Notifiable Disease Report Form

Texas Department of State Health Services Region 2/3
Arlington, Texas
Tel (817) 264 – 4541
Fax (817) 264 – 4557
After Hours (817) 822 – 6786

PATIENT INFORMATION

Name: _____
(Last) (First) (MI)

DOB: ____/____/_____ Age: _____ Sex: ☐ Male ☐ Female Race: ☐ White ☐ Black ☐ Asian ☐American Indian ☐ Other

Ethnicity: ☐ Hispanic ☐ Non- Hispanic ☐ Unknown

Address: _____
(Street) (City) (County) (Zip)

Home Phone: ( ) _____ Work Phone: ( ) _____ Occupation: _____

If patient was a child:
Mother's Name: _____ Maternal Occupation: _____ Phone: _____

Father's Name: _____ Paternal Occupation: _____ Phone: _____

MEDICAL INFORMATION

Disease Diagnosis (Genus, Species, Serotype): _____

For vaccine preventable disease, has patient received vaccinations? ☐ Yes Date: _____/ _____/ _____ ☐ No ☐ Unknown

Type of Diagnosis: ☐ Clinical ☐ Serology ☐ Culture ☐ Biopsy/Smear ☐ Other: _____

Symptom Onset Date: ____/ ____/ _____ Duration of Symptoms: _____

Was patient ill enough to require a doctor's visit? ☐ Yes ☐ No If yes, Name of Physician: _____

Date Seen: ____/ ____/ _____ City: _____ County: _____ Phone: _____

Was patient hospitalized? ☐ Yes ☐ No If yes, Name of Hospital: _____

Admission Date: ____/ ____/ _____ Discharge Date: ____/ ____/ _____ City: _____ Phone: _____

LAB INFORMATION

Please Attach Lab Report If Available

(If not available, please provide the following.)

Date of Test: ____/ ____/ _____ Name of Lab: _____

City: _____ County: _____ Phone: ( ) _____ Results: _____

FOR HEPATITIS REPORTING: Liver Function Test: Date of Test: ALT: AST: Total Bilirubin:

REPORTING INFORMATION

Reporting Person: _____
Name of Person Title

Reporting Facility: _____

Phone number: ( ) _____ Date of Report: _____/ _____/ _____