PHYSICIAN / HOSPITAL NOTIFIABLE DISEASE/CONDITION REPORT FORM

Miami-Dade County Health Department
Epidemiology, Disease Control and Immunization Services
8600 N.W. 17th Street, Suite 200, Miami, FL 33126

PATIENT INFORMATION

Patient's Name: ____________________ (Last name / First name / MI)

SS#: ______________ Medical Record#: ______________

Date of Birth: __________ Gender: ☐Female ☐Male

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐White ☐Alaskan ☐Black ☐American-Indian ☐Asian ☐Other __________

Patient Address: ____________________ (Street / City / State / Zip)

Patient ☎: ______________ Other ☎: ______________

Sensitive Occupation: ☐Daycare worker/attendee ☐Unknown ☐Healthcare Worker ☐School student/staff- Name: ______________ ☐Food Handler ☐Nursing Home/ ALF- Name: ______________

Guardian/Parent Name: ______________

Emergency Contact: ______________ Phone: ______________

DISEASE/CONDITION INFORMATION

Disease/Condition: ______________

Onset Date: __________ Symptoms: ______________ Status: ☐Alive ☐Dead

	Yes	No	Unk	Date
Admitted:	☐	☐	☐	________
ER Visit:	☐	☐	☐	________
Discharged:	☐	☐	☐	________

Room #: ________

Comments/ Treatment: ______________

Admitting Physician: ______________ ☎: __________ Primary Physician: ______________ ☎: __________

Has patient been notified of diagnosis / lab result? ☐Yes ☐No ☐Unknown

LABORATORY INFORMATION

Is laboratory result attached? ☐Yes ☐No

Isolate or specimen sent to State Laboratory for confirmation?☐Yes ☐No ☐N/A ☐Unk

REPORTER INFORMATION

Date: ______ Reporting Agency: ______________ Name of Person completing this form: ______________ (please print) ☎: __________

REPORT BY PHONE, FAX OR MAIL TO:
Epidemiology, Disease Control and Immunization Services
☎(305) 470-5660, Fax: (305) 470-5533, or Mail to above address

Revised MDCHD 5/7/2009

Note: Report to the specific program as indicated on the Reportable Notifiable Disease/Condition Contact List