 **Disaster Health Services Aggregate Morbidity Report Form\***

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| **Part I. General Information**  |
| 1. Disaster Operation # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Reporting Date: \_\_\_/\_\_\_/\_\_\_
3. Reporting Timeframe: \_\_\_\_\_\_\_ – \_\_\_\_\_\_\_
4. County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_
5. Service Type (circle): Shelter Non-Shelter
6. Worksite Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
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| **Part II. Number of Client-Related Interactions**  |  |
| **Tally (llll llll llll)**  | **Total (#)**  |
| 7. **Total Client-related Contacts:**    |    |
| 7b. **Total of Health-related Client Visits: (fill part III)**    |    |

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| **Part III. Demographics (for Health-related Visits Only)**  |
|  **Tally (llll llll llll)**  | **Total (#)**  |
| **Gender**  | Male  |   |   |
| Female  |   |   |
| **Age**  | ≤ 2  |   |   |
| 3 to 18  |   |   |
| ≥ 65  |   |   |
|   |   |

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| **Access/Functional Needs:** mark each individual need based on C-MIST model per 24 hours **Tally (llll llll llll)** **Total (#)**  |
| **C**ommunication  |   |   |
| **M**aintenance of Health  |   |   |
| **I**ndependence  |   |   |
| **S**ervices and Support  |   |   |
| **T**ransportation  |   |   |

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| **Part IV. Reason for Visit: for each client visit, tick ALL reason(s) for visits.**  |  |
|   | **Tally (llll llll llll)**  | **Total (#)**  |  **Tally (llll llll llll)**  | **Total (#)**  |
| **Injury**   | **Behavioral/Mental Health**  |  |
| Bite (includes *ALL* bites)  |   |   | Agitated/disruptive/psychotic  |   |   |
| Burn (thermal or chemical)  |   |   | Anxiety/stress/depressed mood  |   |   |
| Cut/laceration/puncture  |   |   | Suicidal/homicidal thoughts  |   |   |
| Foreign body (e.g., splinter)  |   |   | Substance addiction/withdrawal  |   |   |
| Fall/slip/trip  |   |   | Other mental health  |   |   |
| Hit by or against object  |   |   | **Exacerbation of Chronic Illness**  |  |
| Use of machinery/tools/equip.  |   |   | Asthma  |   |   |
| Assault  |   |   | Obstructive pulmonary disease  |   |   |
| Carbon Monoxide (CO) exposure  |   |   | Cardiovascular (HTN, CHF, CHD)  |   |   |
| Poisoning, non-CO  |   |   | Chronic muscle or joint pain  |   |   |
| Other injury  |   |   | Diabetes  |   |   |
| **Illness/Symptoms**  | Neurological (seizure, stroke, dementia)  |   |   |
| Fever (>100.4°F or 38°C)  |   |   | Previous mental health diagnosis  |   |   |
| Conjunctivitis/eye irritation  |   |   | Other chronic illness  |   |   |
| Dehydration  |   |   | **Health Care Maintenance**  |  |
| Heat stress/heat exhaustion  |   |   | Blood pressure check  |   |   |
| Hypothermia/cold-environment  |   |   | Blood sugar check  |   |   |
| Oral health  |   |   | Pregnancy/post-partum care  |  |  |
| Pain: chest, angina, cardiac arrest  |   |   | Dressing change/wound care  |   |   |
| Pain: muscle or joint pain  |   |   | Immunization/vaccination  |   |   |
| Pain: head, ears, eyes, nose, throat  |   |   | Medical refill (please mark one tick for *each* med refill)  |   |   |
| Pain: other, not specified above  |   |   |
| Gastrointestinal (GI): diarrhea  |   |   | Other health maintenance  |   |   |
| GI: nausea/vomiting  |   |   |   |   |
| GI: other (constipation, GERD)  |   |   |         | **Part V. Disposition**  | **Tally (llll llll llll)**  | **Total (#)**  |
| Genitourinary (GU)  |   |   | Provided Red Cross care  |   |   |
| Skin (includes *ALL* skin conditions)  |   |   | Referred to…  |   |   |
| Allergic reaction  |   |   | Hospital  |  |  |
| Respiratory (include *ALL* resp.)  |   |   | Physician/dentist/clinic  |   |   |
| Influenza-like-illness (ILI)  |   |   | Pharmacist  |   |   |
| Neurological, new onset  |   |   | Other (e.g., DMH)  |   |   |
| Other illness/symptoms  |   |   | Refused Red Cross care  |   |   |

**\*Complete one form per service location per 24 hours. Submit by 4pm local time.**

Print name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Aggregate Morbidity Report Form 2077C (rev. 2/13)

 **Disaster Health Services Aggregate Morbidity Report Form\***

# Basic Instructions

*Purpose*: Use this form to report on all clients medically seen in your site location over the last 24 hours.

*Procedure*:

* **PART I:** Fill out the top portion of this form with Disaster Operation #, Report Date, Timeframe (24hr period), County, State, Type of service site, and Name of worksite location.

* **PART II:**
	+ Total Client-related Contacts = **mark EACH CONTACT** in the 24hr reporting period.
	+ Total Number of Health-Related Client Visits = **mark EACH VISIT** inthe 24hr reporting period for each time client health care was given (e.g., multiple blood sugar checks = mark a tick for each visit)

* **PART III:** Mark one tick for gender (male or female) and for age category, for each **Health–related Visit** o The total number for gender (male + female) and for combined age categories at the end of the 24hr reporting period should equal the **total number of health-related client visits (7b)**.

* **PART IV**: Mark one tick for each complaint for the *current* health visit. o For example, if a client has diabetes and receives a regular blood sugar check, only mark Blood sugar check. Do not mark diabetes unless the client is currently having symptoms consistent with an exacerbation of diabetes.
	+ IMPORTANT: For medication refill, mark one tick for EACH medication supplied

* **Part V:** Mark client disposition for each health-related visit. o Tick **provided Red Cross care** for clients treated and released (back into shelter or community) as well as those referred, if care was given prior to referral.

* **Access/Functional Needs:** Mark each identified individual need based on the C-MIST model ONCE per 24 hour period.

* Print your name and provide contact information on the bottom of the form

* Submit by 4pm local time

**Thank you!**