Please do NOT email the Case Report Card

Reportable Diseases and Conditions

Disease or Condition: ____________________ Date of Onset: __________

Method of Diagnosis: Clinical ❑ and/or Laboratory ❑ Specific Name of Test: _____________________

Specimen (Blood, CSF, sputum, stool, etc.): _________________________

If hospitalized, chart number: _____________ Date Laboratory Specimen Obtained: __________

Name of Patient: ________________________ Occupation: _______________________

Address: ________________________________ Phone (Home): ______________ Phone (Work): ________________

City: ______________________ Zip: _______________ County: ___________________

Date of Birth: __________ Current Age: ____ Sex: _______ Race: ____________ Hispanic Origin: Yes ❑ No ❑

Is patient a food handler? Yes ❑ No ❑ Child/worker in daycare? Yes ❑ No ❑

Person Reporting: ____________________________ Attending Physician: _______________________

Name of Hospital, Clinic/Etc.: ______________________________ Phone: ( ) _______________

Phone: ( ) ____________________ Date of Report: __________

Disease or Condition Specific Information ***(Complete if Appropriate)***

If Hepatitis:

Hepatitis A IgM antibody: Positive ❑ Negative ❑ Not Done ❑

Hepatitis B IgM antibody: Positive ❑ Negative ❑ Not Done ❑

Hepatitis C antibody: Positive ❑ Negative ❑ Not Done ❑

Was patient jaundiced? Yes ❑ No ❑

Is patient pregnant? Yes ❑ No ❑

If yes: EDC __________ or Delivery Date __________

Chemistry Results (Normal Range for Test)
Total Bilirubin: _______ ______________________
SGOT (AST): _________ ______________________
SGPT (ALT): _________ ______________________
Date of Chemistry Test: __________

If Mycobacterial Disease:

SSN: _________________________

PPD Mantoux Date: __________ _____mm

IGRA Date: __________ Positive ❑ Negative ❑ Indeterminate ❑

Sputum Date: __________ Smear ____ Culture ____
Tissue Date: __________ Smear ____ Culture ____
Body Fluid Date: __________ Smear ____ Culture ____

Chest X-Ray Date: __________
Normal ____
Abnormal ____
Cavitary ____
Non-cavitary ____

CT Date: __________
Normal ____
Abnormal ____
Cavitary ____
Non-cavitary ____

If gonorrhea, chlamydia, or syphilis (including congenital), provide the following treatment information:

Date treated: __________

Medication: _________________________________ Dosage: ____________________ Route: PO ❑ IM ❑ IV ❑

Frequency: __________________________________ Duration: ___________________

Individual case reports of influenza-like illnesses are not required.