MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
Section for Communicable Disease Control and Prevention
930 Wildwood Drive, P.O. Box 570, Jefferson City, MO 65102-0570
Telephone: (573) 751-6113 FAX: (573) 526-0235

DISEASE CASE REPORT

IF CONDITION IS SUSPECTED AS BEING RELATED TO A DELIBERATE ACT OR OUTBREAK, CALL THE MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES 24 HOURS A DAY, 7 DAYS A WEEK AT 1-800-392-0272

FOR PUBLIC HEALTH AGENCY USE ONLY	
CONDITION I.D.	PARTY I.D.
OUTBREAK I.D.	DATE RECEIVED BY LPHA
JURISDICTION	

Patient Information

NAME (LAST, FIRST, M.I.)	PATIENT IDENTIFIER	DATE OF BIRTH	AGE	MARITAL STATUS	SEX
					☐ Male ☐ Female

PATIENT'S COUNTRY OF ORIGIN	DATE ARRIVED IN USA	OCCUPATION	RACE/ETHNICITY (CHECK ALL THAT APPLY)
			☐ AMERICAN INDIAN ☐ PACIFIC ISLANDER ☐ UNKNOWN ☐ ASIAN ☐ WHITE ☐ BLACK ☐ OTHER RACE – Specify:
HOME TELEPHONE	WORK TELEPHONE	PARENT OR GUARDIAN	HISPANIC: ☐ YES ☐ NO ☐ UNK

IS PERSON HOMELESS? ☐ YES	ADDRESS	CITY, STATE, ZIP CODE	COUNTY OF RESIDENCE

WAS PATIENT HOSPITALIZED? ☐ YES ☐ NO	IF YES, NAME OF HOSPITAL	HOSPITAL ADDRESS	CITY, STATE, ZIP CODE	HOSPITAL TELEPHONE

Reporter

REPORTER NAME (Form Completed By)	REPORTING FACILITY	REPORTER ADDRESS	CITY, STATE, ZIP CODE	REPORTER TELEPHONE

TYPE OF REPORTING FACILITY	DATE OF REPORT	PHYSICIAN/CLINIC NAME	PHYSICIAN/CLINIC TELEPHONE	HAS PATIENT BEEN NOTIFIED OF DIAGNOSIS/LAB RESULTS?
☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER:				☐ YES ☐ NO ☐ UNK
	PHYSICIAN/CLINIC ADDRESS		CITY, STATE, ZIP CODE	

Risk/Background Information

PREGNANT	OTHER ASSOCIATED CASES?	RECENT TRAVEL OUTSIDE OF IMMEDIATE AREA?		
☐ YES - DUE DATE: ☐ NO ☐ UNK	☐ YES ☐ NO ☐ UNK	☐ YES ☐ NO ☐ UNK	DATE OF DEPARTURE	DATE OF RETURN / TRAVEL LOCATION

CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT YES	PATIENT NO	PATIENT UNK	HHLD MEMBER YES	HHLD MEMBER NO	HHLD MEMBER UNK	IF YES, PROVIDE BUSINESS NAME, ADDRESS AND TELEPHONE NUMBER
IS A FOOD HANDLER?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR ATTENDS CHILD/ ADULT CARE CENTER?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR RESIDENT OF NURSING HOME?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH OR INMATE OF CORRECTIONAL FACILITY?	☐	☐	☐	☐	☐	☐	
ASSOCIATED WITH HOMELESS SHELTER?	☐	☐	☐	☐	☐	☐	
IS A STUDENT OR FACULTY/STAFF OF A SCHOOL?	☐	☐	☐	☐	☐	☐	
IS A HEALTH CARE WORKER?	☐	☐	☐	☐	☐	☐	
OTHER (specify):	☐	☐	☐	☐	☐	☐	

HAS PATIENT DONATED OR RECEIVED BLOOD OR TISSUE?	DATE DONATED	DATE RECEIVED	SPECIFY TYPE OF BLOOD OR TISSUE AND FACILITY NAME/ADDRESS
☐ ☐ ☐			

Disease

DISEASE/CONDITION NAME(S)	ONSET DATE(S)	DIAGNOSIS DATE(S)	SEVERITY OF VARICELLA	VACCINATION HISTORY FOR REPORTED CONDITION/DATES ☐ UNKNOWN
			☐ <50 lesions ☐ 50-249 lesions ☐ 250-500 lesions ☐ >500 lesions	

Symptoms

SYMPTOM	SYMPTOM SITE	ONSET DATE (MO/DAY/YR)	DURATION (DAYS)

DID PATIENT DIE OF THIS ILLNESS? ☐ YES ☐ NO - IF YES, GIVE DATE:

COMMENTS

Diagnostics

DO NOT COMPLETE DIAGNOSTICS IF LAB SLIP IS ATTACHED

RESULT DATE (MO/DAY/YR)	TYPE OF TEST	SPECIMEN TYPE/SOURCE	SPECIMEN DATE (MO/DAY/YR)	QUALITATIVE/QUANTITATIVE RESULTS	REFERENCE RANGE	LABORATORY NAME/ADDRESS (STREET, or RFD, CITY, STATE, ZIP CODE)	LIVER FUNCTION RESULTS
							ALT
							AST

