

# Initial Provider 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
Physician Name		Physician Address <input type="checkbox"/> See Facility address below		<input type="checkbox"/> Absence	<input type="checkbox"/> Office visit
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)		Physician Phone (____) _____ - _____		<input type="checkbox"/> See Facility phone below	
Patient Name (Last)		(First)	(MI)	Telephone (____) _____ - _____	
Address (Street)		City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	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, or additional information such as other lab 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					