

REPORTABLE DISEASE NOTIFICATION FORM

Fax completed form to Southwestern Public Health

St. Thomas Site: 519-631-1682

Woodstock Site: 519-539-6206

Confirmed Case
 Suspect/Probable Case
 New Report
 Update

DISEASE/DIAGNOSIS: _____

DATE & TIME OF REPORT: _____

REPORTED BY: Physician
 Hospital
 Lab
 Other: _____

REPORTING PERSON'S NAME & CONTACT INFORMATION: _____

PATIENT DEMOGRAPHIC INFORMATION

Patient Name (first, last): _____
 Date of Birth (yyyy/mm/dd): _____ Phone #: _____
 Address (street, city, postal code): _____
 Occupation: _____ Workplace: _____
 Emergency Contact: _____ Emergency Phone #: _____
 Family Physician: _____ Family Physician Phone #: _____

PATIENT LAB RESULTS (Please attach lab results, radiologist reports etc.)

Type of Specimen(s) Collected: _____ Date of Collection: _____
 Results: _____ Date of Results: _____
 Other Tests/Results: _____

PATIENT CLINICAL INFORMATION

Signs & Symptoms: _____ Onset Date(s): _____

Underlying Conditions & Other Relevant Risk Factors: _____ Treatment Details: _____

Emergency Room Visit: Yes No
 Hospitalization Required: Yes No
 Name of Hospital: _____ Admit Date/Discharge Date: _____
 Most Responsible Physician: _____