Treatment

TYPE OF TREATMENT (MEDS) IF NOT TREATED, REASON	DOSAGE	TREATMENT START DATE (MO/DAY/YR)	TREATMENT END DATE (MO/DAY/YR)	TREATMENT DURATION (IN DAYS)	PREVIOUS MEDICATIONS USED FOR TREATMENT	PREVIOUS TREATMENT FACILITY	TELEPHONE NUMBER

NOTES FOR ALL RELEVANT SECTIONS

- For cases of varicella, complete only the data fields for the patient's: Name, Date of Birth, County of Residence, Date of Report, Other Associated Cases, Disease/Condition Name(s), Onset Date, Severity of Varicella, Vaccination History for Reported Condition/Dates, and Did Patient Die Of This Illness; if diagnostic test(s) were performed - provide Lab Slip.
- Do not use this form to report weekly aggregate influenza incidence.
- Risk factors, diagnostics, treatments, and symptoms shown below are examples. To see a list of communicable disease resources available online, go to http://www.dhss.mo.gov/CommunicableDisease/. For additional information or to report a case of a reportable disease/condition, you may also contact the Office of Surveillance at 1-866-629-9891.
- All dates must be in MONTH/DAY/YEAR (01/01/2005) format.
- To be complete, all addresses should include the city, state, and zip code.
- All telephone numbers should include the area code.

PATIENT INFORMATION

- Name: Provide the patient's full name, including the full first name.
- Patient Identifier: Provide patient's SSN, medical record, inmate, DCN, or other identifying number and indicate identifier provided.
- Age: If the patient is less than one year, provide patient age in months; or if less than one month, provide patient age in days.
- Race/ethnicity: Patient race/ethnicity is determined by the self-identification of each patient.
- Date arrived in USA: Do not complete this data field for those patients who were born in the United States as an American citizen.
- Address: If homeless, check the appropriate box and provide an address where the patient can be located (i.e., shelter, etc.).
- Patient hospitalized: Indicate if the patient was hospitalized due to the reported disease/condition.

REPORTER

- Reporter name (Form completed by): Provide the name of the individual who completed this form.
- Reporting facility: Provide the name of the facility where the Reporter is employed. Facilities include hospital, physician, local public health agency, etc.
- Date of report: Provide the date the form was submitted by the Reporter.

RISK/BACKGROUND INFORMATION

- Associated cases: Indicate if other cases (individuals with similar symptoms) are associated with the patient's disease/condition.
- Other risk/background information may include environmental exposure or exposure due to animals, recreation, and occupation.

DISEASE

- Disease name(s): Specify the disease(s)/condition(s) that is reported on this form, as listed in 19 CSR 20-20.020 Reporting Communicable, Environmental and Occupational Diseases – Sections (1) and (2).
- Onset date: Indicate the date when the symptoms started.
- Diagnosis date: Indicate the date when a physician diagnosed the disease/condition.
- Severity of varicella: Indicate the estimated number of skin lesions on the patient's total body surface.
- Vaccination history: Provide the vaccination history for the disease/condition, including vaccine type and manufacturer.

SYMPTOMS

- Symptom: Indicate the symptom(s) associated with the disease/condition. Symptoms may include jaundice, fever, headache, rash, lesion, discharge, etc.
- Onset date: Indicate the date when each symptom started.
- Pertinent information: Provide any additional symptoms-related comments. Attach additional sheets if more space is needed.

DIAGNOSTICS - Please attach a copy of all lab results. Do not complete this section if lab results are attached.

- Result date: Indicate the date that each laboratory result was reported, usually to the submitting physician, clinic, etc.
- Type of test: Indicate each type of test performed. Examples of tests are carboxyhemoglobin, chest x-ray, culture, EIA, gram stain, ICP/MS, PCR, RBC/Serum Cholinesterase, RPR, serum organochlorine panel, etc.
- Specimen type/source: Indicate the specimen type/source for each test. Examples of specimen types are blood, cerebrospinal fluid (CSF), hair, nails, smear, stool, urine, etc.
- Specimen date: Indicate the collection date for each specimen.
- Qualitative/quantitative results: Indicate the result for each test.
    - Examples of qualitative results are positive, reactive, negative, equivocal, undetectable, etc.
    - Examples of quantitative results are 1:16, 2.0 mm, 2000 IU/mL, 65 mcg/dL, 1.8 IV, 10 ppb, index value, etc.
    - Examples of quantitative results for tuberculosis when administering the Mantoux test - (PPD), indicate the diameter of the induration (i.e., 2 mm, 15 mm, etc.).
- Reference range: Indicate the reference range for each quantitative result. Examples of reference ranges are: <1:10, <600 IU/mL, 1:64, <10 mcg/dL, etc.
- Liver function results: ALT = alanine aminotransferase (SGPT); AST = aspartate aminostransferase (SGOT)

TREATMENT

- Type of treatment: Indicate the medication(s) and/or therapy(ies) prescribed for treatment of the disease(s)/condition(s).
    - Reasons for not treating include – but are not limited to – 'False Positive', 'Previously Treated', and 'Age'.
- Dosage: Indicate the number of units (i.e., 50, 500, etc.), measurement (i.e., cc, mg, etc.), and number of times taken each day and/or week for each medication.