NOTIFIABLE DISEASE/CONDITION REPORT FORM
NORTH CENTRAL PUBLIC HEALTH DISTRICT

419 East 7th St, The Dalles, OR 97058
Phone: 541-506-2600 Fax: 541-506-2601

Public Health
Prevent. Promote. Protect.

Patient Information

Patient Name:_____ **Date of Birth:**____/____/____

Street:_____ City:_____ State:____ Zip:_____

Patient's Phone:_____ Other patient phone:_____

Preferred Language: ☐ English ☐ Spanish ☐ Other:_____

Sex: ☐ Male ☐ Female ☐ Other:_____ ***Can attach demographics if preferred*

Pregnant? ☐ Yes EDD ____/____/____ ☐ No

Diagnostic Information

Diagnosis: _____

☐ Clinical Dx or Suspect only **OR** ☐ Lab Confirmed **Specimen date:** ____/____/____

Signs/Symptoms: _____Symptom Onset: ____/____/____

Patient Notified of Results? ☐ Yes ☐ No

Hospitalized? ☐ Yes ☐ No Name of Hospital: _____

Admit Date: ____/____/____ Discharge Date: ____/____/____

Treatment Information

If sexually transmitted disease, give specific treatment details.

Date patient treated:____/____/____

Medication(s):_____

Dosage:_____ Duration:_____

Treatment provided for partner? ☐ Yes ☐ No

Details:_____

Reporter Information

Reporter Name:_____ Phone: _____

Reporting Facility:_____ City, State, Zip: _____

Provider Name:_____ Phone: _____

FAX COMPLETED REPORT TO 541-506-2601

NOTE: Attaching lab results will expedite processing.

Please call 541-506-2600 if you have any questions about the reporting process or requirements.