



**DEPARTMENT OF PUBLIC HEALTH
CONFIDENTIAL DISEASE/CONDITION REPORT**



Public Health
Prevent. Promote. Protect.

DATE: _____

DISEASE OR CONDITION: _____

CASE STATUS: Confirmed Suspected Clinical Diagnosis

Reporting Agency: _____

Submitted by: _____ Phone Number: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Sex: Male Female Pregnant: Yes No Unk Death: Yes No Death Date: _____

Ethnic origin: Hispanic Non-Hispanic Race: White Black Asian Other _____

Patient's Address: _____ City / Zip Code: _____

Patient's Telephone (Home): _____ (Work): _____

Patient's Occupation: _____

School Name: _____ Grade: _____

Address: _____ Phone Number: _____

Date of Onset: _____ Date of Diagnosis: _____

Vaccine Date: _____ Provider: _____ Hx of Disease

Rash: Mild Moderate Severe Hospital Admission: Yes No Hospital Name: _____

Date of Admission: _____ Date of Discharge: _____

Attending Physician: _____ Phone Number: _____

Specimen Source: _____ Date Collected: _____

Laboratory Test: _____ Results: _____

COMMENTS: _____

<p>REPORT TO: Department of Public Health Epidemiology Program PHONE: (915) 771-5810 FAX (915) 771-5801</p>

Report taken by: _____ Date entered to NBS: _____ Date entered to Epi DB: _____

The HIPAA Privacy Rule [45 C.F.R. Section 164.512(b)] specifically allows public health disclosures for public health activities to protect the public safety and well being of our communities and residents.