

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.health.mo.gov/living/healthcondisease/communicable/communicabledisease/>. For additional information or to report a case of a reportable disease/condition, you may also contact the Bureau of Communicable Disease Control and Prevention 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 aminotransferase (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.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
 Section for Disease 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 THE CONDITION REQUIRES IMMEDIATE PUBLIC HEALTH INTERVENTION, OR IS SUSPECTED OF BEING A DELIBERATE ACT, OR PART OF AN OUTBREAK, CALL THE DEPT 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 <input type="checkbox"/> Male <input type="checkbox"/> Female
PATIENT'S COUNTRY OF ORIGIN	DATE ARRIVED IN USA	OCCUPATION		RACE/ETHNICITY (CHECK ALL THAT APPLY) <input type="checkbox"/> AMERICAN INDIAN <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> UNKNOWN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> OTHER RACE - Specify: HISPANIC: <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK		
HOME TELEPHONE	WORK TELEPHONE	PARENT OR GUARDIAN				
IS PERSON HOMELESS? <input type="checkbox"/> YES <input type="checkbox"/> NO	ADDRESS	CITY, STATE, ZIP CODE			COUNTY OF RESIDENCE	
WAS PATIENT HOSPITALIZED? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> OUTPATIENT CLINIC <input type="checkbox"/> HOSPITAL <input type="checkbox"/> LABORATORY <input type="checkbox"/> SCHOOL <input type="checkbox"/> OTHER:		DATE OF REPORT	PHYSICIAN/CLINIC NAME	PHYSICIAN/CLINIC TELEPHONE
		PHYSICIAN/CLINIC ADDRESS	CITY, STATE, ZIP CODE	HAS PATIENT BEEN NOTIFIED OF DIAGNOSIS/LAB RESULTS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK

Risk/Background Information

PREGNANT <input type="checkbox"/> YES - DUE DATE: <input type="checkbox"/> NO <input type="checkbox"/> UNK	OTHER ASSOCIATED CASES? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK	RECENT TRAVEL OUTSIDE OF IMMEDIATE AREA? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNK			DATE OF DEPARTURE	DATE OF RETURN	TRAVEL LOCATION
CHECK BELOW IF PATIENT OR MEMBER OF PATIENT'S HOUSEHOLD (HHLD):	PATIENT		HHLD MEMBER			IF YES, PROVIDE BUSINESS NAME, ADDRESS AND TELEPHONE NUMBER	
	YES	NO	UNK	YES	NO	UNK	
IS A FOOD HANDLER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ASSOCIATED WITH OR ATTENDS CHILD/ ADULT CARE CENTER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ASSOCIATED WITH OR RESIDENT OF NURSING HOME?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ASSOCIATED WITH OR INMATE OF CORRECTIONAL FACILITY?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ASSOCIATED WITH HOMELESS SHELTER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IS A STUDENT OR FACULTY/STAFF OF A SCHOOL?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
IS A HEALTH CARE WORKER?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
OTHER (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Disease

HAS PATIENT DONATED OR RECEIVED BLOOD OR TISSUE?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DATE DONATED	DATE RECEIVED	SPECIFY TYPE OF BLOOD OR TISSUE AND FACILITY NAME/ADDRESS
DISEASE/CONDITION NAME(S)	ONSET DATE(S)	DIAGNOSIS DATE(S)	SEVERITY OF VARICELLA <input type="checkbox"/> <50 lesions <input type="checkbox"/> 50-249 lesions <input type="checkbox"/> 250-500 lesions <input type="checkbox"/> >500 lesions	VACCINATION HISTORY FOR REPORTED CONDITION/DATES <input type="checkbox"/> UNKNOWN		

Symptoms

SYMPTOM	SYMPTOM SITE	ONSET DATE (MO/DAY/YR)	DURATION (DAYS)	DID PATIENT DIE OF THIS ILLNESS? <input type="checkbox"/> YES <input type="checkbox"/> 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