SNOHOMISH COUNTY HEALTH DEPARTMENT

Communicable Disease Surveillance & Response

COMMUNICABLE DISEASE REPORT FORM *(Except TB or STD)*

DATE OF REPORT	**DISEASE** (OR ANIMAL BITE TYPE)	**DATE ONSET OF SYMPTOMS**

PATIENT'S NAME LAST: FIRST: MI:	**DATE OF BIRTH** (month/day/year)	**PARENT NAME** **(if minor)** LAST: FIRST:	**GENDER** ☐ Male ☐ Female

PATIENT'S ADDRESS STREET: APT. #: CITY: ZIP:	**PHONE NUMBER** HOME: CELL: LANGUAGE (if not English): _____	**WAS PATIENT INFORMED OF DIAGNOSIS?** ☐ YES ☐ NO ☐ UNKNOWN

HEALTH CARE PROVIDER CLINIC/HOSPITAL: NAME: PHONE #:	**PERSON REPORTING** NAME: PHONE #:

ADDITIONAL INFORMATION – Please provide when possible to expedite investigation

Chief Symptoms/Complaints	**Treatment Given** Start Date: Medication: Dose: Duration:	**Hospitalization** Admission Date: Discharge Date: ER Visit Date:

Comments *(For animal bites, please include any known info about situation and animal owner)*

PLEASE <u>FAX</u> THIS FORM <u>ALONG WITH THE LAB RESULT</u> TO:

Snohomish County Health Department CD at 425.339.8706