



# MORBIDITY REPORT FORM

225 W. Waco Drive, Waco TX 76707  
wacomclennanphd.org

254-750-5450 Phone  
254-750-5411 24/7 Reporting  
254-750-5405 Fax  
WacoEpi@wacotx.gov

Reported By \_\_\_\_\_ Date \_\_\_\_\_ Email \_\_\_\_\_  
Agency \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

## PATIENT DEMOGRAPHIC DATA

Last Name \_\_\_\_\_ First Name & MI \_\_\_\_\_  
Address \_\_\_\_\_ City, Zip code \_\_\_\_\_  
Phone # \_\_\_\_\_ Primary Language \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_  
Race/Ethnicity \_\_\_\_\_ Sex M F  
Occupation/Workplace \_\_\_\_\_ Phone # \_\_\_\_\_  
School/Day Care Center \_\_\_\_\_ Phone # \_\_\_\_\_  
Parent/Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

## DISEASE DATA

Date of Onset \_\_\_\_\_ **REPORTABLE DISEASE/ORGANISM** \_\_\_\_\_  
Species/serotype \_\_\_\_\_

Specimen Type	Collection Date	Test Type and Result	Specimen Type	Collection Date	Test Type and Result

Symptoms \_\_\_\_\_  
Admission Diagnosis \_\_\_\_\_  
Discharge Diagnosis \_\_\_\_\_

## HOSPITAL OR CLINIC DATA

Hospital \_\_\_\_\_ Check all that apply/Date  
Medical Rec Number \_\_\_\_\_  Office/Clinic visit \_\_\_\_\_  
Physician/Clinic \_\_\_\_\_  ER/Outpatient \_\_\_\_\_  
Phone \_\_\_\_\_  Admission \_\_\_\_\_  
Hospital Transferred To/From \_\_\_\_\_  Discharge \_\_\_\_\_  
Transfer Date \_\_\_\_\_  Expired \_\_\_\_\_  
Nursing Home \_\_\_\_\_

## Comments/Patient History/Risk Factors

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Do NOT fax HIV/AIDS related patient information]

Include a positive lab report/results and H&P/clinic visit notes with the submission of this form. Please email report to: WacoEpi@wacotx.gov by secure or encrypted email. The report may also be faxed to 254-750-5405 (a cover sheet is needed). You may call 254-750-5411 with questions, comments, or concerns. Thank you!