

Spokane Regional Health District
 Communicable Disease Report
 (Not to be used for reporting of STDs or HIV)
 FAX: 509.324.3623



Date of Report _____

NECESSARY INFORMATION FOR REPORTING – please complete top section before faxing to SRHD			
PATIENT'S NAME _____ (LAST) (FIRST) (MI)	DATE OF BIRTH _____ (MM) (DD) (YYYY)	RACE <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Other <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> American Indian / Alaska Native	SEX <input type="checkbox"/> M <input type="checkbox"/> F
PATIENT'S ADDRESS Street _____ Apt. # _____ City _____ State _____ Zip _____ Phone (H) _____ (W) _____ Parent's Name _____ Phone _____ Name of School, Daycare or Employment _____ Is this person a: <input type="checkbox"/> Food handler <input type="checkbox"/> Health care worker <input type="checkbox"/> Day care worker <input type="checkbox"/> Day care attendee		ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	DISEASE _____
		DATE OF ONSET _____	DIAGNOSIS (check one) <input type="checkbox"/> Clinical <input type="checkbox"/> Lab confirmed
NAME OF ATTENDING HEALTH CARE PROVIDER _____		PERSON REPORTING Name/Title _____ Address _____ Phone _____	
HEALTH CARE PROVIDER PHONE NUMBER _____			

ADDITIONAL INFORMATION – please provide where possible to expedite investigation				
Date collected, Source of specimen & Laboratory Test Results	Treatment Given	Chief symptoms/complaints		
Laboratory Name Phone Number _____	Possible Source of Infection	Comments		
24 hr CD report line 509.324.1449	CD FAX line 509.324.3623	TB Clinic 509.324.1614	State CD report line 877.539.4344	Spokane Regional Health District Epidemiology – Room #360 1101 W. College Avenue Spokane, WA 99201-2095

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