

County of Residence _____ Serial # _____ Date of Report ____/____/____

Patient Information

Patient's Name _____
Last First MI Maiden

Patient's Alias _____
Last First MI

Guardian's Name _____
Last First MI

Patient's Date of Birth ____/____/____ Patient's Age _____ Patient's Country of Birth _____

Patient's Primary Phone No. (____) _____ - _____ Patient's Secondary Phone No. (____) _____ - _____

Patient's Physical Address _____
Number & Street City Zip Code

Patient's Mailing Address (if different) _____
City Zip Code

Occupation (works at) <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Student/School <input type="checkbox"/> Inmate <input type="checkbox"/> Correction Worker <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Setting (resides/attends) <input type="checkbox"/> Day Care Facility <input type="checkbox"/> Health Care Facility <input type="checkbox"/> School <input type="checkbox"/> Jail/Prison <input type="checkbox"/> Camp <input type="checkbox"/> Homeless <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Race (Check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Amer. Indian /Alaskan <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/ Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
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Is Patient Alive? Yes No Unknown If No, Date of Death ____/____/____

Disease _____ Site of Infection _____

Date of First Symptom: ____/____/____ Date of Diagnosis ____/____/____

Hospitalized? Yes No Unknown

Name of Hospital _____ Medical Record No. _____

Admission Date ____/____/____ Discharge Date ____/____/____

Reporter Information

Reporting Individual _____ Telephone (____) _____ - _____

Address _____

Reporting Source MD Lab Hospital ICN School Nurse Public Health Nurse Other Local Health Department
 Other State Health Dept Other _____ Unknown

Provider Name _____ Provider Telephone (____) _____ - _____

Testing Laboratory _____ Laboratory Telephone (____) _____ - _____

Comments

Include applicable laboratory data, treatment, recent travel, etc. _____

For Local Health Department Use

Outbreak Related <input type="checkbox"/> Sporadic <input type="checkbox"/> Cluster <input type="checkbox"/> Outbreak <input type="checkbox"/> Unknown	Case Status <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Suspect <input type="checkbox"/> Unknown	Local Health Department Signature _____ Date Form Received ____/____/____ Investigation Start Date ____/____/____	Was Patient Notified? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis	Cyclosporiasis	Hospital associated infections (as defined in section 2.2 10NYCRR)	Poliomyelitis	Streptococcal infection (invasive disease) ⁵
Amebiasis	Diphtheria	Influenza, laboratory-confirmed	Psittacosis	Group A beta-hemolytic strep
Animal bites for which rabies prophylaxis is given¹	E.coli O157:H7 infection ⁴	Legionellosis	Q Fever²	Group B strep
Anthrax²	Ehrlichiosis	Listeriosis	Rabies¹	Streptococcus pneumoniae
Arboviral infection³	Encephalitis	Lyme disease	Respiratory syncytial virus (RSV) laboratory-confirmed	Syphilis, specify stage⁷
Babesiosis	Foodborne Illness	Lymphogranuloma venereum	Respiratory syncytial virus (RSV) pediatric fatalities	Tetanus
Botulism²	Giardiasis	Malaria	Rocky Mountain spotted fever	Toxic shock syndrome
Brucellosis²	Glanders²	Measles	Rubella	Transmissible spongiform encephalopathies ⁸ (TSE)
Campylobacteriosis	Gonococcal infection	Melioidosis²	(including congenital rubella syndrome)	Trichinosis
Chancroid	Haemophilus influenzae ⁵ (invasive disease)	Meningitis	Salmonellosis	Tuberculosis current disease (specify site)
Chlamydia trachomatis infection	Hantavirus disease	Aseptic or viral	Shigatoxin-producing E.coli ⁴ (STEC)	Tularemia²
Cholera	Hemolytic uremic syndrome	Haemophilus	Shigellosis ⁴	Typhoid
Coronavirus	Hepatitis A	Meningococcal	Smallpox²	Vaccinia disease⁹
COVID-19 (SARS CoV-2)	Hepatitis A in a food handler	Other (specify type)	Staphylococcus aureus ⁶ (due to strains showing reduced susceptibility or resistance to vancomycin)	Varicella (not shingles)
Severe Acute Respiratory Syndrome (SARS)	Hepatitis B (specify acute or chronic)	Meningococcemia	Staphylococcal enterotoxin B poisoning²	Vibriosis ⁶
Middle East Respiratory Syndrome (MERS)	Hepatitis C (specify acute or chronic)	Mpox		Viral hemorrhagic fever²
Cryptosporidiosis	Pregnant hepatitis B carrier	Mumps		Yersiniosis
	Herpes infection, infants aged 60 days or younger	Pertussis		
		Plague²		

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides.

Contact Person **Communicable Disease Nurse**

Name Seneca County Health Department

Address 2465 Bonadent Drive, Suite 3
Waterloo, NY 13165

Phone (315) 539-1920 Fax (315) 539-9493

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Report all other diseases promptly to county health department where individual resides.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in **bold type** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS (Stage 3) are reportable on the Medical Provider HIV/AIDS and Partner/Contact Report Form DOH-4189. The form may be obtained by contacting:**
Division of Epidemiology, Evaluation and Partner Services
P.O. Box 2073, ESP Station
Albany, NY 12220-2073
(518) 474-4284
In NYC: New York City Department of Health and Mental Hygiene
For HIV/AIDS reporting, call: (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test $\geq 1:16$ or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinal encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting, call your local health department or the New York State Department of Health Bureau of Communicable Disease Control at (518) 473-4439 or (866) 881-2809 after hours. In New York City, 1 (866) NYC-DOH1.

PLEASE POST THIS CONSPICUOUSLY