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

Patient Information

Patients Name
Last Name:______________________________________ First Name:_____________________________ MI:_________

Patients Address
Street:____ City:____________________ State:____ Zip:____________
Patient's Phone #:________________________________ Patient's Work #:_______________________________
Date of Birth:________/________/________ Age:________

County
☐ Wasco ☐ Gilliam ☐ Sherman ☐ Hood River ☐ Klickitat ☐ Other_______________________

Occupation	**Sex**	**Pregnant**
________________________ *Write in*	☐ Male ☐ Female ☐ Unknown	☐ Yes ☐ No EDD ___/___/___

Clinical Information

Signs/Symptoms:
____
____

Clinical Diagnosis/Suspect Dx:
____

Illness Onset Date:
_____/_____/_____

Date of Diagnosis:
_____/_____/_____

Was Patient Notified:
☐ Yes
☐ No

Hospitalized:
☐ Yes Name of Hospital: ____________________________________
☐ No Admit Date: ___/___/___ Discharge Date: ___/___/___
☐ Unknown

Treatment:
____
____

If sexually transmitted disease, give specific treatment details:
Date patient treated:____/____/____
Medication(s):____
____
Dosage:____
Duration:____

Reporter Information

Date Reported to Health Department: _____/_____/_____
Reporting Individual:____ Phone Number:_____________________
Reporting Source:
☐ MD ☐ Lab ☐ Nurse ☐ Other:____

Provider Name:____ Provider Telephone:______________________
Testing Laboratory: ☐ MCMC ☐ Quest ☐ Interpath ☐ Labcorp ☐ Other_______________________

FAX COMPLETED REPORT TO 541-506-2601.