



Galveston County Health District Epidemiology Services

Send completed forms to:
GCHD Epidemiology Services
P.O. Box 939 La Marque, TX 77568
Phone: 409.938.2208 or 409.938.2215
Fax: 409.938.2399

Infectious Disease Report

This form may be used to report suspected cases and cases of notifiable conditions in Texas, listed with their reporting timeframes on the reverse side of this form or available at <http://www.gchd.org/notify>

Patient	Name (last, first): _____ Address: _____ <input type="checkbox"/> Homeless City/County/Zip: _____ Phone(s): _____ Occupation: _____ <input type="checkbox"/> Daycare <input type="checkbox"/> Food Handler Employer: _____ School/daycare name: _____ Alt. Contact: <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Spouse <input type="checkbox"/> Other _____ Name: _____ Daytime Phone: _____	Birth date: ___/___/___ Age: ___ Gender: <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> Other <input type="checkbox"/> Unkn Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non Hispanic or Latino Race (check all that apply): <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____
	Diagnosis: _____ <input type="checkbox"/> Confirmed <input type="checkbox"/> Suspect Diagnosis Method: <input type="checkbox"/> Clinical <input type="checkbox"/> Serology <input type="checkbox"/> Culture <input type="checkbox"/> biopsy/smear Onset Date: ___/___/___ Illness duration: _____ days Symptoms: _____ Therapy: _____ Prognosis: _____ <input type="checkbox"/> Pregnant Due Date: _____	Physician: _____ Phone: _____ Hospital: _____ Admitted: _____ Discharged: _____ MRN: _____
Lab Data	Pathogen: _____ Specimen Type: _____ Date Collected: ___/___/___ Other lab results: _____	
Other Info	Please provide additional relevant information below such as case contacts with same disease/symptoms or needing prophylaxis, possible sources of illness, dates, and places of exposure, schools/child care facilities attended, etc. _____ _____ _____	
Report Source	Initial Report Date: ___/___/___ Reporter: <input type="checkbox"/> Lab <input type="checkbox"/> Hospital <input type="checkbox"/> Other _____ Reporter Name: _____ Reporter Phone: _____	GCHD Use Only: Date Received: ___/___/___ Investigation start date: ___/___/___ Entered into registry? <input type="checkbox"/> Y <input type="checkbox"/> N Entered into NBS? <input type="checkbox"/> Y <input type="checkbox"/> N

***Report AIDS, chancroid, *Chlamydia trachomatis* infection, gonorrhea, HIV infection, and syphilis to:
Galveston County Health District – STI Control Services – P.O.Box 939 – La Marque, TX 77568
Forms for these reports are available at this address or telephone (409) 765-2530.**