New Jersey Department of Health

(For Submission to Local Health Department)

COMMUNICABLE DISEASE REPORT

(NOTE: Shaded areas are for Local Health Department Use Only.)

Name of Disease (Specify Organism)	Setting of Infection ☐Sporadic Case ☐Household Cluster ☐Institutional Cluster ☐Outbreak	State E No. **E-**	CDRS ID No.

Name of Patient *(Last)* *(First)* *(MI)*	Date of Birth _____ / _____ / _____ *Month* *Day* *Year*	Telephone Number ( )

Onset Date of Illness	Age	If <2 Years	Sex	Race	Ethnicity	Patient Pregnant?
_____ / _____ / _____	_____ Yrs.	_____ Mos.	☐M ☐F ☐Unk.	☐White ☐Black ☐Amer. Indian/Alaskan ☐Asian/Pacific Islander ☐Unknown ☐Other	☐Hispanic ☐Non-Hisp. ☐Unknown	☐Yes ☐No ☐Unknown

Mailing Address (Include Name of Institution, if Applicable) *(Street)* *(City)* *(Zip)* *(County)*	Residence Location, if Different	Municipality Code of Residence

Occupation/School/Day Care ☐Child Care Worker ☐Day Care Attendee ☐Health Care Worker ☐Student ☐Food Handler ☐Other:	Place of Occupation/School/Day Care Site

Hospital Inpatient?	Admission date	Hospital	Deceased?
☐Yes ☐No ☐Unknown	_____ / _____ / _____ *Month* *Day* *Year*	*(Name)* *(City)* *(State)*	☐Yes ☐No ☐Unknown

Treating Physician Name and Address, If Known	Telephone Number, If Known	Case Status
	( )	☐Possible ☐Probable ☐Confirmed

Has Patient Had Recent (in past 6 months):

A. Blood Transfusion? ☐Yes ☐No ☐Unknown B. Renal Dialysis? ☐Yes ☐No ☐Unknown

Was Travel Associated with Illness?	Country/State/County Visited	Date (Month/Day/Year) of Travel
☐Yes ☐No ☐Unknown		From: To:

For Vaccine-Preventable Disease, Was Patient Vaccinated?	If Vaccinated, Vaccine Used	Date of Immunization
☐Yes ☐No ☐Unknown		_____ / _____ / _____ *Month* *Day* *Year*

SUPPORTING LABORATORY RESULTS

☐No Specimens Collected ☐Results Pending (Specify): _____ ☐Unknown

☐CULTURE POSITIVE

Specimen Collection Date: _____ Organism: _____ LAB: _____

Specimen Source: ☐Blood ☐CSF ☐Stool ☐Other: _____

☐ANTIGEN TEST POSITIVE

(e.g. fluorescent antibody)

Specimen Collection Date: _____ Organism: _____ LAB: _____

Specimen Source: ☐Sputum ☐CSF ☐Urine ☐Other: _____

Test Done: ☐LA ☐FA ☐DNA ☐Other: _____

SEROLOGY / OTHER TESTS (Please specify test done)

Test Done	First Blood				Second Blood			
	Date	Pos.	Neg.	Titer	Date	Pos.	Neg.	Titer

Lab Performing Serology / Other Tests, if Known:

Supporting Clinical Information

Name of Person Submitting Report (Print)	Title	Telephone
		( )
Name of Reporting Health Officer Representative	**Name of Health Department**	**Date Initially Reported**
		_____ / _____ / _____ *Month* *Day* *Year*