NEW YORK STATE DEPARTMENT OF HEALTH
Division of Epidemiology

Confidential Case Report

County of Residence ____________ Serial # ____________ Date of Report ___/___/___

Patient Information

Patient's Name ______________________________
Last First MI Maiden

Patient's Alias ______________________________
Last First MI

Guardian's Name ______________________________
Last First MI

Patient's Date of Birth ___/___/___ Patient's Age ______ Patient's Country of Birth ____________

Patient's Primary Phone No. (____) ____ - ______ Patient's Secondary Phone No. (____) ____ - ______

Patient's Physical Address ______________________________
Number & Street City Zip Code

Patient's Mailing Address (if different) ______________________________
City Zip Code

Occupation (works at)
- ☐ Food Service
- ☐ Day Care
- ☐ Health Care
- ☐ Student/School
- ☐ Inmate
- ☐ Correction Worker
- ☐ Unemployed
- ☐ Retired
- ☐ Other ________
- ☐ Unknown

Setting (resides/attends)
- ☐ Day Care Facility
- ☐ Health Care Facility
- ☐ School
- ☐ Jail/Prison
- ☐ Camp
- ☐ Homeless
- ☐ Other ________
- ☐ Unknown

Sex
- ☐ Male
- ☐ Female
- ☐ Unknown

Pregnant
- ☐ Yes
- ☐ No
- ☐ Unknown

If Pregnant Due Date: ___/___/___

Race (Check all that apply)
- ☐ White
- ☐ Black
- ☐ Amer. Indian /Alaskan
- ☐ Asian ________
- ☐ Native Hawaiian/ Pacific Islander ________
- ☐ Other
- ☐ Unknown

Ethnicity
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Unknown

Is Patient Alive? ☐ Yes ☐ No ☐ Unknown If No, Date of Death ___/___/___

Disease ______________________ Site of Infection ______________

Date of First Symptom: ___/___/___ Date of Diagnosis ___/___/___

Hospitalized? ☐ Yes ☐ No ☐ Unknown

Name of Hospital ______________________ Medical Record No. ______________

Admission Date ___/___/___ Discharge Date ___/___/___

Reporter Information

Reporting Individual ______________________ Telephone (____) ____ - ____

Address ______________________________

Reporting Source ☐ MD ☐ Lab ☐ Hospital ICN ☐ School Nurse ☐ Public Health Nurse ☐ Other Local Health Department ☐ Other State Health Dept ☐ Other ______________ ☐ Unknown

Provider Name ______________________ Provider Telephone (____) ____ - ____

Testing Laboratory ______________________ Laboratory Telephone (____) ____ - ____

Comments

Include applicable laboratory data, treatment, recent travel, etc. ______________________________

For Local Health Department Use

Outbreak Related
- ☐ Sporadic
- ☐ Cluster
- ☐ Outbreak
- ☐ Unknown

Case Status
- ☐ Confirmed
- ☐ Probable
- ☐ Suspect
- ☐ Unknown

Local Health Department Signature ______________________

Date Form Received ___/___/___

Investigation Start Date ___/___/___

Was Patient Notified?
- ☐ Yes
- ☐ No
- ☐ Unknown