

# Confidential Case Report

County of Residence \_\_\_\_\_ Serial # \_\_\_\_\_ Date of Report \_\_\_\_/\_\_\_\_/\_\_\_\_

## Patient Information

Patient's Name \_\_\_\_\_  
Last First MI Maiden

Patient's Alias \_\_\_\_\_  
Last First MI

Guardian's Name \_\_\_\_\_  
Last First MI

Patient's Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Patient's Age \_\_\_\_\_ Patient's Country of Birth \_\_\_\_\_

Patient's Primary Phone No. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Patient's Secondary Phone No. (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Patient's Physical Address \_\_\_\_\_  
Number & Street City Zip Code

Patient's Mailing Address (if different) \_\_\_\_\_  
City Zip Code

<b>Occupation (works at)</b> <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Student/School <input type="checkbox"/> Inmate <input type="checkbox"/> Correction Worker <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<b>Setting (resides/attends)</b> <input type="checkbox"/> Day Care Facility <input type="checkbox"/> Health Care Facility <input type="checkbox"/> School <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Camp <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	<b>Sex</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown  <b>Pregnant</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If Pregnant Due Date: ____/____/____	<b>Race (Check all that apply)</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian /Alaskan <input type="checkbox"/> Asian  <input type="checkbox"/> Native Hawaiian/ Pacific Islander  <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
---	--	--	---	--

Is Patient Alive? ☐ Yes ☐ No ☐ Unknown If No, Date of Death \_\_\_\_/\_\_\_\_/\_\_\_\_

Disease \_\_\_\_\_ Site of Infection \_\_\_\_\_

Date of First Symptom: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Diagnosis \_\_\_\_/\_\_\_\_/\_\_\_\_

Hospitalized? ☐ Yes ☐ No ☐ Unknown

Name of Hospital \_\_\_\_\_ Medical Record No. \_\_\_\_\_

Admission Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Discharge Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Reporter Information

Reporting Individual \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Address \_\_\_\_\_

Reporting Source ☐ MD ☐ Lab ☐ Hospital ICN ☐ School Nurse ☐ Public Health Nurse ☐ Other Local Health Department  
☐ Other State Health Dept ☐ Other \_\_\_\_\_ ☐ Unknown

Provider Name \_\_\_\_\_ Provider Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Testing Laboratory \_\_\_\_\_ Laboratory Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Comments

Include applicable laboratory data, treatment, recent travel, etc. \_\_\_\_\_

## For Local Health Department Use

<b>Outbreak Related</b> <input type="checkbox"/> Sporadic <input type="checkbox"/> Cluster <input type="checkbox"/> Outbreak <input type="checkbox"/> Unknown	<b>Case Status</b> <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Unknown	<b>Local Health Department Signature</b> _____ <b>Date Form Received</b> ____/____/____ <b>Investigation Start Date</b> ____/____/____	<b>Was Patient Notified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	---	---	---

# NEW YORK STATE DEPARTMENT OF HEALTH

## Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis	Cyclosporiasis	Hospital associated	<b>Poliomyelitis</b>	Streptococcal infection
Amebiasis	<b>Diphtheria</b>	infections (as defined in	Psittacosis	(invasive disease) <sup>5</sup>
<b>Animal bites for which</b>	E.coli O157:H7 infection <sup>4</sup>	section 2.2 10NYCRR)	<b>Q Fever</b> <sup>2</sup>	Group A beta-hemolytic
<b>rabies prophylaxis is</b>	Ehrlichiosis	Influenza,	<b>Rabies</b> <sup>1</sup>	strep
<b>given</b> <sup>1</sup>	<b>Encephalitis</b>	laboratory-confirmed	Respiratory syncytial virus (RSV)	Group B strep
<b>Anthrax</b> <sup>2</sup>	<b>Foodborne Illness</b>	Legionellosis	laboratory-confirmed	Streptococcus pneumoniae
<b>Arboviral infection</b> <sup>3</sup>	Giardiasis	Listeriosis	Respiratory syncytial virus (RSV)	<b>Syphilis, specify stage</b> <sup>7</sup>
Babesiosis	<b>Glanders</b> <sup>2</sup>	Lyme disease	pediatric fatalities	Tetanus
<b>Botulism</b> <sup>2</sup>	Gonococcal infection	Lymphogranuloma venereum	Rocky Mountain spotted fever	Toxic shock syndrome
<b>Brucellosis</b> <sup>2</sup>	Haemophilus influenzae <sup>5</sup>	Malaria	<b>Rubella</b>	Transmissible spongiform
Campylobacteriosis	(invasive disease)	<b>Measles</b>	(including congenital	encephalopathies <sup>8</sup> (TSE)
Chancroid	<b>Hantavirus disease</b>	<b>Melioidosis</b> <sup>2</sup>	rubella syndrome)	Trichinosis
Chlamydia trachomatis	Hemolytic uremic syndrome	Meningitis	Salmonellosis	<b>Tuberculosis current</b>
infection	Hepatitis A	Aseptic or viral	Shigatoxin-producing E.coli <sup>4</sup>	<b>disease (specify site)</b>
<b>Cholera</b>	<b>Hepatitis A in a food handler</b>	<b>Haemophilus</b>	(STEC)	<b>Tularemia</b> <sup>2</sup>
Coronavirus	Hepatitis B (specify acute or	<b>Meningococcal</b>	Shigellosis <sup>4</sup>	<b>Typhoid</b>
COVID-19 (SARS CoV-2)	chronic)	Other (specify type)	<b>Smallpox</b> <sup>2</sup>	<b>Vaccinia disease</b> <sup>9</sup>
<b>Severe Acute Respiratory</b>	Hepatitis C (specify acute or	<b>Meningococcemia</b>	Staphylococcus aureus <sup>6</sup> (due	Varicella
<b>Syndrome (SARS)</b>	chronic)	<b>Mpox</b>	to strains showing reduced	(not shingles)
<b>Middle East Respiratory</b>	Pregnant hepatitis B carrier	Mumps	susceptibility or resistance	Vibriosis <sup>6</sup>
<b>Syndrome (MERS)</b>	Herpes infection, infants	Pertussis	to vancomycin)	<b>Viral hemorrhagic fever</b> <sup>2</sup>
Cryptosporidiosis	aged 60 days or younger	<b>Plague</b> <sup>2</sup>	<b>Staphylococcal</b>	Yersiniosis
			enterotoxin B poisoning <sup>2</sup>	

### WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

### WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person **Communicable Disease Nurse**

Name Seneca County Health Department

Address 2465 Bonadent Drive, Suite 3  
Waterloo, NY 13165

Phone (315) 539-1920 Fax (315) 539-9493

### WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Report all other diseases promptly to county health department where individual resides.
- In New York City use form PD-16.

### SPECIAL NOTES

- Diseases listed in **bold type** **P** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS (Stage 3) are reportable on the Medical Provider HIV/AIDS and Partner/Contact Report Form DOH-4189. The form may be obtained by contacting:**  
Division of Epidemiology, Evaluation and Partner Services  
P.O. Box 2073, ESP Station  
Albany, NY 12220-2073  
(518) 474-4284  
In NYC: New York City Department of Health and Mental Hygiene  
For HIV/AIDS reporting, call: (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test  $\geq 1:16$  or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinal encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

### ADDITIONAL INFORMATION

For more information on disease reporting, call your local health department or the New York State Department of Health Bureau of Communicable Disease Control at (518) 473-4439 or (866) 881-2809 after hours. In New York City, 1 (866) NYC-DOH1.

**PLEASE POST THIS CONSPICUOUSLY**