

REPORT FORM – Reportable Diseases, Poisonings, and Organisms
Confidential Communications



FAX FORM AND ANY ACCOMPANYING LAB REPORT TO 402-727-5399

Provider Info.

Person Reporting			Date
Clinic/Institution	Address		Phone #
City	State	Zip	Fax #

Patient Information

Today's Date	Attending Physician		
Patient Name (Last)	(First)	(MI)	
If < 19, Parent's Name (Last)	(First)		
Address	City	State	Zip
Phone #	Race: (Circle) Other	Am. Indian	Black Pacific Islander White
Age/DOB	Ethnicity: (Circle) Other	Hispanic	Non-Hispanic
Sex	Marital Status: (Circle) Other	Single	Married
Disease		Status (circle): Case Suspected Case Asympt. Carrier	
Date of Onset	Diagnosis Date	Treatment	
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Hospital name:		Admit Date ____/____/____	Discharge Date ____/____/____
Check all of the following that apply:	<input type="checkbox"/> Patient is part of an outbreak	<input type="checkbox"/> Patient has contact with children in day care	<input type="checkbox"/> Suspected food or waterborne illness
<input type="checkbox"/> Patient died as result of this illness	<input type="checkbox"/> Patient is a foodhandler	<input type="checkbox"/> Blood level test result _____ µg/dL	<input type="checkbox"/> Source of Illness, Known / suspected List:

NOTES:

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