# 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, Guamanian, Samoan, 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 San Diego Epidemiology
Fax (858) 715-6458
Phone (619) 692-8499

(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:**