

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 patient-based case morbidity reports 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).

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 on the patient if necessary.

This document identifies the fields contained in the portal. The initial step is for a provider to select the disease or condition they are reporting.

The screenshot shows the 'Confidential Morbidity Report' form. At the top left is the VDH logo and 'VIRGINIA DEPARTMENT OF HEALTH'. At the top right are accessibility icons (AAA, +, -). The form title is 'Confidential Morbidity Report'. Below the title are instructions: '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.' The form is divided into sections: 'Reportable Condition' (with a dropdown menu for 'Disease or Condition' and a red asterisk indicating a required field), 'Date of Onset' (with a date input field, a 'Today' button, and 'M-D-Y' format), and 'Date of Diagnosis' (with a date input field, a 'Today' button, and 'M-D-Y' format).

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"/>
Date of Birth <input type="text"/> <input type="button" value="Today"/> M-D-Y <small>(mm-dd-yyyy)</small>	
Age <input type="text"/> <small>Enter age in whole years</small>	
Street Address	<input type="text"/>
City	<input type="text"/>
City or County of Residence <small>* must provide value</small>	<input type="text"/>
State	<input type="text" value="Virginia"/>
Zip Code	<input type="text"/>
Home Phone <small>xxx-xxx-xxxx</small>	<input type="text"/>

First Name - **REQUIRED**

Last Name - **REQUIRED**

Middle Initial

Date of Birth

Age

*If < 18 years, Parent/Proxy Name - **REQUIRED***

Street Address

City

City or County of Residence - **REQUIRED**

State

Zip Code

Home Phone

Work Phone

Race

Ethnicity

Sex

If Female, Pregnant

Is the patient deceased

If Yes, Date of Death

Was the patient hospitalized for this illness

If Yes, Hospital Name, Date of Admission, MRN

Symptoms

If Reporting Syphilis

Your are reporting a case of syphilis, please enter the following information.

Clinical manifestations

Neurological manifestations Ocular manifestations Otic manifestations Late clinical manifestations

Syphilis only

Treatment – Non-STIs

Treatment

Treatment (including dates)

Expand

Free text treatment notation.

Treatment – STIs

Treatment
Medication Name <input type="text"/>
Medication Dose <input type="text"/>
Medication Frequency <input type="text"/>
Medication Duration <input type="text"/>
Medication Route <input type="text"/>
Treatment Date <input type="text"/> <input type="button" value="Today"/> M-D-Y <small>(mm-dd-yyyy)</small>
<input type="radio"/> Click to add another medication

Medication Name

If Other, Please Specify

Medication Dose

If Other, Please Specify

Medication Frequency

If Other, Please Specify

Medication Duration

If Other, Please Specify

Medication Route

Treatment Date

Physician/Clinician Information

Physician/Clinician Information	
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" value="Virginia"/>
Physician Zip Code	<input type="text"/>
Physician Phone	<input type="text"/>

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

If the Condition Reported is Neonatal Abstinence Syndrome (NAS)

Neonatal Abstinence Syndrome (NAS) Supplemental Questions			
<p>Exposure to opioids <i>in-utero</i> can result in different outcomes for the infant. Please select the outcome for this infant.</p> <p> <input type="radio"/> No clinical signs of withdrawal <input type="radio"/> Mild clinical signs requiring non-pharmacologic treatment <input type="radio"/> Severe clinical signs requiring pharmacotherapy </p>			
<p>Has a diagnostic test (e.g., hair, urine, meconium or umbilical cord) been ordered for this baby?</p> <p> <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> I don't know </p>			
Are any OTHER SUPPORTIVE ELEMENTS FOR NAS DIAGNOSIS present?			
	Yes	No	Unknown
Maternal history of substances known to cause NAS (e.g., an opioid)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive MATERNAL screening test for substances known to cause NAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive NEONATAL screening test for substances known to cause NAS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No other supportive elements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
What is the SOURCE OF THE SUBSTANCE CAUSING NAS, if known?			
	Yes	No	Unknown
Medication-assisted treatment (e.g. methadone, buprenorphine, or buprenorphine-naloxone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal prescription of an opioid pain reliever (e.g. hydrocodone, oxycodone)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Legal prescription of a non-opioid (e.g. selective serotonin reuptake inhibitor)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Prescription opioid obtained WITHOUT a prescription (e.g. hydrocodone intended for someone else)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-opioid prescription substance obtained WITHOUT a prescription (e.g. benzodiazepine intended for someone else)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other non-prescription substance (e.g. illicit drugs other than heroin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
No know exposure but clinical signs consistent with NAS (select this option ONLY if you did not select any other options)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other (e.g. SSRIs, another "drug" used in the polysubstance instances)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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?

Laboratory Information and Results – It is possible to enter up to 5 lab results

Laboratory Information and Results	
Specimen Collection Date	<input type="text"/> <input type="button" value="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

Specimen Collection Date

Source of specimen

Other Source of Specimen

Laboratory Test

If other laboratory test, please specify

Test Result

Quantitative Test Result

Other Information

Other Information

Risk Situations

Food Handler Patient Care Child Care Outbreak Associated

Check all that apply

Comments

Expand

(e.g., Immunization status, Exposure, etc.)

Risk Situations

Comments

Reporter Information

Reporter Information	
Reporter First Name	<input type="text"/>
<small>* must provide value</small>	
Reporter Last Name	<input type="text"/>
<small>* must provide value</small>	
Reporter Title	<input type="text"/>
Reporter Facility / Practice Name	<input type="text"/>
Reporter Street Address	<input type="text"/>
<small>* must provide value</small>	
Reporter City	<input type="text"/>
<small>* must provide value</small>	
Reporter City or County	<input type="text"/>
Reporter State	<input type="text" value="Virginia"/>
<small>* must provide value</small>	
Reporter Zip Code	<input type="text"/>
<small>* must provide value</small>	
Reporter Phone	<input type="text"/>
<small>* must provide value</small>	
<small>xxx-xxx-xxxx</small>	

Reporter First Name - **REQUIRED**

Reporter Last Name - **REQUIRED**

Reporter Title

Reporter Facility / Practice Name

Reporter Street Address - **REQUIRED**

Reporter City - **REQUIRED**

Reporter City or County

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 the Submit button the portal will provide a pop-up notice of the missing information. Required information must be entered in order to 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 image shows a screenshot of the Virginia Department of Health (VDH) Confidential Morbidity Report form. The page header includes the VDH logo and the text "VIRGINIA DEPARTMENT OF HEALTH" and "Confidential Morbidity Report". A "Page 2 of 7" indicator is visible in the top right corner. The form is titled "Patient Information" and contains several input fields: "First Name", "Last Name", "Middle", "Street Address", "City", and "City or County of Residence". A red asterisk and the text "* must p" are visible next to the "First Name" and "Last Name" labels. A pop-up dialog box is overlaid on the form, containing the following text: "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.", and a list of required fields: "• First Name" and "• Last Name". An "Okay" button is located at the bottom right of the dialog box.