NC Electronic Disease Surveillance System (NCEDSS)

For Local Health Department Use Only: NCEDSS EVENT ID#_____

NC Department of Health and Human Services Division of Public Health • Epidemiology Section Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department **where the patient received care.**

CONFIDENTIAL COMMUNICABLE DISEASE REPORT – PART 1

NAME OF DISEASE/CONDITION

Forsyth County Department of Public Health
Fax: (336) 748-3644
Attention: Communicable Disease

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias

Birthdate (mm/dd/yyyy)	Sex	Parent or Guardian *(of minors)*	Medical Record Number
/ /	☐ M ☐ F ☐ Trans.		

Patients Street Address	City	State	ZIP	County	Phone
					( )

Age	Age Type	Race (check all that apply):		Ethnic Origin	Was patient hospitalized for this disease? (>24 hours)	Did patient die from this disease?	Is the patient pregnant?
	☐ Years ☐ Months ☐ Weeks ☐ Days	☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Native Hawaiian or Pacific Islander	☐ Asian ☐ Other ☐ Unknown	☐ Hispanic ☐ Non-Hispanic	☐ Yes ☐ No Date / /	☐ Yes ☐ No	☐ Yes ☐ No

Patient is associated with (check all that apply):

- ☐ Child Care (child, household contact, or worker in child care)
- ☐ School (student or worker)
- ☐ College/University (student or worker)
- ☐ Food Service (food worker)
- ☐ Health Care (health care worker)
- ☐ Migrant Worker Camp
- ☐ Correctional Facility (inmate or worker)
- ☐ Long Term Care Facility (resident or worker)
- ☐ Military (active military, dependent, or recent retiree)
- ☐ Travel (outside continental United States in last 30 days)
- ☐ Other

In what geographic location was the patient MOST LIKELY exposed?

- ☐ In patient's county of residence
- ☐ Outside county, but within NC - County:
- ☐ Out of state - State/Territory:
- ☐ Out of USA - Country:
- ☐ Unknown

CLINICAL INFORMATION

Is/was patient symptomatic for this disease?
☐ Yes ☐ No ☐ Unknown

If yes, symptom onset date (mm/dd/yyyy):
/ /

SPECIFY SYMPTOMS_____:

If a sexually transmitted disease, give specific treatment details

1. Date patient treated:(mm/dd/yyyy) / /

Medication:_____
Dosage:_____
Duration:_____

2. Date patient treated:(mm/dd/yyyy) / /

Medication: _____
Dosage: _____
Duration:_____

DIAGNOSTIC TESTING

Provide lab information below and fax copy of lab results and other pertinent records to local health department.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name –City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

LOCAL HEALTH DEPARTMENT USE ONLY

Initial Date of Report to Public Health:
/ /

Initial Source of Report to Public Health:

- ☐ Health Care Provider (specify):
  - ☐ Hospital
  - ☐ Private clinic/practice
  - ☐ Health Department
  - ☐ Correctional facility
- ☐ Laboratory
- ☐ Other:_____

Is the patient part of an outbreak of this disease? ☐ Yes ☐ No

Outbreak setting:

- ☐ Household/Community (specify index case):
- ☐ Restaurant/Retail
- ☐ Child Care
- ☐ Long term care
- ☐ Healthcare setting
- ☐ Migrant Worker Camp
- ☐ Adult care home
- ☐ Assisted living facility
- ☐ Adult day care
- ☐ School
- ☐ Prison
- ☐ Other

Name of facility:_____

Address of facility:_____