# Brazoria County Health Department
# Infectious Disease Report

Form is published at https://brazoriacountytx.gov/departments/health-department/public-health-emergency-preparedness/reportable-notifiable-conditions.

*Suspected cases and cases should be reported to Brazoria County Health Department via fax to **(979) 864-3694** or by phone to **(979) 864-1166** during normal business hours and to **(979) 583-1979** after hours.*

## 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. Reports are confidential and are handled in accordance with HIPPA regulations. Please complete as much as applicable/possible.

| | | | | | |
|---|---|---|---|---|---|
| Disease or Condition | Date: _____ (*Check type*) *(Please fill in onset or closest known date)* ☐ Onset ☐ Specimen collection ☐ Absence ☐ Office visit | | | | |
| Practitioner/Clinic Name | Clinic Address/☐ See Facility address below | Practitioner Phone/☐ See Facility phone below ( _____ ) _____ - _____ | | | |
| Patient Name (Last) | (First) | (MI) | Phone Number: | | |
| Address (Street) | City | State | Zip Code | | |
| Date of Birth (mm/dd/yyyy) | Age | Sex ☐ Male ☐ Female ☐ Other _____ | Ethnicity ☐ Hispanic ☐ Not Hispanic | Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown | |
| Occupation | Employer or School Name | ☐ **Daycare** ☐ **Food Handler** | | | |
| Alternate Contact ☐Parent/Guardian ☐Spouse ☐Other _____ | Name | Phone Number: | | | |

**CLINICAL & LABORATORY INFORMATION**

| | | | | | |
|---|---|---|---|---|---|
| Date of Onset | Diagnosis | ☐ **Confirmed** ☐ **Suspect** | | | |
| Symptoms | Illness Duration (days) | ☐ Pregnant Due date: | | | |
| Diagnosis Method ☐Clinical ☐Culture ☐Serology ☐PCR ☐Other: _____ | Date of Collection | Specimen Type | | | |
| Pathogen | Other Results | | | | |

**HOSPITAL INFORMATION**

| | | | |
|---|---|---|---|
| MRN | Date of Admission | Date of Discharge | ☐ Expired |

**ADDITIONAL RELEVANT INFORMATION**

***Notes, comments, additional information such as other lab tests/results, clinical info, name of daycare, sick contacts, contacts needing prophylaxis, travel history, any possible sources of exposure or potential disease spread***

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

***BCHD 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.* **(Rev. 08/22)**