

Virginia Department of Health Electronic Morbidity Reporting Portal

The Virginia Department of Health (VDH) Electronic Morbidity Reporting Portal (portal) provides health care professionals the ability to submit both patient-based case morbidity reports and summary influenza laboratory results as an alternative to the paper-based EPI-1 reporting mechanism. The elements included in this portal are similar to those on the paper EPI-1; however, some areas have been expanded to allow the most actionable information to be entered. In accordance with the Board of Health Regulations, this portal is the only mechanism for the reporting of Neonatal Abstinence Syndrome (NAS).

The portal supports the reporting both patient-based disease reports and result-based aggregate influenza reports, which are limited to the number and type of influenza. In both types of reports, it is necessary to enter information on the person making the report. This information is both required and important in order to allow VDH to contact someone for further information in the case of patient reports, and the regional allocation of influenza reports.

This document identifies the fields contained in the portal. On the first page of the portal, a provider selects the type of report they are making.

VDH VIRGINIA DEPARTMENT OF HEALTH

Confidential Morbidity Report

Please use the form below to submit [reportable diseases or conditions](#) to the Virginia Department of Health.

If you are reporting a rapidly reportable condition, please call your local health department directly.

Please enter as much information as is available in order to ensure that the health department is able to respond to your report effectively.

Questions on the use of this electronic form for the submission of patient information can be directed to your [local health department](#).

Page 1 of 7

Select report type

Type of morbidity report

Disease Report

Influenza (number and type only)

reset

Next Page >>

Data fields for patient-based case morbidity reports:

Patient Information

Patient Information	
First Name <small>* must provide value</small>	<input type="text"/>
Last Name <small>* must provide value</small>	<input type="text"/>
Middle Initial	<input type="text"/>
Street Address	<input type="text"/>
City	<input type="text"/>
City or County of Residence	<input type="text"/>
State	<input type="text" value="Virginia"/>
Zip Code	<input type="text"/>
Home Phone	<input type="text"/>
<small>xxx-xxx-xxxx</small>	
Work Phone	<input type="text"/>
<small>xxx-xxx-xxxx</small>	
Date of Birth	<input type="text"/> <input type="button" value="Today"/> MM-D-Y <small>(mm-dd-yyyy)</small>
Age	<input type="text"/>
<small>Enter age in whole years</small>	
Race	<input type="text"/>
Ethnicity	<input type="text"/>
Sex	<input type="text"/>
<input style="float: left; margin-right: 20px;" type="button" value=" << Previous Page "/> <input style="float: right;" type="button" value=" Next Page >> "/>	

- First Name - REQUIRED
- Last Name - REQUIRED
- Middle Initial
- Street Address
- City
- City or County of Residence
- State
- Zip Code

Home Phone
Work Phone
Date of Birth
Age
Race
Ethnicity
Sex
Pregnant

Reportable Condition

Reportable Condition
Disease or Condition <small>Must provide value</small> <input type="text"/>
Date of Onset <input type="text"/> <input type="button" value="Today"/> M-D-Y <small>(mm-dd-yyyy)</small>
Date of Diagnostic <input type="text"/> <input type="button" value="Today"/> M-D-Y <small>(mm-dd-yyyy)</small>
<input type="radio"/> Click to add another reportable condition reset
Facility / Practice Name <input type="text"/>
Physician First Name <input type="text"/>
Physician Last Name <input type="text"/>
Physician Street Address <input type="text"/>
Physician City <input type="text"/>
Physician City or County of Practice <input type="text"/>
Physician State <input type="text"/>
Physician Zip Code <input type="text"/>
Physician Phone <input type="text"/> <small>000-000-0000</small>
Is the patient deceased? <input type="text"/>
Was the patient hospitalized for this illness? <input type="text"/>
Treatment (including dates) <input type="text"/>

Disease or Condition - REQUIRED

Date of Onset

Date of Diagnosis

Facility / Practice Name

Physician First Name

Physician Last Name

Physician Street Address

Physician City

Physician City or County of Practice

Physician State

Physician Zip Code

Physician Phone

Is the patient deceased

Date of death

Was the patient hospitalized for this illness?

Hospital Name

Other Hospital Name

Date of Admission

Medical Record Number

Treatment (including dates)

If the Condition Reported is Neonatal Abstinence Syndrome (NAS)

Neonatal Abstinence Syndrome (NAS) supplemental questions.

Exposure to opioids *in-utero* can result in different outcomes for the infant. Please select the outcome for this infant.

No clinical signs of withdrawal

Mild clinical signs requiring non-pharmacologic treatment

Severe clinical signs requiring pharmacotherapy reset

Has a diagnostic test (e.g., hair, urine, meconium or umbilical cord) been ordered for this baby?

Yes

No

I don't know reset

Are any OTHER SUPPORTIVE ELEMENTS FOR DIAGNOSIS present?

Check all that apply.

Maternal history of substances known to cause NAS (e.g. an opioid)

Positive MATERNAL screening test for substances known to cause NAS

Positive NEONATAL screening test for substances known to cause NAS

No other supportive elements

What is the SOURCE OF THE SUBSTANCE CAUSING NAS, if known?

Check all that apply.

Medication-assisted treatment (e.g. methadone, buprenorphine or buprenorphine-naloxone)

Legal prescription of an opioid pain reliever (e.g. hydrocodone, oxycodone)

Legal prescription of a non-opioid (e.g. selective serotonin reuptake inhibitor)

Prescription opioid obtained WITHOUT a prescription (e.g. hydrocodone intended for someone else)

Non-opioid prescription substance obtained WITHOUT a prescription (e.g. benzodiazepine intended for someone else)

Heroin

Other non-prescription substance (e.g. illicit drugs other than heroin).

