

Notifiable Disease Case Report (Confidential)

Philadelphia Department of Public Health
Division of Disease Control
 Acute Communicable Disease Program
 1101 Market St, 12th Floor, Philadelphia, PA 19107



Patient Information

Report Date (Mo., Day, Yr.) ____/____/____		Name (Last, First, M.I.)		Parent or caretaker (if applicable)	
DOB (Mo., Day, Yr.) ____/____/____		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Occupation	
Name of Employer or School				Employer/School Address (Number, Street, City, Zip Code)	
Telephone (Home) _____ (Cell) _____ (Work) _____					

Medical Information

Disease or Condition		Date of Onset (Mo., Day, Yr.) ____/____/____	Diagnosis <input type="checkbox"/> Clinical <input type="checkbox"/> Lab confirmed	Fatal (check one) <input type="checkbox"/> No <input type="checkbox"/> Yes
Chief Symptoms / Complaints <input type="checkbox"/> cough <input type="checkbox"/> nausea <input type="checkbox"/> diarrhea <input type="checkbox"/> headache <input type="checkbox"/> joint pain <input type="checkbox"/> coryza <input type="checkbox"/> vomiting <input type="checkbox"/> fever <input type="checkbox"/> body aches <input type="checkbox"/> rash		Suspected source(s) of Infection (if known) <input type="checkbox"/> school/daycare <input type="checkbox"/> home/relative <input type="checkbox"/> park/outdoors <input type="checkbox"/> work <input type="checkbox"/> restaurant <input type="checkbox"/> recreational water <input type="checkbox"/> travel (where/dts: _____) <input type="checkbox"/> other _____		
If Case Hospitalized (Name of Hospital/Medical Provider)			Admission Date ____/____/____	Discharge Date ____/____/____

Laboratory Information If Pertinent (attach copies if applicable)

Name of Lab	Name of Test	Site Source	Result	Collection Date	Result Date
		<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Other _____			

Antibiotic Sensitivities (if applicable)

Antibiotic	Resistant	Intermediate	Susceptible
Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftriaxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trimethoprim/ Sulfamethoxazole (Bactrim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes

Reporter Information

Facility Name	Reporter Name	Reporter Phone #	Reporter <input type="checkbox"/> ICP <input type="checkbox"/> ED <input type="checkbox"/> School Nurse <input type="checkbox"/> Lab <input type="checkbox"/> Other _____
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DO NOT WRITE IN AREA BELOW - FOR DEPARTMENT USE

Name (Person Receiving Report)	Method of reporting <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other _____
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Any unusual illness, disease clusters or possible outbreaks should be reported *immediately* by telephone. Please fax all completed reports to 215-238-6947 or call 215-685-6748 to report by phone.

If reporting influenza, animal exposure, TB, please use specific form.