New Jersey Department of Health
(For Submission to Local Health Department)

COMMUNICABLE DISEASE REPORT

(NOTE: Shaded areas are for Local Health Department Use Only.)

Name of Disease (Specify Organism)	Setting of Infection ☐ Sporadic Case ☐ Household Cluster ☐ Institutional Cluster ☐ Outbreak	State E No. E-	CDRS ID No.

Name of Patient (Last) (First) (MI)	Date of Birth ___ / ___ / ___ (Month / Day / Year)	Telephone Number ( )

Onset Date of Illness ___ / ___ / ___	Age ___ Yrs.	If <2 Years ___ Mos.	Sex ☐M ☐F ☐Unk.	Race ☐White ☐Black ☐Amer. Indian/Alaskan ☐Asian/Pacific Islander ☐Unknown ☐Other	Ethnicity ☐Hispanic ☐Non-Hisp. ☐Unknown	Patient Pregnant? ☐Yes ☐No ☐Unknown

Mailing Address (Include Name of Institution, If Applicable) (Street) (City) (Zip) (County)	Residence Location, If Different	Municipality Code of Residence

Occupation/School/Day Care ☐Child Care Worker ☐Day Care Attendee ☐Health Care Worker ☐Student ☐Food Handler ☐Other:	Place of Occupation/School/Day Care Site

Hospital Inpatient? ☐Yes ☐No ☐Unknown	Admission date ___ / ___ / ___ (Month / Day / Year)	Hospital (Name) (City) (State)	Deceased? ☐Yes ☐No ☐Unknown

Treating Physician Name and Address, If Known	Telephone Number, If Known ( )	Case Status ☐Possible ☐Probable ☐Confirmed

Has Patient Had Recent (in past 6 months):
A. Blood Transfusion? ☐Yes ☐No ☐Unknown B. Renal Dialysis? ☐Yes ☐No ☐Unknown

Was Travel Associated with Illness? ☐Yes ☐No ☐Unknown	Country/State/County Visited	Date (Month/Day/Year) of Travel From: To:

For Vaccine-Preventable Disease, Was Patient Vaccinated? ☐Yes ☐No ☐Unknown	If Vaccinated, Vaccine Used	Date of Immunization ___ / ___ / ___ (Month / Day / Year)

SUPPORTING LABORATORY RESULTS

☐No Specimens Collected ☐Results Pending (Specify): _____ ☐Unknown

☐CULTURE POSITIVE
Specimen Collection Date: _____ Organism: _____ LAB: _____
Specimen Source: ☐Blood ☐CSF ☐Stool ☐Other: _____

☐ANTIGEN TEST POSITIVE
(e.g. fluorescent antibody)
Specimen Collection Date: _____ Organism: _____ LAB: _____
Specimen Source: ☐Sputum ☐CSF ☐Urine ☐Other: _____
Test Done: ☐LA ☐FA ☐DNA ☐Other: _____

SEROLOGY / OTHER TESTS (Please specify test done)

Test Done	First Blood				Second Blood			
	Date	Pos.	Neg.	Titer	Date	Pos.	Neg.	Titer

Lab Performing Serology / Other Tests, If Known:

Supporting Clinical Information

Name of Person Submitting Report (Print)	Title	Telephone ( )

Name of Reporting Health Officer Representative	Name of Health Department	Date Initially Reported ___ / ___ / ___ (Month / Day / Year)

CDS-1 AUG 12