

CONFIDENTIAL CASE REPORT

Serial # _____

Date Form Received _____
Date Supplemental Received _____

Patient's name: _____
Last First MI Maiden

Phone No. () _____ Work () _____

City Village
 Town Hamlet

Address: (Number & Street) _____

_____-_____-_____-_____-_____-_____-_____-_____-_____-_____-

City Zip Code Date of Birth Age

Occupation/Setting 1 <input type="checkbox"/> Food Service 2 <input type="checkbox"/> Day Care 3 <input type="checkbox"/> Health Care 4 <input type="checkbox"/> Student/School 5 <input type="checkbox"/> Inmate 6 <input type="checkbox"/> Other Occ: _____ 7 <input type="checkbox"/> Correction Worker 9 <input type="checkbox"/> Unknown	Ethnicity: 1 <input type="checkbox"/> Hispanic 2 <input type="checkbox"/> Non-Hispanic 9 <input type="checkbox"/> Unknown	Pregnant: 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 9 <input type="checkbox"/> Unknown
	Sex: 1 <input type="checkbox"/> Male 2 <input type="checkbox"/> Female 9 <input type="checkbox"/> Unknown	Race (Check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan <input type="checkbox"/> Asian _____ <input type="checkbox"/> Native Hawaiian/Oth. Pacific Islander _____ <input type="checkbox"/> Other <input type="checkbox"/> Unknown

Hospitalized? Y N Admission Date _____ Discharge Date _____

Name of Hospital _____ Chart # _____

Disease _____ Site of Infection _____

Date of First Symptom _____ Date of Diagnosis _____ Date of Report _____ Date of Death _____

Comments (Agent, laboratory data, treatment, etc) _____

Where was disease acquired if not in above municipality _____

Reporting Individual _____ Telephone () _____

Address _____

For Local Health Unit Use	
Outbreak Related <input type="checkbox"/> Sporadic <input type="checkbox"/> Cluster <input type="checkbox"/> Outbreak <input type="checkbox"/> Unknown	Case Status <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Unknown
Local Health Unit Signature _____	
Date Report Received _____	