IOWA DISEASE REPORTING CARD

FAX VERSION

Disease reporting is required by Iowa Administrative Code [641]-1 (139A)

Fax report to (515) 281-5698 or call (800) 362-2736

DISEASE AND LABORATORY INFORMATION

DISEASE/EVENT: _____ **Laboratory:** _____

Diagnosis date: / / **Lab city/state/zip:** _____

Onset date: / / **Collection date:** / /

Outcome: ☐Survived this illness ☐Died from this illness ☐Died unrelated to this illness ☐Unknown **Specimen source:** _____

Provider name: _____ **Lab test:** _____

Provider title: ☐ARNP ☐DO ☐MD ☐NP ☐PA **Result date:** / /

Facility name: _____ **Result:** ☐Positive/detected ☐Undetermined ☐Negative/undetected ☐Equivocal ☐Other: _____

Address: _____

Phone : ( ) - **City/State/Zip:** _____

Clinical sx: ☐Abdominal pain ☐Cough ☐Gland swelling ☐Sore throat ☐Anorexia ☐Diarrhea ☐Jaundice ☐Stiff neck ☐Bull's eye rash ☐Fever ☐Rash ☐Vomiting Other: _____

☐ **Specimen sent to UHL**

PATIENT INFORMATION

Name (last, first, middle): _____

Address: _____

City: _____ **County:** _____ **Zip:** _____

Long-term care resident: ☐Yes ☐No ☐Unk **Facility name:** _____

DOB: / / **Age:** _____ ☐Years ☐Months **Gender:** ☐M ☐F ☐Unk

Pregnant? ☐Yes ☐No ☐Unk **Due Date:** / /

Race: ☐White ☐Black or African American ☐American Indian or Alaska Native ☐Hawaiian or Pacific Islander ☐Asian ☐Unknown ☐Other

Marital status: ☐Single ☐Married ☐Widowed ☐Unknown ☐Divorced

Ethnicity: ☐Hispanic or Latino ☐Not Hispanic or Latino ☐Unknown

If minor, Parent name(s): _____

Phone: Home ( ) - Work ( ) - Other ( ) -

OCCUPATION INFORMATION

Job title: _____ **Facility name:** _____

Worked after symptom onset: ☐Yes ☐No ☐Unknown **Address:** _____

Handle food: ☐Yes ☐No ☐Unknown

Attend or provide child care: ☐Yes ☐No ☐Unknown **Zip code:** _____

Attend school: ☐Yes ☐No ☐Unknown

Work in a lab setting: ☐Yes ☐No ☐Unknown **City/State/County:** _____

Work in a health care setting: ☐Yes ☐No ☐Unknown

Direct patient care duties in lab or health care setting: ☐Yes ☐No ☐Unknown **Phone:** ( ) - Type: _____

Health care worker type:

HOSPITALIZATION INFORMATION

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown **Hospital:** _____

Admission date: / / **Discharge date:** / / ☐**Still hospitalized** **Days hospitalized:**

REPORTER INFORMATION

Reporter name: _____ **Reporter facility name:** _____

Reporter phone: _____ **Date reported to IDPH:** _____

Comments:

Revised 2/09