

# 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	
<i>Notes, comments, additional information such as other lab tests/results, clinical info, pregnancy status, occupation (food handler), school name/grade, travel history</i>					

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				<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	
<i>Notes, comments, additional information such as other lab tests/results, clinical info, pregnancy status, occupation (food handler), school name/grade, travel history</i>					

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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	
<i>Notes, comments, additional information such as other lab tests/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: (____) ____ - ____		
Date of Report (mm/dd/yyyy)		E-mail			