



Natural Disaster Morbidity Surveillance Individual Form

Complete this form for every patient that comes to the Medical Unit/First Aid Station and **keep confidential**.

Part I: VISIT INFORMATION	Name of Facility <input style="width: 90%;" type="text"/>	City <input style="width: 90%;" type="text"/>	State <input style="width: 90%;" type="text"/>	Date of Visit <input style="width: 80%;" type="text"/> / <input style="width: 80%;" type="text"/> / <input style="width: 80%;" type="text"/>	Time of Visit <input style="width: 80%;" type="text"/> AM <input style="width: 80%;" type="text"/> PM
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Part II: PATIENT INFORMATION	Unique Identifier/Medical Record Number <input style="width: 95%;" type="text"/>	Age <input type="checkbox"/> <1yrs <input style="width: 80%;" type="text"/> yrs	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No/NA	If yes, due date <input style="width: 80%;" type="text"/> / <input style="width: 80%;" type="text"/> / <input style="width: 80%;" type="text"/>
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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)

<p style="text-align: center;">TYPE OF INJURY</p> <p><input type="checkbox"/> Abrasion, laceration, cut</p> <p><input type="checkbox"/> Avulsion, amputation</p> <p><input type="checkbox"/> Concussion, head injury</p> <p><input type="checkbox"/> Fracture</p> <p><input type="checkbox"/> Sprain/strain</p> <p style="text-align: center;">MECHANISM OF INJURY</p> <p><input type="checkbox"/> <u>Bite/sting</u>, specify: <input type="checkbox"/> Insect <input type="checkbox"/> Snake <input type="checkbox"/> Other specify _____</p> <p><input type="checkbox"/> <u>Burn</u>, specify: <input type="checkbox"/> Chemical <input type="checkbox"/> Fire, hot object or substance <input type="checkbox"/> Sun exposure</p> <p><input type="checkbox"/> <u>Cold/heat exposure</u>, specify: <input type="checkbox"/> Cold (e.g., hypothermia) <input type="checkbox"/> Heat (e.g., stress, hyperthermia)</p> <p><input type="checkbox"/> Electric shock</p> <p><input type="checkbox"/> <u>Fall, slip, trip</u>, specify: <input type="checkbox"/> From height <input type="checkbox"/> Same level</p> <p><input type="checkbox"/> Foreign body (e.g., glass shard)</p> <p><input type="checkbox"/> Hit by or against an object</p> <p><input type="checkbox"/> <u>Motor vehicle crash</u>, specify: <input type="checkbox"/> Driver/occupant <input type="checkbox"/> Pedestrian/bicyclist</p> <p><input type="checkbox"/> Non-fatal drowning, submersion</p> <p><input type="checkbox"/> <u>Poisoning</u>, specify: <input type="checkbox"/> Carbon monoxide exposure <input type="checkbox"/> Inhalation of fumes, dust, other gas <input type="checkbox"/> Ingestion specify _____</p> <p><input type="checkbox"/> Use of machinery, tools, or equipment</p> <p><input type="checkbox"/> <u>Violence/assault</u>, specify: <input type="checkbox"/> Self-inflicted injury/suicide attempt <input type="checkbox"/> Sexual assault <input type="checkbox"/> Other assault specify _____</p>	<p style="text-align: center;">ACUTE ILLNESS/SYMPTOMS</p> <p><input type="checkbox"/> Conjunctivitis/eye irritation</p> <p><input type="checkbox"/> Dehydration</p> <p><input type="checkbox"/> <u>Dermatologic/skin</u>, specify: <input type="checkbox"/> Rash <input type="checkbox"/> Infection <input type="checkbox"/> Infestation (e.g., lice, scabies)</p> <p><input type="checkbox"/> Fever (≥100°F or 37.8°C)</p> <p><input type="checkbox"/> <u>Gastrointestinal</u>, specify: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody <input type="checkbox"/> Watery <input type="checkbox"/> Nausea or vomiting</p> <p><input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> Meningitis/encephalitis-like ★</p> <p><input type="checkbox"/> Neurological (e.g., altered mental status, confused/disoriented, syncope)</p> <p><input type="checkbox"/> <u>Obstetrics/Gynecology</u>, specify: <input type="checkbox"/> GYN condition not associated with pregnancy or post-partum <input type="checkbox"/> In labor <input type="checkbox"/> Pregnancy complication (e.g., bleeding, fluid leakage) <input type="checkbox"/> Routine pregnancy check-up</p> <p><input type="checkbox"/> <u>Pain</u>, specify: <input type="checkbox"/> Abdominal pain or stomachache <input type="checkbox"/> Chest pain, angina, cardiac arrest <input type="checkbox"/> Ear pain or earache <input type="checkbox"/> Headache or migraine <input type="checkbox"/> Muscle or joint pain (e.g., back, hip) <input type="checkbox"/> Oral/dental pain</p> <p><input type="checkbox"/> <u>Respiratory</u>, specify: <input type="checkbox"/> Congestion, runny nose, sinusitis <input type="checkbox"/> Cough, specify: <input type="checkbox"/> Dry <input type="checkbox"/> Productive <input type="checkbox"/> With blood ★ <input type="checkbox"/> Pneumonia, suspected <input type="checkbox"/> Shortness of breath/difficulty breathing <input type="checkbox"/> Wheezing in chest</p> <p><input type="checkbox"/> Sore throat</p>	<p style="text-align: center;">EXACERBATION OF CHRONIC DISEASE</p> <p><input type="checkbox"/> <u>Cardiovascular</u>, specify: <input type="checkbox"/> Hypertension <input type="checkbox"/> Congestive heart failure</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Immunocompromised (e.g., HIV, lupus)</p> <p><input type="checkbox"/> <u>Neurological</u>, specify: <input type="checkbox"/> Seizure <input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> <u>Respiratory</u>, specify: <input type="checkbox"/> Asthma <input type="checkbox"/> COPD</p> <p style="text-align: center;">MENTAL HEALTH</p> <p><input type="checkbox"/> Agitated behavior (e.g. violent behavior/threatening violence)</p> <p><input type="checkbox"/> Anxiety or stress</p> <p><input type="checkbox"/> Depressed mood</p> <p><input type="checkbox"/> Drug/alcohol intoxication or withdrawal</p> <p><input type="checkbox"/> Previous mental health diagnosis (e.g. PTSD)</p> <p><input type="checkbox"/> Psychotic symptoms (e.g. paranoia)</p> <p><input type="checkbox"/> Suicidal thoughts or ideation</p> <p style="text-align: center;">ROUTINE/FOLLOW-UP</p> <p><input type="checkbox"/> Medication refill If yes, how many medications? _____</p> <p><input type="checkbox"/> Blood sugar check <input type="checkbox"/> Vaccination</p> <p><input type="checkbox"/> Blood pressure check <input type="checkbox"/> Wound care</p> <p style="text-align: center;">OTHER</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
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<p><input type="checkbox"/> Influenza-like-illness (ILI) – Fever (temperature of 100°F [37.8°C] or greater) AND a cough or a sore throat</p>	<p>★ Call the NH DPHS ASAP at 603-271-4496 or (NH only) 1- 800-852-3345 ext. 4496 (weekdays) or ext. 5300 (after hours)</p>
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Instructions for Completing the Natural Disaster Morbidity Surveillance Individual Form (“Individual Form”)

