TEXAS Department of State Health Services

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 current *Texas Notifiable Conditions List* available at http://www.dshs.state.tx.us/idcu/investigation/conditions/. 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.

Suspected cases and cases should be reported to your local or regional health department.
Collin County Health Care Services 972-548-4707 After Hours 972-547-5350 Fax 972-548-4436

Contact information for your local or regional health department can be found at:
http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

As needed, cases may be reported to the Department of State Health Services by calling 1-800-252-8239.

Disease or Condition	Date: _____ (*Check type*) *(Please fill in onset or closest known date)*	☐ Onset ☐ Absence	☐ Specimen collection ☐ Office visit	
Practitioner Name	Practitioner Address/☐ See Facility address below	Practitioner Phone/☐ See Facility phone below (_____) _____ - _____		
Diagnostic Criteria (Diagnostic Lab Test Type, Result, and Specimen Source if applicable and/or Clinical Indicators)				
Patient: Name (Last)	(First)	(MI)	Phone Number: (_____) _____ - _____	
Address (Street)	City	State	Zip Code	County
Date of Birth (mm/dd/yyyy)	Age	Sex ☐ Male ☐ Female ☐ Other _____	Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, additional information such as other lab tests/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. 1/17)**