

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.

*City of Amarillo Department of Public Health
(p) 806-378-6321 (f) 806-378-6306*

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>					
Name of Reporting Facility			Address		
Name of Person Reporting		Title	Phone Number (____) _____ - _____ extension _____		
Date of Report (mm/dd/yyyy)		E-mail			
<i>Health Department (local, regional, or state) use only</i>					
<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspected <input type="checkbox"/> Dropped <input type="checkbox"/> Duplicate, with new information					