

Investigation #: _____
MPI#: _____ MMWR (yr-wk): _____ -- _____
THIS BOX for DC DOH USE ONLY

FINAL Dx: _____
 Confirm Probable Suspect Transfer Not a Case
THIS BOX for DC DOH USE ONLY



GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health
COMMUNICABLE DISEASE CASE REPORT FORM

Submitted by: _____ Date: _____
*Hospital/Laboratory/Physician: _____ *Phone No.: _____
*Disease: _____ Outcome: Survived Died Unknown

PATIENT INFORMATION

*Last Name: _____ *First Name: _____
*Address: _____ *City: _____ *State: _____ *Zip: _____
*Home Phone: _____ Work Ph: _____ Other Ph: _____
*Birth Date: _____ *Sex: Male Female
*Race: Black White Native American/Alaskan Asian/Pacific Unknown
(*Ethnicity*): Hispanic Non-Hispanic Unknown

*If Patient is a minor, Name of Parents(s): _____
Occupation/School: _____ or Food Handler Child Caregiver Attends School/Daycare
Household contacts, names, ages: _____

CLINICAL INFORMATION Acute Illness or Chronic Illness Patient Notified of Lab Result: Yes No
*Onset Date: _____ *Admission Date/Seen: _____ Discharge Date: _____
Symptoms and Duration: _____
Past medical history: _____

If female, is the patient pregnant? Yes No If yes, expected date of delivery? _____

DIAGNOSTIC TEST

*Collection Date	*Specimen Type	*Test	*Result
_____	_____	_____	_____
_____	_____	_____	_____

*Drug Resistant: Yes[†] No Unknown/Not Tested

[†]If Yes, list resistant Drugs: _____

TREATMENT

Date Started	Drug	Dosage	Duration
_____	_____	_____	_____

Additional Comments: _____