MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

# DISEASE CASE REPORT

**REPORT TO LOCAL PUBLIC HEALTH AGENCY**

| **1** DATE OF REPORT | **2** DATE RECEIVED BY LOCAL HEALTH AGENCY |
|---|---|
| _____ / _____ / _____ | _____ / _____ / _____ |

| **3** NAME (LAST, FIRST, M.I.) | **4** GENDER ☐ MALE ☐ FEMALE | **5** DATE OF BIRTH _____ / _____ / _____ | **6** AGE | **7** HISPANIC ☐ YES ☐ NO ☐ UNKNOWN |
|---|---|---|---|---|

| **8** RACE (CHECK ALL THAT APPLY) ☐ BLACK ☐ ASIAN ☐ PACIFIC ISLANDER ☐ WHITE ☐ AMERICAN INDIAN ☐ UNKNOWN | **9** PATIENT'S COUNTRY OF ORIGIN | **10** DATE ARRIVED IN USA _____ / _____ / _____ |
|---|---|---|

| **11** ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE) | **12** COUNTY OF RESIDENCE | **13** TELEPHONE NUMBER ( ) |
|---|---|---|

| **14** PREGNANT ☐ YES (IF YES NUMBER OF WEEKS _____) ☐ NO ☐ UNKNOWN | **15** PARENT OR GUARDIAN | **16** RECENT TRAVEL OUTSIDE OF MISSOURI OR USA ☐ YES ☐ NO IF YES, WHERE _____ | **17** DATE OF RETURN _____ / _____ / _____ |
|---|---|---|---|

| **18** OCCUPATION | **19** SCHOOL/DAY CARE/WORKPLACE ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE) |
|---|---|

| **20** WORK TELEPHONE NUMBER ( ) | **21** OTHER ASSOCIATED CASES ☐ YES ☐ NO ☐ UNKNOWN IS REPORT PART OF AN OUTBREAK ☐ YES ☐ NO ☐ UNKNOWN | **22** TYPE OF COMPLAINT/OUTBREAK ☐ FOODBORNE ☐ WATERBORNE ☐ OTHER (SPECIFY) _____ |
|---|---|---|

| **23** WAS PATIENT HOSPITALIZED ☐ YES ☐ NO ☐ UNKNOWN | **24** PATIENT RESIDE IN NURSING HOME ☐ YES ☐ NO ☐ UNKNOWN | **25** PATIENT DIED OF THIS ILLNESS ☐ YES ☐ NO ☐ UNKNOWN |
|---|---|---|

| **26** CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD): | PATIENT | | | HHLD MEMBER | | |
|---|---|---|---|---|---|---|
| | YES | NO | UNK | YES | NO | UNK |
| IS A FOOD HANDLER | | | | | | |
| ATTENDS OR WORKS AT A CHILD OR ADULT DAY CARE CENTER | | | | | | |
| IS A HEALTH CARE WORKER | | | | | | |

| **27** NAME OF HOSPITAL/NURSING HOME | |
|---|---|
| **28** HOSPITAL/NURSING HOME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE) | |
| **29** REPORTER NAME | **30** TELEPHONE NUMBER ( ) |

| **31** REPORTER ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE) | **32** TYPE OF REPORTER/SUBMITTER ☐ PHYSICIAN ☐ OUTPATIENT CLINIC ☐ PUBLIC HEALTH CLINIC ☐ HOSPITAL ☐ LABORATORY ☐ SCHOOL ☐ OTHER _____ |
|---|---|

| **33** ATTENDING PHYSICIAN/CLINIC NAME ADDRESS (STREET OR RFD, CITY, STATE, ZIP CODE) | **34** TELEPHONE NUMBER ( ) |
|---|---|

| **35** DISEASE NAME(S) | **36** ONSET DATE(S) _____ / _____ / _____ _____ / _____ / _____ | **37** DIAGNOSIS DATE(S) _____ / _____ / _____ _____ / _____ / _____ | **38** DISEASE STAGE/ RISK FACTOR | **39** PREVIOUS DISEASE/STAGE | **40** PREVIOUS DISEASE DATE(S) _____ / _____ / _____ _____ / _____ / _____ |
|---|---|---|---|---|---|