This form is completed for each individual that visits the first aid or Medical Unit in a disaster response facility. It should be considered a **confidential** document and kept with the medical narratives completed for each individual. This form should **not** be posted to WebEOC and should **not** be sent to the SEOC.

Part I: Visit Information	<ul style="list-style-type: none"> • Name of Facility: location where the person sought medical care • City, State: location of facility • Date of Visit: date of visit to the Medical Unit or first aid station in MM/DD/YY format • Time of Visit: time the individual visited the Medical Unit or first aid station
Part II: Individual Information	<ul style="list-style-type: none"> • Unique Identifier/Medical Record Number: unique number that was assigned to the individual as a medical record number or client number when entering the shelter. If this type of system is not used, you can put the individual’s first and last name • Age in years: Age in years, if age is less than one year please check the appropriate box • Gender: Male, female • Pregnant: if individual is pregnant, check the “Yes” box and if known include due date • Race/Ethnicity: check the appropriate box(es) • Work Injury: If it is a work related injury as a result of the disaster response or rebuilding efforts, check the “Yes” box. If the answer is “yes” include the occupation or role during the response and the activity at the time of injury/illness (e.g. cutting down trees)
Part III: Reason for Visit	<p>Reason for Visit: Check all the boxes that relate to the individual’s current reason for seeking care.</p>
Part IV: Disposition	<p>Disposition: Check the box that indicates what happened to the person once they left the Medical Unit or first aid station.</p>