

Notifiable Condition Report Form

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

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"/> Bordetella species (including pertussis)* <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"/> Middle East Respiratory Syndrome <input type="checkbox"/> Plague* <input type="checkbox"/> Poliomyelitis (<input type="checkbox"/> Paralytic <input type="checkbox"/> Non-paralytic) <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"/> Viral Hemorrhagic fever <input type="checkbox"/> Yellow fever <input type="checkbox"/> Suspected outbreak (specify): _____ _____ _____	<input type="checkbox"/> Arboviral (other): _____ <input type="checkbox"/> Brucellosis <input type="checkbox"/> Campylobacteriosis* <input type="checkbox"/> Carbapenem-resistant Enterobacteriaceae (CRE or CP-CRE)* <input type="checkbox"/> Carbapenem-resistant pseudomonas aeruginosa* <input type="checkbox"/> Chikungunya virus disease <input type="checkbox"/> Clostridium difficile <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"/> Dengue <input type="checkbox"/> <i>E. coli</i> , Shiga toxin-producing (including <i>E. coli</i> O157:H7)* <input type="checkbox"/> Encephalitis (other): _____ <input type="checkbox"/> Giardiasis <input type="checkbox"/> Group A Streptococcus, invasive* <input type="checkbox"/> Group B Streptococcus, invasive* <input type="checkbox"/> Hansen's Disease/Leprosy <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"/> Influenza-associated pediatric death	<input type="checkbox"/> Influenza, laboratory confirmed hospitalization <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"/> Necrotizing fasciitis* <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

Provider 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

Collection Date	Test and Result

Please fax this form with a copy of relevant lab reports to 505-827-0013

Laboratory or clinical samples for conditions marked with [] are required to be sent to the Scientific Laboratory Division.

Comments