

County of Residence _____ Serial # _____ Date of Report ____/____/____

Patient Information

Patient's Name _____
Last First MI Maiden

Patient's Alias _____
Last First MI

Guardian's Name _____
Last First MI

Patient's Date of Birth ____/____/____ Patient's Age _____ Patient's Country of Birth _____

Patient's Primary Phone No. (____) _____ - _____ Patient's Secondary Phone No. (____) _____ - _____

Patient's Physical Address _____
Number & Street City Zip Code

Patient's Mailing Address (if different) _____
City Zip Code

Occupation (works at) <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Student/School <input type="checkbox"/> Inmate <input type="checkbox"/> Correction Worker <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Setting (resides/attends) <input type="checkbox"/> Day Care Facility <input type="checkbox"/> Health Care Facility <input type="checkbox"/> School <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Camp <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Race (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian /Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
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Is Patient Alive? Yes No Unknown If No, Date of Death ____/____/____

Disease _____ Site of Infection _____

Date of First Symptom: ____/____/____ Date of Diagnosis ____/____/____

Hospitalized? Yes No Unknown

Name of Hospital _____ Medical Record No. _____

Admission Date ____/____/____ Discharge Date ____/____/____

Reporter Information

Reporting Individual _____ Telephone (____) _____ - _____

Address _____

Reporting Source MD Lab Hospital ICN School Nurse Public Health Nurse Other Local Health Department
 Other State Health Dept Other _____ Unknown

Provider Name _____ Provider Telephone (____) _____ - _____

Testing Laboratory _____ Laboratory Telephone (____) _____ - _____

Comments

Include applicable laboratory data, treatment, recent travel, etc. _____

For Local Health Department Use

Outbreak Related <input type="checkbox"/> Sporadic <input type="checkbox"/> Cluster <input type="checkbox"/> Outbreak <input type="checkbox"/> Unknown	Case Status <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Unknown	Local Health Department Signature _____ Date Form Received ____/____/____ Investigation Start Date ____/____/____	Was Patient Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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