PROMOTE • PREVENT • PROTECT

WACO-MCLENNAN COUNTY
Public Health District

Initial Provider
Infectious Disease Report

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.

Confirmed and suspected cases **should be reported to your local or regional health department at the following address, phone or fax number:**

Waco-McLennan County Public Health District
225 West Waco Drive, Waco, TX 76707

Phone: (254)750-5411 *(24/7 reporting)*
Fax: (254) 750-5405

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	
Occupation (if student also include school name and grade)					
(if under 18) Guardian's Name	Occupation			Telephone (_____) _____ - _____	

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

Admission Date: ____/_____/_____ Discharge Date: _____/_____/_____ Discharge status: ☐ Recovering/Recovered ☐ Deceased ☐ Unknown

FOR HEPATITIS REPORTING: Liver Function Test Date: ALT: AST:

Name of Reporting Facility	Address	
Name of Person Reporting	Title	Phone Number (_____) _____ - _____ extension _____
Date of Report (mm/dd/yyyy)	E-mail	

Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, travel history, etc. PLEASE ATTACH LAB REPORT IF AVAILABLE.

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

☐ Entered into Epi Tracker ☐ Entered into NEDSS (date): _____ Case ID# _____

Above Information is CONFIDENTIAL. Please notify sender if received in error and return or destroy. **EEPI-2 (HSR7 Rev. 8/08)**