Division of Preparedness, Response, Infectious Disease and EMS
3 Capitol Hill – Room 106
Providence, RI 02908

INFECTIOUS DISEASE CASE REPORT FORM

(For Lyme disease, HIV/AIDS, STDs, and TB use disease-specific form)

To report or request forms:
Office: (401) 222-2577
After hours: (401) 276-8046
Fax: (401) 222-2488
www.health.ri.gov/diseases/for/providers

PATIENT INFORMATION *Required*

NAME (Last, First) | ADDRESS (Street & No.)

CITY/TOWN | COUNTY | STATE | ZIP | PHONE

DATE OF BIRTH _____/_____/_____ | AGE | SEX ☐Male ☐Female ☐Unknown | ETHNICITY ☐Hispanic ☐Non-Hispanic ☐Unknown

RACE ☐American Indian or Alaska Native ☐Asian ☐Black or African-American ☐Caucasian or White ☐Native Hawaiian or Other Pacific Islander ☐Other ☐Unknown

OCCUPATION ☐Resident of Long-Term Care Facility ☐Food Handler ☐Daycare Worker/Attendee ☐Healthcare Worker ☐Student

NAME OF EMPLOYER/SCHOOL/DAYCARE/INSTITUTION ETC.

Pregnant? ☐Y ☐N ☐UNK

Hospitalized? ☐Y ☐N ☐UNK
If yes, Facility:________________________ Admit Date: _____/_____/_____ Days Stayed: _____

Travel in 30 days before illness onset? ☐Y ☐N ☐UNK *If yes*, Location:_________________ Dates: _____/_____/_____ - _____/_____/_____

DISEASE INFORMATION *Required*

DISEASE/ORGANISM

PLEASE ATTACH ALL RELEVANT LAB DATA

Date of Illness Onset: _____/_____/_____
☐Asymptomatic

SIGNS/SYMPTOMS

DISEASE-SPECIFIC IMMUNIZATIONS (Name and Date)
___________________________________ _____/_____/_____
___________________________________ _____/_____/_____

TREATMENT
_____________________________ Dose:________ Duration:______
_____________________________ Dose:________ Duration:______

Underlying medical conditions? ☐Y ☐N ☐UNK
If yes, specify:____

COMMENTS

VARICELLA SPECIFIC

Rash present:☐Y ☐N *If yes*, Onset: _____/_____/_____ Location:__________________

Past history of varicella? ☐Y ☐N ☐UNK

Number of lesions: ☐<50 ☐50-249 ☐250-500 ☐>5000

Lesion Type (check all that apply) ☐Macules #: ☐Papules #: ☐Vesicles #:

Lab confirmed (attach lab report)? ☐Y ☐N

Has individual been vaccinated? ☐Y ☐N ☐UNK *If yes*, date(s): _____/_____/_____
_____/_____/_____

HEPATITIS SPECIFIC

RISK FACTORS: Sexual Partner(s) (check all that apply): ☐F ☐M ☐Other ☐None ☐UNK
Pregnancy Status: ☐Y ☐N ☐Sexual partner is pregnant ☐UNK

History of IV drug use? ☐Y ☐N ☐UNK

HEPATITIS A, B, AND C LAB RESULTS (Leave blank ONLY if not done)

	Positive/ Detected	Negative/ Undetected	Ind.	Coll. Date		Positive/ Detected	Negative/ Undetected	Ind.	Coll. Date
Hep A IgM	☐	☐	☐		HBsAg	☐	☐	☐	
anti-HCV	☐	☐	☐		IgM anti-HBc	☐	☐	☐	
HCV Genotype __________________					HBeAg	☐	☐	☐	
HCV NAT (qual)	☐	☐	☐		HBV NAT (qual)	☐	☐	☐	
HCV NAT (quant)	☐ ui/mL __________________	☐	☐		HBV NAT (quant)	☐ ui/mL __________________	☐	☐	

AST Date: _____/_____/_____	ALT Date: _____/_____/_____	Bilirubin Date: _____/_____/_____
AST Result:	ALT: Result:	Bilirubin Result:

HEALTHCARE PROVIDER REPORTING INFORMATION *Required*

REPORTED BY | REPORT DATE

ORDERING PROVIDER | FACILITY NAME

CITY/TOWN | STATE | ZIP | PHONE | FAX