NEW YORK STATE DEPARTMENT OF HEALTH
Division of Epidemiology

Confidential Case Report

County of Residence _____ Serial # _____ Date of Report ____/____/____

Patient Information

Patient's Name _____
Last First MI Maiden

Patient's Alias _____
Last First MI

Guardian's Name _____
Last First MI

Patient's Date of Birth ____/____/____ Patient's Age _____ Patient's Country of Birth _____

Patient's Primary Phone No. (____) _____ - _____ Patient's Secondary Phone No. (____) _____ - _____

Patient's Physical Address _____
Number & Street City Zip Code

Patient's Mailing Address (if different) _____
City Zip Code

Occupation (works at)
- ☐ Food Service
- ☐ Day Care
- ☐ Health Care
- ☐ Student/School
- ☐ Inmate
- ☐ Correction Worker
- ☐ Unemployed
- ☐ Retired
- ☐ Other _____
- ☐ Unknown

Setting (resides/attends)
- ☐ Day Care Facility
- ☐ Health Care Facility
- ☐ School
- ☐ Jail/Prison
- ☐ Camp
- ☐ Homeless
- ☐ Other _____
- ☐ Unknown

Sex
- ☐ Male
- ☐ Female
- ☐ Unknown

Pregnant
- ☐ Yes
- ☐ No
- ☐ Unknown

If Pregnant Due Date: ____/____/____

Race (Check all that apply)
- ☐ White
- ☐ Black
- ☐ Amer. Indian /Alaskan
- ☐ Asian _____
- ☐ Native Hawaiian/ Pacific Islander _____
- ☐ Other
- ☐ Unknown

Ethnicity
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

Is Patient Alive? ☐ Yes ☐ No ☐ Unknown If No, Date of Death ____/____/____

Disease _____ Site of Infection _____

Date of First Symptom: ____/____/____ Date of Diagnosis ____/____/____

Hospitalized? ☐ Yes ☐ No ☐ Unknown

Name of Hospital _____ Medical Record No. _____

Admission Date ____/____/____ Discharge Date ____/____/____

Reporter Information

Reporting Individual _____ Telephone (____) _____ - _____

Address _____

Reporting Source ☐ MD ☐ Lab ☐ Hospital ICN ☐ School Nurse ☐ Public Health Nurse ☐ Other Local Health Department ☐ Other State Health Dept ☐ Other _____ ☐ Unknown

Provider Name _____ Provider Telephone (____) _____ - _____

Testing Laboratory _____ Laboratory Telephone (____) _____ - _____

Comments

Include applicable laboratory data, treatment, recent travel, etc. _____

For Local Health Department Use

Outbreak Related
- ☐ Sporadic
- ☐ Cluster
- ☐ Outbreak
- ☐ Unknown

Case Status
- ☐ Confirmed
- ☐ Probable
- ☐ Suspect
- ☐ Unknown

Local Health Department Signature _____

Date Form Received ____/____/____

Investigation Start Date ____/____/____

Was Patient Notified?
- ☐ Yes
- ☐ No
- ☐ Unknown