit
1060 Emeline Ave., Bldg F
Santa Cruz, CA 95060
Phone: (831) 454-4114/ FAX: (831) 454-5049

After 5:00pm/Weekends/Holidays
Phone: (831) 471-1170

(Obtain additional forms from your local health department.)

DEPARTMENT OF MOTOR VEHICLES (DMV)

California Driver License or Identification Card Number (eight characters): ☐☐☐☐☐☐☐☐

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode?: _____ *(mm/dd/yyyy)*
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.
   (a): _____ *(mm/dd/yyyy)* (b): _____ *(mm/dd/yyyy)* (c): _____ *(mm/dd/yyyy)* (d): _____ *(mm/dd/yyyy)* (e): _____ *(mm/dd/yyyy)* (f): _____ *(mm/dd/yyyy)*
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving? ☐ Yes ☐ No ☐ Uncertain
4. Are additional lapses of consciousness likely to occur? ☐ Yes ☐ No ☐ Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake? ☐ Yes ☐ No ☐ Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease? ☐ Yes ☐ No ☐ Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition? ☐ Yes ☐ No ☐ Uncertain
8. Does this patient's condition represent a permanent driving disability? ☐ Yes ☐ No ☐ Uncertain
9. Would you recommend a driving evaluation by DMV? ☐ Yes ☐ No ☐ Uncertain

Remarks: