

Reported By \_\_\_\_\_ Date \_\_\_\_\_ E-mail \_\_\_\_\_  
Agency \_\_\_\_\_ Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

**PATIENT DEMOGRAPHIC DATA**

Last Name \_\_\_\_\_ First Name & MI \_\_\_\_\_  
Address \_\_\_\_\_ City, Zip code \_\_\_\_\_  
Home Phone ( ) -- Primary Language \_\_\_\_\_  
DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex M F  
Race/Ethnicity \_\_\_\_\_ Soc Sec Number \_\_\_\_\_  
Occupation/Work Place \_\_\_\_\_ Tel ( ) --  
School/Day Care Center \_\_\_\_\_ Tel ( ) --  
Parent/Contact Person \_\_\_\_\_ Tel ( ) --

**DISEASE DATA**

Date of Onset \_\_\_\_\_ **REPORTABLE DISEASE/ORGANISM** \_\_\_\_\_  
Species/serotype \_\_\_\_\_

Source of Specimen	Date of Collection	Diagnostic test and Result	Source of Specimen	Date of Collection	Diagnostic test and Result

**Symptoms** \_\_\_\_\_  
**Admission DX** \_\_\_\_\_  
**Discharge DX** \_\_\_\_\_

**HOSPITAL OR CLINIC DATA**

Hospital \_\_\_\_\_ Check all that apply/Date \_\_\_\_\_  
Medical Rec Number \_\_\_\_\_  Office/Clinic visit \_\_\_\_\_  
Physician/Clinic \_\_\_\_\_  ER/Outpatient \_\_\_\_\_  
Phone/Pager \_\_\_\_\_  Admission \_\_\_\_\_  
Hospital Transferred \_\_\_\_\_  Discharge \_\_\_\_\_  
To/From \_\_\_\_\_  Expired \_\_\_\_\_  
Transfer Date \_\_\_\_\_

**Comments/Patient History/Risk Factors**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

[Do NOT fax HIV/AIDS related patient information]

All STDs (gonorrhea, syphilis, chancroid, laboratory confirmed *Chlamydia trachomatis*, and AIDS/HIV) should be reported to:  

- STD Control, Houston Department of Health and Human Services (HDHHS)  
8000 North Stadium Dr. (77054), phone: (832) 393-5080.

Tuberculosis should be reported based on residence of case to:  

- Houston residents-HDHHS, 8000 North Stadium Dr. (77054)  
Phone: (832) 393-5173 fax: (832) 393-5247
- Harris County residents (outside Houston) HCPH, 2223 West Loop S. (77027) attention: TB Program  
Phone: (713) 439-6214 fax: (713) 439-6391