NC Electronic Disease Surveillance System

NC EDSS EVENT ID# _____

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

Public Health
HEALTH AND HUMAN SERVICES

Confidential Communicable Disease Report—Part 1

NAME OF DISEASE / CONDITION

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

Guilford County Dept. of Health and Human Services
Public Health Division
1100 East Wendover Ave
Greensboro, NC 27405
Tammy Koonce, BSN, RN 336-641-6500
Denise Smith, BSN, RN 336-641-5598
Website: www.guilfordcountync.gov
Email: tkoonce@guilfordcountync.gov or dsmith7@guilfordcountync.gov

Patient's Last Name | First | Middle | Suffix | Maiden/Other | Alias

Birthdate *(mm/dd/yyyy)* | **Sex** ☐M ☐F ☐Trans. | **Parent or Guardian** *(of minors)* | **Medical Record Number**

Patient's Street Address | **City** | **State** | **ZIP** | **County** | **Phone** (____) ____-____

Age _____ **Age Type** ☐Years ☐Months ☐Weeks ☐Days

Race (check all that apply): ☐White ☐Black/African American ☐American Indian/Alaska Native ☐Native Hawaiian or Pacific Islander ☐Asian ☐Other ☐Unknown

Ethnic Origin ☐Hispanic ☐Non-Hispanic

Was patient hospitalized for this disease? (>24 hours) ☐Yes ☐No Date / /

Did patient die from this disease? ☐Yes ☐No

Is the patient pregnant? ☐Yes ☐No

Patient is associated with (check all that apply):
- ☐ Child Care (child, household contact, or worker in child care)
- ☐ School (student or worker)
- ☐ College/University (student or worker)
- ☐ Food Service (food worker)
- ☐ Health Care (health care worker)
- ☐ Correctional Facility (inmate or worker)
- ☐ Long Term Care Facility (resident or worker)
- ☐ Military (active military, dependent, or recent retiree)
- ☐ Travel (outside continental United States in last 30 days)

In what geographic location was the patient MOST LIKELY exposed?
- ☐ In patient's county of residence
- ☐ Outside county, but within NC - County: _____
- ☐ Out of state - State/Territory: _____
- ☐ Out of USA - Country: _____
- ☐ Unknown

CLINICAL INFORMATION

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): / /
SPECIFY SYMPTOMS:

If a sexually transmitted disease, give specific treatment details

1. Date patient treated:(mm/dd/yyyy) _____
   Medication _____
   Dosage _____
   Duration _____
2. Date patient treated:(mm/dd/yyyy) _____
   Medication _____
   Dosage _____
   Duration _____

DIAGNOSTIC TESTING

Provide lab information below and fax copy of lab results and other pertinent records to local health department.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

Reporting Physician/Practice: _____
Contact Person/Title: _____
Phone: (____) ____-____ Fax:(____) ____-____

Health Care Provider for this disease (if not reporting physician): _____
Contact Person/Title: _____
Phone: (____) ____-____ Fax: (____) ____-____

LOCAL HEALTH DEPARTMENT USE ONLY

Initial Date of Report to Public Health: ____/____/____

Initial Source of Report to Public Health:
- ☐ **Health Care Provider (specify):**
  - ☐ Hospital
  - ☐ Private clinic/practice
  - ☐ Health Department
  - ☐ Correctional facility
- ☐ **Laboratory**
- ☐ **Other**

Is the patient part of an outbreak of this disease? ☐Yes ☐No

Outbreak setting: ☐ Household/Community (specify index case): _____
- ☐ Restaurant/Retail
- ☐ Child Care
- ☐ Long term care
- ☐ Healthcare setting
- ☐ Adult care home
- ☐ Assisted living facility
- ☐ Adult day care
- ☐ School
- ☐ Prison

Name of facility _____
Address of facility _____