This form may be used to ***report suspected cases and cases of notifiable conditions*** in Texas, as listed on the current *TexasNotifiable Conditions List* (http://www.dshs.state.tx.us/idcu/investigation/conditions). In addition, ***any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported*** *by the most expeditious means available.* You may be contacted to further investigate this Infectious Disease Report.

Report cases to Williamson County & Cities Health District by faxing this form to (512) 248-3267 secure e-mail to epi@wilco.org or calling (512) 943-3660

REPORTING FACILITY INFORMATION		
Reporter Name	**Date Reported**	**Reporter Phone**
Healthcare Provider Name	**Provider Address**	**Provider Phone**

PATIENT INFORMATION			
Last Name	**First Name**	**Phone** (Primary)	**Phone** (Secondary)
Date of Birth	**Age**	**Sex** ☐ Male ☐ Female	**Ethnicity** ☐ Hispanic ☐ Not Hispanic
Race ☐ White ☐ Black ☐ Unknown ☐ Asian ☐ Other			
Address	**City**	**State**	**Zip Code**
County			
CLINICAL INFORMATION			
Disease or Condition	**Illness Onset Date**		
Test Name/Type	**Date of Collection**	**Specimen Source** ☐ Blood ☐ Throat ☐ Urine ☐ Nose ☐ Stool ☐ Other _______	**Result** (attach copy)

PATIENT INFORMATION			
Last Name	**First Name**	**Phone** (Primary)	**Phone** (Secondary)
Date of Birth	**Age**	**Sex** ☐ Male ☐ Female	**Ethnicity** ☐ Hispanic ☐ Not Hispanic
Race ☐ White ☐ Black ☐ Unknown ☐ Asian ☐ Other			
Address	**City**	**State**	**Zip Code**
County			
CLINICAL INFORMATION			
Disease or Condition	**Illness Onset Date**		
Test Name/Type	**Date of Collection**	**Specimen Source** ☐ Blood ☐ Throat ☐ Urine ☐ Nose ☐ Stool ☐ Other _______	**Result** (attach copy)

PATIENT INFORMATION			
Last Name	**First Name**	**Phone** (Primary)	**Phone** (Secondary)
Date of Birth	**Age**	**Sex** ☐ Male ☐ Female	**Ethnicity** ☐ Hispanic ☐ Not Hispanic
Race ☐ White ☐ Black ☐ Unknown ☐ Asian ☐ Other			
Address	**City**	**State**	**Zip Code**
County			
CLINICAL INFORMATION			
Disease or Condition	**Illness Onset Date**		
Test Name/Type	**Date of Collection**	**Specimen Source** ☐ Blood ☐ Throat ☐ Urine ☐ Nose ☐ Stool ☐ Other _______	**Result** (attach copy)