Davis County Health Department
CONFIDENTIAL DISEASE REPORT FORM

Patient's Name (Last)	**(First)**			**Date of Birth** ____/____/____
Street Address	**City**	**State**	**Zip Code**	**County**
Phone Number	**Alternate Phone Number**			

Gender ☐ Male ☐ Female	**Race** (check all that apply) ☐ White ☐ Black/African American ☐ American Indian ☐ Asian ☐ Alaskan Native ☐ Native Hawaiian/Pacific Islander ☐ Unknown	**Ethnicity** (check one) ☐ Hispanic ☐ Not Hispanic ☐ Unknown

Disease			**Date of Onset** ____/____/____
Laboratory tested?	**Laboratory results/Serotype**	**Specimen source**	**Date of Collection** ____/____/____
Name of Laboratory			**Phone**
Name of Ordering Provider			**Phone**
Name of Ordering Facility			**Phone**

Died? ☐ Yes ☐ No	**Cause of Death**		**Date of Death** ____/____/____
Hospitalized? ☐ Yes ☐ No	**Name of Hospital**	**Admission Date** ____/____/____	**Discharge Date** ____/____/____

Pregnant?
☐ Yes ☐ No If yes, estimated weeks at diagnosis? _____

Man having sex with men (MSM)?
☐ Yes ☐ No

Food Service Worker? ☐ Yes ☐ No	**Facility Employed**	**Position**
Health Care Provider? ☐ Yes ☐ No	**Facility Employed**	**Position**
Day Care? ☐ Yes ☐ No	**Facility Employed/Attending**	☐ Attend ☐ Employee

Was the patient treated for this disease?
☐ Yes ☐ No
☐ Prescribed ☐ Administered

Treatment _____ **Dosage** _____ **Date:** ___/___/___
Treatment _____ **Dosage** _____ **Date:** ___/___/___
Comments _____

Name of Person Reporting	**Telephone Number**
Reporting Agency	**Date Reported** ____/____/____

Comments

Please send completed form and a copy of lab results to: Davis County Health Department
FAX (801) 525-5210
Davis County Health Department 24/7 Disease Reporting Line (801) 525-5220