

Notifiable Disease/Condition Report

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Instructions:

This form is to be used to report any disease or condition as required by the state of Texas. A full list of these conditions can be found at <http://www.dshs.state.tx.us/idcu/investigation/conditions/default.asp> The form should be printed, completed legibly, and faxed to the above fax number. E-mailed reports are not acceptable. Be sure to fill out the **required fields**, which include the **disease or condition, city, name of the reporting facility, the name of the person reporting, and their phone number**. The individual reporting will be contacted by epidemiology staff to verify this information. Also, this form may be accompanied by any laboratory forms that are related to the case, which also should be faxed to the above number.

Disease or condition*				Date: (check type) <input type="checkbox"/> Onset <input type="checkbox"/> Specimen Collection			
Test & Results							
Patient Name (Last)			(First)		(MI)	Telephone:	
Address (Street)			City*		State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		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	
Physician Name		Physician Address				Physician Telephone	
Name of Reporting Facility*				Address			
Name of Person Reporting*			Phone Number*			Date of Report (mm/dd/yyyy)	
Notes							

Disease or condition*				Date: (check type) <input type="checkbox"/> Onset <input type="checkbox"/> Specimen Collection			
Test & Results							
Patient Name (Last)			(First)		(MI)	Telephone:	
Address (Street)			City*		State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Female <input type="checkbox"/> Male		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	
Physician Name		Physician Address				Physician Telephone	
Name of Reporting Facility*				Address			
Name of Person Reporting*			Phone Number*			Date of Report (mm/dd/yyyy)	
Notes							

*Required Fields