# West Virginia Bureau for Public Health
# Confidential Reportable Disease Case Report

*[Send completed card to local health department. Keep a copy for your records.]*

Please Print and Complete Each Question:

| | | | |
|---|---|---|---|
| Disease Name: | | Symptom Onset Date: / / | |
| Patient's Name (Last, First):<br><br>Parent's Name--if child (Last, First): | Date of Birth<br><br>/ /<br><br>Age: | Sex<br><br>❍Male<br>❍Female<br>❍Unknown | Race/Ethnicity (mark one or more)<br>❍ White ❍ Black / Afr. Amer.<br>❍ Hispanic ❍ Asian<br>❍ Amer. Ind. or Alaskan Native<br>❍ Nat. Hawaiian or other Pac. Isl.<br>❍ Unknown |
| Address City State Zip | | County | Phone<br>( ) - |
| Was patient hospitalized?<br>❍ No ❍ Yes<br>If yes,<br>Facility_____ | | Did patient die?<br>❍ No ❍ Unknown<br>❍ Yes, Date of Death: / / | |
| How was diagnosis made?<br>❍ Clinical<br>❍ Laboratory<br>❍ Both | Laboratory tests, dates and results (culture, serology, etc.). **Attach copies.** | Laboratory Name:<br><br>Phone: ( ) - | |
| Does patient work as a food service worker, health care worker, or child care worker?<br>❍ No ❍ Unknown<br>❍ Yes, Establishment name & address: | | Does patient attend a day care, preschool, or adult day care program, or reside in a long-term care facility?<br>❍ No ❍ Unknown<br>❍ Yes, Facility name & address: | |
| Reporting Source<br>Name:<br><br>Facility:<br><br>Address:<br><br>Phone: ( ) -<br><br>Signature:_____Date: / / | | Provider with further patient information (if other than reporting source)<br><br>Name:<br><br>Phone: ( ) - | Case reported to health department in patient's county of residence?<br><br>❍ No ❍ Yes<br><br>❑ Check here if more report cards are needed. |
| Comments / Other pertinent information: | | | |

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## To Be Completed By Local Health Department

1. Date first notified of case (phone call, card received, etc.): ___/___/___

2. If case follow-up will delay card submission for more than one week, fax the completed front of the card to the Division of Surveillance and Disease Control. Date faxed: ___/___/___

3. Pertinent public health information related to this case (e.g. risk factors for disease or disease spread, travel history, epidemiologic links to other cases, outbreak association, etc.)

4. Public health actions taken (e.g. education, contact tracing, prophylaxis administered, etc.)
Please include dates.

5. Case classification:
   Using CDC case definitions: ❍ confirmed ❍ probable ❍ does not meet surveillance definition

   Other: ❍ not reportable for state surveillance purposes, but requires public health follow-up

6. Name, title and signature of health department professional responsible for reviewing and assuring appropriate follow-up of case.

   Name _____ Title _____

   Local Health Department _____

   Signature_____ Date: ___/___/___