CONTRA COSTA
HEALTH SERVICES

Contra Costa Public Health
(925) 313-6740
FAX: (925) 313-6465

Unusual Disease Case History Form

REQUIRED INFORMATION

IMPORTANT NOTE: *Physicians and/or healthcare providers need to report the suspect case by telephone to Contra Costa Public Health at (925) 313-6740.*

Suspected Disease: _____

Patient Demographics

Last Name: _____ First Name: _____ Suffix: ____

DOB: ____ /____ / _____ Gender: ☐Male ☐Female Phone #: _____

Address: _____ City: _____ Zip Code: _____

Healthcare Provider

Reporting Health Care Provider: _____

Reporting Health Care Facility: _____

Address: _____ City: _____

Phone #: _____ Fax #: _____

Significant Medical History:

Symptom Onset: ___/____/_____ ☐ N/A (MM/DD/YYYY)	**Evaluation Date:** ____/____/_____ (MM/DD/YYYY)

Pregnant: ☐Yes ☐No ☐Unknown ☐N/A	**Estimated Delivery Date:** ____/____/_____ (MM/DD/YYYY)

General Clinical Findings:
☐Fever_____◦F
☐Generalized aches
☐Malaise
☐Headache
☐Chills
☐Joint aches/stiffness
☐Conjunctivitis
☐Rash/ Lesion(s) (origin, direction, progression, etc.):
_____

GI Findings:
☐Bloody diarrhea
☐Diarrhea
☐Vomiting
☐Nausea
☐Hepatitis
☐Other: _____

Central Nervous System Findings:
☐Encephalitis
☐Meningitis

Respiratory Findings:
☐Coryza
☐Cough
☐Bronchiolitis/ Bronchitis
☐Pneumonia
☐ARDS (acute respiratory distress syndrome)
☐Other: _____

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Gastroenteritis
□ Individual Case □ Outbreak (describe below):
_____
_____

Key Hospital Dates:

Admission Date: ___/____/_____ (MM/DD/YYYY)	**ICU Adm. Date** ___/____/_____ (MM/DD/YYYY)
Discharge Date: ____/____/_____ (MM/DD/YYYY)	**Death Date:** ___/____/_____ (MM/DD/YYYY)

Current Status (check all that apply):
□Sent Home
via following transportation method:
□ private car □taxi □bus □unknown
□Emergency Department
□Hospitalization (≥24 hours)
□ICU
□Intubated
□Deceased

Vaccination History (Vaccine Preventable Diseases):
Patient vaccinated for disease? □Yes □No □Unknown
If yes, how many doses of vaccine received?
□One □Two □Three
If yes, dates of vaccinations:
Dose 1: ____/____/_____
Dose 2: ____/____/_____
Dose 3: ____/____/_____
Possible vaccine response □Yes □No □Unknown

If patient is <6 months old was mom vaccinated?
□Yes □No □Unknown

Epidemiologic Links
(known exposures during the incubation period):
Contact to Known Case: □Yes □No
If yes, details: _____
_____
Travel: □International □Domestic □N/A
Details (Location(s) & Dates): _____
_____
_____
_____
_____

REPORT SUSPECT CASE BY TELEPHONE TO PUBLIC HEALTH AT (925) 313-6740 AND OBTAIN APPROVAL FOR LAB TESTING AT REFERENCE LABORATORY.
THEN,
FAX THIS FORM TO PUBLIC HEALTH AT (925) 313-6465 AND ATTACH COPY TO SPECIMEN REQUISTION FORM (cchealth.org/laboratory) FOR SUBMITTAL TO PUBLIC HEALTH LABORATORY

02/2016