

# Notifiable Disease Case Report *(Confidential)*

**Philadelphia Department of Public Health**  
**Division of Disease Control**  
 Communicable Disease Control Program  
 500 S. Broad Street, Philadelphia, PA. 19146



## Patient Information

Report Date (Mo., Day, Yr.) ____/____/____	Name (Last, First, M.I.)	Parent or caretaker (if applicable)
Address (Number, Street, Apt #, City, Zip Code)		Telephone (Home) _____ (Cell) _____ (Work) _____
DOB (Mo., Day, Yr.) ____/____/____	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Occupation		
Name of Employer or School	Employer/School Address (Number, Street, City, Zip Code)	

## Medical Information

Disease or Condition	Date of Onset (Mo., Day, Yr.) ____/____/____	Diagnosis <input type="checkbox"/> Clinical <input type="checkbox"/> Lab confirmed	Fatal (check one) <input type="checkbox"/> No <input type="checkbox"/> Yes Date of Death _____
Chief Symptoms / Complaints <input type="checkbox"/> cough <input type="checkbox"/> nausea <input type="checkbox"/> diarrhea <input type="checkbox"/> headache <input type="checkbox"/> joint pain <input type="checkbox"/> coryza <input type="checkbox"/> vomiting <input type="checkbox"/> fever <input type="checkbox"/> body aches <input type="checkbox"/> rash <input type="checkbox"/> other _____		Suspected source(s) of Infection (if known) <input type="checkbox"/> school/daycare <input type="checkbox"/> home/relative <input type="checkbox"/> park/outdoors <input type="checkbox"/> work <input type="checkbox"/> restaurant <input type="checkbox"/> recreational water <input type="checkbox"/> travel <input type="checkbox"/> other _____	
If Case Hospitalized (Name of Hospital/Medical Provider)		Admission Date ____/____/____	Discharge Date ____/____/____

## Laboratory Information If Pertinent *(attach copies if applicable)*

Name of Lab	Name of Test	Site Source	Result	Collection Date	Result Date
		<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Other _____			
		<input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Other _____			

## Antibiotic Sensitivities (if applicable)

Antibiotic	Resistant	Intermediate	Susceptible
Ampicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ceftriaxone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ciprofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Levofloxacin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trimethoprim/ Sulfamethoxazole (Bactrim)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Notes

## Reporter Information

Facility Name	Reporter Name	Reporter Phone #	Reporter <input type="checkbox"/> ICP <input type="checkbox"/> ED <input type="checkbox"/> School Nurse <input type="checkbox"/> Lab <input type="checkbox"/> Other _____
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## DO NOT WRITE IN AREA BELOW - FOR DEPARTMENT USE

Name (Person Receiving Report)	Method of reporting <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> Mail <input type="checkbox"/> Other _____
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**Any unusual illness, disease clusters or possible outbreaks should be reported *immediately* by telephone. Please fax all completed reports to 215-238-6947 or call 215-685-6748 to report by phone.**