

Notifiable Condition Report Form

Date of report: / /	Reporting Facility:
Person preparing report:	Phone:

Patient Information

Patient Name (last, first):		DOB: / /	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Is patient deceased? <input type="checkbox"/> Yes <input type="checkbox"/> No	Date of Death: / /	Died from this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No
Address (street):		City:	State: ZIP:
Phone # (Home):		Phone # (Work):	Phone # (Cell):
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown			
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian / Alaskan Native <input type="checkbox"/> Black / African American <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown			
Occupation:		If minor, parent or guardian name:	
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Associated with a nursing home? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Food handler? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Associated with a health care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Associated with a day care facility? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Suspected foodborne or waterborne illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		

Condition

EMERGENCY Reporting (IMMEDIATE reporting required, call ID EPI at 505-827-0006)	ROUTINE Reporting (Report within 24 hours, fax report to ID EPI at 505-827-0013)	
<input type="checkbox"/> Anthrax <input type="checkbox"/> Avian or novel influenza <input type="checkbox"/> Botulism (<input type="checkbox"/> infant, <input type="checkbox"/> foodborne, <input type="checkbox"/> wound) <input type="checkbox"/> Cholera <input type="checkbox"/> Diphtheria <input type="checkbox"/> <i>Haemophilus influenzae</i> , invasive <input type="checkbox"/> Measles <input type="checkbox"/> Meningococcal infection, invasive <input type="checkbox"/> Pertussis <input type="checkbox"/> Plague <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Rabies <input type="checkbox"/> Rubella, including congenital <input type="checkbox"/> SARS <input type="checkbox"/> Smallpox <input type="checkbox"/> Tularemia <input type="checkbox"/> Typhoid fever (<i>Salmonella</i> Typhi infection) <input type="checkbox"/> Yellow fever <input type="checkbox"/> Suspected outbreak (specify):	<input type="checkbox"/> Brucellosis <input type="checkbox"/> Campylobacteriosis <input type="checkbox"/> Coccidioidomycosis <input type="checkbox"/> Colorado tick fever <input type="checkbox"/> Cryptosporidiosis <input type="checkbox"/> Cysticercosis <input type="checkbox"/> Cyclosporiasis <input type="checkbox"/> <i>E. coli</i> , Shiga toxin-producing (including <i>E. coli</i> O157:H7) <input type="checkbox"/> Encephalitis <input type="checkbox"/> Giardiasis <input type="checkbox"/> Group A Streptococcus, invasive <input type="checkbox"/> Group B Streptococcus, invasive <input type="checkbox"/> Hantavirus pulmonary syndrome <input type="checkbox"/> Hemolytic uremic syndrome <input type="checkbox"/> Hepatitis A, acute <input type="checkbox"/> Hepatitis B (<input type="checkbox"/> acute, <input type="checkbox"/> chronic) <input type="checkbox"/> Hepatitis C (<input type="checkbox"/> acute, <input type="checkbox"/> chronic) <input type="checkbox"/> Hepatitis E, acute <input type="checkbox"/> Legionnaires' disease <input type="checkbox"/> Leptospirosis <input type="checkbox"/> Listeriosis	<input type="checkbox"/> Lyme disease <input type="checkbox"/> Malaria <input type="checkbox"/> Mumps <input type="checkbox"/> Psittacosis <input type="checkbox"/> Q fever <input type="checkbox"/> Relapsing fever (tick-borne) <input type="checkbox"/> Rocky Mountain spotted fever <input type="checkbox"/> Salmonellosis <input type="checkbox"/> Shigellosis <input type="checkbox"/> St. Louis encephalitis <input type="checkbox"/> <i>Streptococcus pneumoniae</i> , invasive <input type="checkbox"/> Tetanus <input type="checkbox"/> Trichinosis (Trichinellosis) <input type="checkbox"/> Toxic shock syndrome <input type="checkbox"/> Varicella (chickenpox) <input type="checkbox"/> <i>Vibrio</i> infections <input type="checkbox"/> West Nile virus infections <input type="checkbox"/> Western equine encephalitis <input type="checkbox"/> <i>Yersinia</i> infections <input type="checkbox"/> Other (specify):

Clinical Information

Physician name:	Illness Onset Date: / /	Diagnosis Date: / /
Was the patient hospitalized for this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hospital Name:	

Lab Information – Please fax copies of labs with this form

Treatment Information

Collection Date	Test and Result	Treatment Date	Drug and Dosage
/ /		/ /	
/ /		/ /	
/ /		/ /	

Comments