## 41 - DIAGNOSTICS

| TEST DATE (MO/DAY/YR) | TYPE OF TEST | SPECIMEN TYPE | COLLECTION DATE (MO/DAY/YR) | QUALITATIVE / QUANTITATIVE RESULTS | REFERENCE RANGE | LABORATORY NAME/ADDRESS (INCLUDE STREET OR RFD, CITY, STATE, ZIP CODE) |
|---|---|---|---|---|---|---|
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## 42 - TREATMENTS

| TREATED (Y/N/UNK) | REASON NOT TREATED | TYPE OF TREATMENT | DRUG | DOSAGE | TREATMENT DATE (MO/DAY/YR) | TREATMENT DURATION (IN DAYS) | PREVIOUS TREATMENT | PREVIOUS LOCATION (LIST CITY, STATE) |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

## 43 - SYMPTOMS

| SYMPTOM (IF APPLICABLE) | SYMPTOM SITE (IF APPLICABLE) | SYMPTOM ONSET DATE (MO/DAY/YR) | SYMPTOM DURATION (IN DAYS) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**44** COMMENTS

**NOTES FOR ALL RELEVANT SECTIONS:**

- Stages, risk factors, diagnostics, treatments, and symptoms shown below are examples. To see a more complete listing, please go to ***http://www.dhss.state.mo.us/Diseases/DDwelcome.htm***. You may also contact the Office of Surveillance at 1-800-392-0272 for additional information or to report a case.
- All dates should be in Mo/Day/Year (01/01/2001) format.
- All complete addresses should include city, state and zip code.
- Required fields referenced below are italicized and bold, however fill form as complete as possible.

***(1) Date of Report*** -- date sent by submitter of document.

(2) Date received will be filled in by receiving agency.

(3-8) **CASE DEMOGRAPHICS/IDENTIFIERS:** ***Last name, First Name,*** Gender, ***Date of Birth,*** Hispanic, Race - please check all that apply

(23) Was patient hospitalized due to this illness?

(32) Type of reporter/submitter (doctor, nursing home, hospital, laboratory) (33-34) Attending physician or clinic (full physician name and degree, address, phone)

**DISEASE:** ***(35) Disease name or name(s), (36) Onset date(s), (37) Diagnosis Date(s)***

**(38) Disease Stage or Risk Factor**

| **Syphilis** | **Gonorrhea or Chlamydia** | **TB Infection** |
|---|---|---|
| Primary (chancre present) | Asymptomatic | Contact to TB case |
| Secondary (skin lesions, rash) | Uncomplicated urogenital (urethritis, cervicitis) | Immunocompromised |
| Early Latent (asymptomatic < 1 year) | Salpingitis (PID) | Abnormal CXR |
| Late Latent (over 1 year duration) | Ophthalmia/conjunctivitis | Foreigner/Immigrant |
| Neurosyphilis | Other (arthritis, skin lesions, etc) | IV Drug/Alcohol Abuse |
| Cardiovascular | | Resident, correctional |
| Congenital | | Employee, correctional |
| Other | | Over 70 |
| | | Homeless |
| | | Diabetes |
| | | Healthcare worker |
| | | Converter/2 yrs ≥ 10 |
| | | Converter/2 yrs ≥ 15 |

***(39) Previous Disease/Stage (if applicable)*** ***(40) Previous Disease Dates (if applicable)***

**(41) Diagnostics (Please Attach Lab Slip)**

**Test Type**

| **Hepatitis** | **TB** | **Other** |
|---|---|---|
| Igm Anti-HBc | Not Done | Elisa |
| Anti-HBs | Mantoux | Western Blot |
| Anti-HBc Total | Multiple puncture device | Culture |
| Igm Anti-HAV | X-Ray | ALT |
| HBsAg | Smear | AST |
| Hep C | Culture | |

**Specimen Type** (blood, urine, CSF, smear, swab), **Collection Date** (Mo/Day/Yr), **Qualitative** (negative, positive, reactive), **Quantitative Results** (1:1, 2.0 mm reading,) **Reference Range** (1:1neg, 1:64 equivocal, 1:128 positive, > 2 positive), **Laboratory** (name, address)

**(42) TREATMENT**

| **Reason not treated** | **Drug** |
|---|---|
| False positive | **TB** |
| Previous treated | Isoniazid |
| Age | Ethambutol |
| | Pyrazinamide |
| | Rifampin |

**(43) SYMPTOMS:**

**Symptom** (jaundice, fever, dark urine, headache) **Symptom Site** (head, liver, lungs, skin), **Symptom Onset Date** (Mo/Day/Yr) and **Symptom Duration** (in days)

(44) **Comments:** Attach additional sheets if more comments needed.