Government of the District of Columbia
Department of Health
Communicable Disease Report Form

Center for Policy, Planning, and Evaluation
Division of Epidemiology-Disease Surveillance & Investigation (DE-DSI)

Final Dx:_____ MMWR Wk _____ MMWR Yr _____
Investigation ID:_____ Patient ID:_____ ☐ Confirmed ☐ Probable
☐ Suspect ☐Transfer ☐ Not a case

THIS BOX FOR DC DOH USE ONLY

NOTE: This form should be used for all reportable conditions EXCEPT the following: HIV, Tuberculosis, Hepatitis B,C, and STDs

Clinical/Suspected Diagnosis: _____ Date: _____

Outcome: ☐ Survived ☐ Deceased (if deceased, date):_____

*Submitter Name	*Affiliation/Organization	Phone	Fax Number

Submitter Email	☐ Hospital ☐ Laboratory ☐ Clinic ☐ School/Daycare

PATIENT INFORMATION

*Last Name:_____ *First Name:_____ Birth Date:_____
MRN:_____ *Home Phone:_____ Email:_____
Address:_____ *City:_____ *State:_____ *Zip:_____
Occupation:_____ ☐ Food Handler ☐ Child Caregiver ☐ Health care worker
School/Daycare Attends: _____ Sex: ____ Male ____ Female
*Race: ☐ Black ☐ White ☐ Asian/Pacific Islander ☐ Native American/Alaskan ☐ Unknown
Ethnicity: ☐ Hispanic ☐ Non-Hispanic Household contacts: names/ages:_____
If patient is a minor, name of Parent(s)/guardian(s):_____
Recent Travel History (Location/dates): _____

CLINICAL INFORMATION ☐ Acute illness ☐ Chronic Illness Patient notified of lab result? Yes ☐ No ☐
Date of visit: _____ Admitted? ☐Yes ☐No Discharge Date:_____
Name of health care provider patient seen by:_____ Email:_____
Past Medical History_____ Symptom onset date:_____
Symptoms:_____ Symptom Duration:_____
Referred to/Follow-up:_____

DIAGNOSTIC TESTING

*Collection date	*Specimen Type	Test	Result Date	Result

*Drug resistant: ☐ Yes# ☐ No ☐ Unknown/Not tested
#If Yes, resistant drugs:_____ **(Please include the laboratory results with this form)**

TREATMENT

Date Started	Drug	Dose	Route	Frequency	Duration

Additional Comments

Please Fax this Form to DE-DSI: (202) 442-8060

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