

**North Carolina Department of Health and Human Services  
Division of Public Health • Epidemiology Section  
Communicable Disease Branch**



**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

Communicable Disease Control  
Henderson County Dept. of Public Health  
1200 Spartanburg Highway, Suite 100  
Hendersonville, NC 28792  
Phone: 828-692-4223  
Fax: 828-697-4504

**Confidential Communicable Disease Report—Part 1**

**NC DISEASE CODE**  
(see reverse side for code)

Patient's Last Name		First	Middle	Suffix	Maiden/Other	Alias
Birthdate (mm/dd/yyyy)		Sex <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Trans.		Parent or Guardian (of minors)		Patient Identifier SSN
Patient's Street Address			City	State	ZIP	County Phone ( ) -
Age	Age Type <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Weeks <input type="checkbox"/> Days	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander		Ethnic Origin <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Was patient hospitalized for this disease? (>24 hours) <input type="checkbox"/> Yes <input type="checkbox"/> No
Patient is associated with (check all that apply): <input type="checkbox"/> Child Care (child, household contact, or worker in child care) <input type="checkbox"/> School (student or worker) <input type="checkbox"/> College/University (student or worker) <input type="checkbox"/> Food Service (food worker) <input type="checkbox"/> Health Care (health care worker)				In what geographic location was the patient MOST LIKELY exposed? <input type="checkbox"/> In patient's county of residence <input type="checkbox"/> Outside county, but within NC - County: _____ <input type="checkbox"/> Out of state - State/Territory: _____ <input type="checkbox"/> Out of USA - Country: _____ <input type="checkbox"/> Unknown		Did patient die from this disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
				Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**CLINICAL INFORMATION**

Is/was patient symptomatic for this disease? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	If a sexually transmitted disease, give specific treatment details:
If yes, symptom onset date (mm/dd/yyyy): ___/___/___	1. Date patient treated:(mm/dd/yyyy) _____
SPECIFY SYMPTOMS:	2. Date patient treated:(mm/dd/yyyy) _____
	Medication _____
	Medication _____
	Dosage _____
	Dosage _____
	Duration _____
	Duration _____

**DIAGNOSTIC TESTING**

Provide lab information below OR attach a copy of lab results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name— City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

Reporting Physician/Practice: _____ Contact Person/Title: _____ Phone: ( ) - Fax: ( ) -	Health Care Provider for this disease (if not reporting physician): _____ Contact Person/Title: _____ Phone: ( ) - Fax: ( ) -
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**LOCAL HEALTH DEPARTMENT USE ONLY**

Initial Date of Report to Public Health: ___/___/___	Is the patient part of an outbreak of this disease? <input type="checkbox"/> Yes <input type="checkbox"/> No
Initial Source of Report to Public Health: <input type="checkbox"/> Health Care Provider (specify): <input type="checkbox"/> Hospital <input type="checkbox"/> Private clinic/practice <input type="checkbox"/> Health Department <input type="checkbox"/> Correctional facility	Outbreak setting: <input type="checkbox"/> Restaurant/Retail (name): _____ <input type="checkbox"/> Household (specify index case): _____ <input type="checkbox"/> Child Care (name): _____ <input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Laboratory <input type="checkbox"/> Other	<input type="checkbox"/> Community (specify index case): _____

Part 1: NC Confidential Communicable Disease Report  
NC EDSS  
Instructions for Completing

This form is used by physicians to make a written report of a communicable disease to the local health department.

1. Enter NC Disease Code number for the disease being reported.  
(Refer to list of NC Disease Code numbers on page 2 of Part 1)
  
2. Provide Demographic Information for the Patient
  - Name...last name, first
  - Birthdate...(dd/mm/yyyy)
  - Sex
  - Parent or Guardian, if patient is a minor
  - Patient Identifier  
    May enter medical chart number or identifier - optional
  - Social Security Number (SSN)  
    Enter only if number is known to be accurate.
  - Address, City, State, Zip Code ...where patient is currently living
  - County...patient's current county of residence
  - Phone...number where patient can be reached
  - Age  
    Enter age in months if patient is less than 12 months.  
    Enter age in years only if patient is 12 months or older.
  - Race and Ethnic Origin - Complete both sections.
  - Was patient hospitalized for this disease? (>24 hours)  
    Enter "Yes" only if hospitalization occurred as a result of the reported disease.
  - Did patient die from this disease?  
    Enter "Yes" only if the reported disease was the primary cause of death.
  - Is the patient pregnant?  
    Enter "Yes" only if the patient is currently pregnant.
  - Patient is associated with...  
    This information is especially important for respiratory and enteric diseases.
  - In what geographic location was the patient MOST LIKELY exposed?  
    Indicate where the disease was acquired.
  
3. Clinical Findings
  - Is/was patient symptomatic for this disease?  
    Enter "Yes" if symptoms of reported disease are/were present
  - Symptom onset date (dd/mm/yyyy)...date symptoms began
  - Specify symptoms  
    List symptoms experienced as a result of reported disease

- Treatment details  
For Sexually Transmitted Diseases, provide specifics of treatment, administration date, medication, dose, duration of treatment.
4. Diagnostic Testing  
Provide lab information that is specific to reported disease.  
(A copy of lab results may be attached to Part 1).
  5. Reporting Physician/Practice  
Give name of physician/practice reporting disease to public health
  6. Health Care Provider  
Give name of physician treating patient for disease, if not the reporter of the disease.