



Infectious Disease Report

This form expires on January 1, 2008.
Go to <http://www.dshs.state.tx.us/idcu/investigation/conditions/> or call your local or regional health department before this date to obtain the new form.

General Instructions

This form may be used to **report suspected cases and cases of notifiable conditions** in Texas, listed with their reporting timeframes on the reverse side of this form or available at www.dshs.state.tx.us/idcu/investigation/forms/101A.pdf. In addition to specified reportable conditions, **any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported by the most expeditious means available**. A health department epidemiologist may contact you to further investigate this Infectious Disease Report. Information needed to classify cases of infectious disease is outlined in the Epi Case Criteria Guide found at www.dshs.state.tx.us/idcu/investigation/forms/EpiCaseGuide.pdf.

Suspected cases and cases should be reported to your local or regional health department at the following address, phone or fax number.

Information for your local or regional health department can be found at:
<http://www.dshs.state.tx.us/regions/default.shtm>

As needed, cases may be reported to the Department of State Health Services at 1-800-252-8239, 512-458-7676, or after-hours at 512-458-7111

Disease or Condition		Date: _____ (Check type) <small>(Please fill in onset or closest known date)</small>		<input type="checkbox"/> Onset	<input type="checkbox"/> Specimen collection
				<input type="checkbox"/> Absence	<input type="checkbox"/> Office visit
Physician Name		Physician Address <input type="checkbox"/> See Facility address below		Physician Phone (____) _____ - _____ <input type="checkbox"/> See Facility phone below	
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)					
Patient Name (Last)		(First)	(MI)	Telephone (____) _____ - _____	
Address (Street)		City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
<i>Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history</i>					

Disease or Condition		Date: _____ (Check type) <small>(Please fill in onset or closest known date)</small>		<input type="checkbox"/> Onset	<input type="checkbox"/> Specimen collection
				<input type="checkbox"/> Absence	<input type="checkbox"/> Office visit
Physician Name		Physician Address <input type="checkbox"/> See Facility address below		Physician Phone (____) _____ - _____ <input type="checkbox"/> See Facility phone below	
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)					
Patient Name (Last)		(First)	(MI)	Telephone (____) _____ - _____	
Address (Street)		City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Not Hispanic	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
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<i>Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history</i>					

Name of Reporting Facility		Address			
Name of Person Reporting		Title	Phone Number (____) _____ - _____ extension _____		
Date of Report (mm/dd/yyyy)		E-mail			

Above Information is CONFIDENTIAL. Please notify sender if received in error, and return or destroy.