

Infectious Disease Report

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 current **Texas Notifiable Conditions List** available at <http://www.dshs.state.tx.us/idcu/investigation/conditions/>. 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.



Suspected cases and cases should be reported to your local or regional health department.

Contact information for your local or regional health department can be found at:

<http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/>

As needed, cases may be reported to the Department of State Health Services by calling 1-800-252-8239.

Disease or Condition		Date: _____ (Check type) (Please fill in onset or closest known date)		<input type="checkbox"/> Onset	<input type="checkbox"/> Specimen collection
				<input type="checkbox"/> Absence	<input type="checkbox"/> Office visit
Practitioner Name		Practitioner Address/ <input type="checkbox"/> See Facility address below		Practitioner Phone/ <input type="checkbox"/> See Facility phone below (____) _____ - _____	
Diagnostic Criteria (Diagnostic Lab Test Type, Result, and Specimen Source if applicable and/or Clinical Indicators)					
Patient: Name (Last)		(First)	(MI)	Phone Number: (____) _____ - _____	
Address (Street)		City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	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	
Notes, comments, additional information such as other lab tests/results, clinical info, pregnancy status, occupation (food handler), school name/grade, travel history					

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Practitioner Name		Practitioner Address/ <input type="checkbox"/> See Facility address below		Practitioner Phone/ <input type="checkbox"/> See Facility phone below (____) _____ - _____	
Diagnostic Criteria (Diagnostic Lab Test Type, Result, and Specimen Source if applicable and/or Clinical Indicators)					
Patient: Name (Last)		(First)	(MI)	Phone Number: (____) _____ - _____	
Address (Street)		City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	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	
Notes, comments, additional information such as other lab tests/results, clinical info, pregnancy status, occupation (food handler), school name/grade, travel history					

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Patient: Name (Last)		(First)	(MI)	Phone Number: (____) _____ - _____	
Address (Street)		City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____	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	
Notes, comments, additional information such as other lab tests/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: (____) _____ - _____	
Date of Report (mm/dd/yyyy)	E-mail		