



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
Medical Record#:
Date of Birth: Gender: Female Male
Patient Address: Street City State Zip
Patient: Other:
Guardian/Parent Name:
Emergency Contact: Phone:
Race: White Alaskan
Ethnicity: Hispanic Non-Hispanic Black American-Indian
Sensitive Occupation: Daycare worker/attende Unknown
Healthcare Worker Other
Food Handler

DISEASE/CONDITION INFORMATION

Disease/Condition:
Onset Date: Symptoms: Status: Alive Dead
Admitted: Yes No Unk Date Room #: Comments/ Treatment:
ER Visit:
Discharged:
Admitting Physician: Primary Physician:
Has patient been notified of diagnosis / lab result? Yes No Unknown
Is laboratory result attached? Yes No

LABORATORY INFORMATION

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 12/1/2008

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