



Disaster Health Services Aggregate Morbidity Report Form*

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: _____	

Part II. Number of Client-Related Interactions	
Tally ()	Total (#)
7. Total Client-related Contacts:	
7b. <u>Total of Health-related Client Visits: (fill part III)</u>	

Part III. Demographics (for Health-related Visits Only)		
	Tally ()	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 ()	Total (#)
<u>C</u> ommunication		
<u>M</u> aintenance of Health		
<u>I</u> ndependence		
<u>S</u> ervices and Support		
<u>T</u> ransportation		

Part IV. Reason for Visit: for each client visit, tick ALL reason(s) for visits.					
	Tally ()	Total (#)		Tally ()	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			Other health maintenance		
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					

Part V. Disposition		
	Tally ()	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.

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** 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!