No known exposure but clinical signs consistent with NAS (select this option ONLY if you did not select any other options)

Other

<< Previous Page Next Page >>

Exposure to opioids in-utero can result in different outcomes for the infant.

Has a diagnostic test been ordered for this baby?

Are any OTHER SUPPORTIVE ELEMENTS FOR DIAGNOSIS present?

What is the SOURCE OF THE SUBSTANCE CAUSING NAS, if known?

If the Condition is Chlamydia, Gonorrhea or Syphilis

Please answer the questions on this page only for Chlamydia, Gonorrhea, or Syphilis.

Clinical manifestations
 Neurological manifestations Ocular manifestations Otic manifestations Late clinical manifestations
Syphilis only

Medication Name

Medication Dose

Medication Frequency

Medication Duration

Medication Route

Treatment Date
 M-D-Y
(mm-dd-yyyy)

Click to add another reportable condition [reset](#)

Clinical manifestations

Medication Name

Other, please specify:

Medication Dose

Other, please specify:

Medication Frequency

Other, please specify


Medication Duration

Other, please specify

Medication Route

Treatment Date

Laboratory Information and Results

Laboratory Information and Results	
Specimen Collection Date	<input type="text"/>  Today M-D-Y <small>(mm-dd-yyyy)</small>
Source of specimen	<input type="text"/>
Laboratory Test	<input type="text"/>
Test Result	<input type="text"/>
<input type="radio"/> Click to add another lab result	reset
<p style="text-align: center;"><< Previous Page Next Page >></p>	

Specimen Collection Date

Source of specimen

Other Source of Specimen

Laboratory Test

If other laboratory test, please specify

Test Result

Quantitative Test Result

Other / Reporter Information

VDH VIRGINIA DEPARTMENT OF HEALTH

Confidential Morbidity Report

Page 7 of 7

Other Information

Comments

(e.g., Immunization status, Signs/Symptoms, Exposure, etc.) [Expand](#)

Reporter First Name
* must provide value

Reporter Last Name
* must provide value

Reporter Title
* must provide value

Reporter Street Address
* must provide value

Reporter City
* must provide value

Reporter City or County

Reporter State
* must provide value

Reporter Zip Code
* must provide value

Reporter Phone
* must provide value

xxx-xxx-xxxx

[<< Previous Page](#) [Submit](#)

Comments

Reporter First Name - REQUIRED

Reporter Last Name - REQUIRED

Reporter Title - REQUIRED

Reporter Street Address - REQUIRED

Reporter City - REQUIRED

- Reporter City or County - REQUIRED
- Reporter State - REQUIRED
- Reporter Zip Code - REQUIRED
- Reporter Phone - REQUIRED

Data fields for Influenza reporting:

The screenshot shows a web form titled "Confidential Morbidity Report" from the Virginia Department of Health (VDH). The form is for "Influenza: (Report # and type only. No patient identification)". It contains four main sections: "Influenza A" with a text input field and "Number of Cases" label; "Influenza B" with a text input field and "Number of Cases" label; "Influenza - Type Unknown" with a text input field and "Number of Cases" label; and "Date for Flu Counts" with a date picker set to "Today" and "M-D-Y" format. The form also includes "Previous Page" and "Next Page" navigation buttons. The VDH logo and "Page 6 of 7" are visible at the top.

Influenza A – *Number only*

Influenza B – *Number only*

Influenza – Type Unknown – *Number only*

Date for Flu Counts – *Providers can report with a frequency that best suits their practice, every Friday for example, and in that case utilize that Friday's date.*

Other / Reporter Information for Influenza summary reports

VDH VIRGINIA
DEPARTMENT
OF HEALTH

Confidential Morbidity Report

Page 7 of 7

Other Information

Comments

(e.g., Immunization status, Signs/Symptoms, Exposure, etc.) Expand

Reporter First Name
* must provide value

Reporter Last Name
* must provide value

Reporter Title
* must provide value

Reporter Street Address
* must provide value

Reporter City
* must provide value

Reporter City or County

Reporter State
* must provide value

Reporter Zip Code
* must provide value

Reporter Phone
* must provide value

xxx-xxx-xxxx

Comments

Reporter First Name - REQUIRED

Reporter Last Name - REQUIRED

Reporter Title - REQUIRED

Reporter Street Address - REQUIRED

Reporter City - REQUIRED

Reporter City or County - REQUIRED

Reporter State - REQUIRED
Reporter Zip Code - REQUIRED
Reporter Phone – REQUIRED

In the event that a required field is not entered at the time that the reporter clicks either the Next Page or Submit button the portal will provide a pop-up notice of the missing information. Required information must be entered in order to move forward or complete submission of the report. Should the browser be closed prior to completing entry of all information, what had been entered up to that point will be saved; however, without a complete record it is possible that VDH will not be able to take action on that partial record.

The screenshot shows the 'Confidential Morbidity Report' form from the Virginia Department of Health. The form is titled 'Patient Information' and includes fields for First Name, Last Name, Middle, Street Address, City, and City or County of Residence. A pop-up message is displayed over the form, stating: 'NOTE: Some fields are required! Your data was successfully saved, but you did not provide a value for some fields that require a value. Please enter a value for the fields on this page that are listed below. Provide a value for... • First Name • Last Name'. An 'Okay' button is visible at the bottom right of the pop-up. The page number 'Page 2 of 7' is visible in the top right corner.