TEXAS Department of State Health Services

Initial Provider Infectious Disease Report

Form is published at http://www.dshs.state.tx.us/idcu/investigation/conditions/

General Instructions

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 www.dshs.state.tx.us/idcu/investigation/forms/101A.pdf. In addition to specified reportable conditions, ***any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported*** *by the most expeditious means available*. A health department epidemiologist may contact you to further investigate this Infectious Disease Report. Information needed to classify cases of infectious disease is outlined in the Epi Case Criteria Guide found at www.dshs.state.tx.us/idcu/investigation/forms/EpiCaseGuide.pdf.

Suspected cases and cases should be reported to your local or regional health department at the following address, phone or fax number.

In Region 8, Report to DSHS Region 8 Office 24-Hour Phone 210-949-2121 or by Fax 210-692-1457

As needed, cases may be reported to the Department of State Health Services at 1-800-252-8239, 512-458-7676, or after-hours at 512-458-7111

Disease or Condition	Date: _____ (*Check type*) *(Please fill in onset or closest known date)*		☐ Onset ☐ Specimen collection ☐ Absence ☐ Office visit		
Physician Name	Physician Address ☐ See Facility address below		Physician Phone ☐ See Facility phone below (_____) _____ - _____		
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)					
Patient Name (Last)	(First)		(MI)	Telephone (_____) _____ - _____	
Address (Street)	City		State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex ☐ Male ☐ Female	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown	
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history					
Name of Reporting Facility	Address				
Name of Person Reporting	Title	Phone Number (_____) _____ - _____ extension _____			
Date of Report (mm/dd/yyyy)	E-mail				

Health Department (local, regional, or state) use only

☐ Confirmed ☐ Probable ☐ Suspected ☐ Dropped ☐ Duplicate, with new information

Above Information is CONFIDENTIAL. Please notify sender if received in error and return or destroy. **EEPI-2 (Rev. 2/09)**