**Aggregate Morbidity Report Form**

*Complete one form per service location per 24 hours. Submit by 4pm local time.*

Print name: __________________ Contact information: __________________

### 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

<table>
<thead>
<tr>
<th>Tally (llll llll llll)</th>
<th>Total (#)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Total Client-related Contacts (includes CMIST):</td>
<td></td>
</tr>
<tr>
<td>7b. Total of Health-related Client Visits: (fill part III)</td>
<td></td>
</tr>
</tbody>
</table>

### Part III. Demographics (for Health-related Visits Only)

<table>
<thead>
<tr>
<th>Tally (llll llll llll)</th>
<th>Total (#)</th>
</tr>
</thead>
</table>

**Gender**

- Male
- Female

**Age**

- ≤ 2
- 3 to 18
- 19 to 64
- ≥ 65

### Part IV. Reason for Visit: for each client visit, tick ALL reason(s) for visits.

<table>
<thead>
<tr>
<th>Tally (llll llll llll)</th>
<th>Total (#)</th>
</tr>
</thead>
</table>

**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

**Illness/Symptoms**

- fever (>100.4°F or 38°C)
- Conjunctivitis/eye irritation
- Dehydration
- 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

**Behavioral/Mental Health**

- Agitated/disruptive/psychotic
- Anxiety/stress/depressed mood
- Suicidal/homicidal thoughts
- Substance addiction/withdrawal
- Other mental health

**Health Care Maintenance**

- Exacerbation of Chronic Illness
- 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

<table>
<thead>
<tr>
<th>Tally (llll llll llll)</th>
<th>Total (#)</th>
</tr>
</thead>
</table>

- Provided Red Cross care
- Referred to...
  - Hospital
  - Physician/dentist/clinic
  - Pharmacist
  - Other (e.g., DMH)
- Refused Red Cross care
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!