Natural Disaster Morbidity Surveillance Summary Report Form

For Reporting Purposes

Submit completed form every operational period to the Mass Care Supervisor at the SHOC via phone (302-223-1720) or fax (302-223-1724)

Part I FACILITY INFORMATION

LOCATION:

STATE ZIPCODE NAME OF FACILITY

REPORTING PERSON/CONTACT:

PHONE /FAX NAME

EMAIL:

Part II REPORTING PERIOD

START: AM PM

END: AM PM

MONTH DAY YEAR HOUR CIRCLE)

TOTAL SHELTER POPULATION AT START OF OPERATING PERIOD:	#

Part III PERSONS SEEN OR TREATED

TOTAL SEEN OR TREATED DURING REPORTING PERIOD:	#
Race/Ethnicity (Total) White	#
Black/African American	#
American Indian/Alaskan Native	#
Asian	#
Native Hawaiian/Pacific Islander	#
Not Hispanic or Latino	#
Hispanic or Latino	#
AGE 0-4 YEARS	#
5-24 YEARS	#
25-49 YEARS	#
50-64 YEARS	#
≥65 YEARS	#
Pregnant females	#
TOTAL REFERRED TO HOSPITAL:	#

Part IV Treated Patients

Use categories that best describe current reasons for care. Complete the **TOTAL** tallies for each syndrome category. Be as specific as possible. A single patient may be counted more than once.

SYNDROME CATEGORY	TOTAL
WORKERS/VOLUNTEERS - TOTAL	__ __ __
INJURY - TOTAL	__ __ __
Fall, slip, trip (from height or same level)	__ __ __
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	__ __ __
RESPIRATORY ILLNESS - TOTAL	__ __ __
Congestion, runny nose, sinusitis	__ __ __
Cough or wheezing in chest	__ __ __
Shortness of breath or difficulty breathing	__ __ __
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)	__ __ __
Diabetes	__ __ __
Immunocompromised (e.g., HIV, lupus)	__ __ __
Neurological (e.g., seizure, stroke)	__ __ __
Respiratory (e.g., Asthma, COPD)	__ __ __
MENTAL HEALTH - TOTAL	__ __ __
Agitated behavior	__ __ __
Anxiety/stress/depressed mood	__ __ __
Drug/alcohol intoxication or withdrawal	__ __ __
Previous mental health diagnosis	__ __ __
Psychotic symptoms (e.g. paranoia)	__ __ __
Suicidal thoughts or ideation	__ __ __
ROUTINE/FOLLOW-UP - TOTAL	__ __ __
Medication refill	__ __ __
Blood sugar check	__ __ __
Blood pressure check	__ __ __
Wound care	__ __ __
OTHER REASON FOR VISIT, not listed above	__ __ __