TEXAS Department of State Health Services

Infectious Disease Report

Form is published at
http://www.dshs.state.tx.us/idcu/investigation/conditions/

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)*		☐ Onset ☐ Absence	☐ Specimen collection ☐ Office visit
Physician Name	Physician Address ☐ See Facility address below		Physician Phone ☐ See Facility phone below (_____) _____ - _____		
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)					
Patient Name (Last)	(First)	(MI)	Telephone (_____) _____ - _____		
Address (Street)	City	State	Zip Code	County	
Date of Birth (mm/dd/yyyy)	Age	Sex ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown	
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history					

Disease or Condition		Date: _____ (*Check type*) *(Please fill in onset or closest known date)*		☐ Onset ☐ Absence	☐ Specimen collection ☐ Office visit
Physician Name	Physician Address ☐ See Facility address below		Physician Phone ☐ See Facility phone below (_____) _____ - _____		
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)					
Patient Name (Last)	(First)	(MI)	Telephone (_____) _____ - _____		
Address (Street)	City	State	Zip Code	County	
Date of Birth (mm/dd/yyyy)	Age	Sex ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown	
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history					

Disease or Condition		Date: _____ (Check type) *((Please fill in onset or closest known date)*		☐ Onset ☐ Absence	☐ Specimen collection ☐ Office visit
Physician Name	Physician Address ☐ See Facility address below		Physician Phone ☐ See Facility phone below (_____) _____ - _____		
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)					
Patient Name (Last)	(First)	(MI)	Telephone (_____) _____ - _____		
Address (Street)	City	State	Zip Code	County	
Date of Birth (mm/dd/yyyy)	Age	Sex ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown	
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history					

Name of Reporting Facility	Address	
Name of Person Reporting	Title	Phone Number (_____) _____ - _____ extension _____
Date of Report (mm/dd/yyyy)	E-mail	

Above Information is CONFIDENTIAL. Please notify sender if received in error, and return or destroy. **EEPI-1(Rev. 10/12)**