TEXAS Department of State Health Services

Infectious Disease Report

Form is published at
http://www.dshs.state.tx.us/idcu/investigation/conditions/

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*) *(Please fill in onset or closest known date)*	☐ Onset ☐ Absence	☐ Specimen collection ☐ Office visit
Physician Name	Physician Address ☐ See Facility address below		Physician Phone ☐ 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 ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history				

Disease or Condition		Date: _____ (*Check type*) *(Please fill in onset or closest known date)*	☐ Onset ☐ Absence	☐ Specimen collection ☐ Office visit
Physician Name	Physician Address ☐ See Facility address below		Physician Phone ☐ 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 ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history				

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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 ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history				

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. **EEPI-1(Rev. 2/09)**