Aggregate Morbidity Report Form*

Part I. General Information
1. Disaster Name: _____
2. Reporting Start Date: ___/___/___ Time: _____
3. Reporting End Date: ___/___/___ Time: _____
4. City: _____ State _____
5. Shelter Name: _____

Part II. Number of Client-Related Interactions	Tally (𝍸 𝍸 𝍸)	Total (#)
7. **Total Client-related Contacts (includes CMIST):**		
7b. **Total of Health-related Client Visits: (fill part III)**		

Part III. Demographics (for Health-related Visits Only)		Tally (𝍸 𝍸 𝍸)	Total (#)
Gender	Male		
	Female		
Age	≤ 2		
	3 to 18		
	19 to 64		
	≥ 65		

Functional/Access Needs: mark each individual need based on C-MIST model per 24 hours	Tally (𝍸 𝍸 𝍸)	Total (#)
Communication		
Maintenance of Health		
Independence		
Safety and Security		
Transportation		

Part IV. Reason for Visit: for each client visit, tick ALL reason(s) for visits.	Tally (𝍸 𝍸 𝍸)	Total (#)
Injury		
Bite (includes *ALL* bites)		
Burn (thermal or chemical)		
Cut/laceration/puncture		
Foreign body (e.g., splinter)		
Fall/slip/trip		
Hit by or against object		
Use of machinery/tools/equip.		
Assault		
Carbon Monoxide (CO) exposure		
Poisoning, non-CO		
Other injury		
Illness/Symptoms		
Fever (>100.4°F or 38°C)		
Conjunctivitis/eye irritation		
Dehydration		
Heat stress/heat exhaustion		
Hypothermia/cold-environment		
Oral health		
Pain: chest, angina, cardiac arrest		
Pain: muscle or joint pain		
Pain: head, ears, eyes, nose, throat		
Pain: other, not specified above		
Gastrointestinal (GI): diarrhea		
GI: nausea/vomiting		
GI: other (constipation, GERD)		
Genitourinary (GU)		
Skin (includes *ALL* skin conditions)		
Allergic reaction		
Respiratory (include *ALL* resp.)		
Influenza-like-illness (ILI)		
Neurological, new onset		
Other illness/symptoms		

	Tally (𝍸 𝍸 𝍸)	Total (#)
Behavioral/Mental Health		
Agitated/disruptive/psychotic		
Anxiety/stress/depressed mood		
Suicidal/homicidal thoughts		
Substance addiction/withdrawal		
Other mental health		
Exacerbation of Chronic Illness		
Asthma		
Obstructive pulmonary disease		
Cardiovascular (HTN, CHF, CHD)		
Chronic muscle or joint pain		
Diabetes		
Neurological (seizure, stroke, dementia)		
Previous mental health diagnosis		
Other chronic illness		
Health Care Maintenance		
Blood pressure check		
Blood sugar check		
Pregnancy/post-partum care		
Dressing change/wound care		
Immunization/vaccination		
Medical refill (please mark one tick for *each* med refill)		
Other health maintenance		

Part V. Disposition	Tally (𝍸 𝍸 𝍸)	Total (#)
Provided Red Cross care		
Referred to…		
Hospital		
Physician/dentist/clinic		
Pharmacist		
Other (e.g., DMH)		
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*

Basic Instructions

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

Procedure:

- **PART I:** Fill out the top portion of this form with disaster name, report date and timeframe (24hr period), city, state, and name of shelter.

- **PART II:**
  - Total Client-related Contacts = **mark EACH CONTACT** in the 24hr reporting period.
  - Total Number of Health-Related Client Visits = **mark EACH VISIT** in the 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**
  - 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.
  - 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.
  - 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.

- **Functional/Access 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!