

ACUTE & COMMUNICABLE DISEASE CASE REPORT

Information for completing this form on reverse side

DEMOGRAPHIC DATA PATIENT INFORMATION	Case Identification for all Category I and II Diseases						
	Patient's Name (Last) (First) (M.I.)		Date of Birth (mm/dd/yyyy)	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
	Patient's Address		Telephone No. (Home) (Work)				
	City	State	Zip Code	County of Residence			
	Patient's Parent / Guardian if patient is a minor (Not needed for STD)		Patient's Employer & Occupation or School, Day Care, Institution				
	Race: <input type="checkbox"/> Asian (or Pacific Islander) <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other, specify:			Ethnic Origin: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			
MORBIDITY DATA	Patient pregnant? If Yes, Due date (mm/dd/yy) <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient died of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No		Patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Disease / Organism	Date of Onset <input type="checkbox"/> Asymptomatic	Specimen type	Outbreak related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Underlying medical condition? <input type="checkbox"/> Unknown <input type="checkbox"/> Yes, specify: <input type="checkbox"/> No		
Test or Immunization. Include confirmatory lab data / immunization dates:			Date (mm/dd/yyyy)	Results (Hep B and C see below)			
SEXUALLY TRANSMITTED DISEASES	Complete appropriate section for specific disease(s)						
	<input type="checkbox"/> Syphilis		<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia		<input type="checkbox"/> Other STD		
	<input type="checkbox"/> Primary (chancere present) <input type="checkbox"/> Secondary (skin lesions, rash, etc.) <input type="checkbox"/> Early Latent (asymptomatic, < 1 yr) <input type="checkbox"/> Late Latent (over 1 yr duration) <input type="checkbox"/> Neurosyphilis <input type="checkbox"/> Cardiovascular <input type="checkbox"/> Other <input type="checkbox"/> Congenital		<input type="checkbox"/> Asymptomatic <input type="checkbox"/> Uncomplicated Urogenital (Urethritis, Cervicitis) <input type="checkbox"/> Salpingitis (PID) <input type="checkbox"/> Ophthalmia/Conjunctivitis <input type="checkbox"/> Other (Arthritis, skin lesions, etc.) <input type="checkbox"/> Resistant Gonorrhea <input type="checkbox"/> Penicillinase-Producing <input type="checkbox"/> Other		<input type="checkbox"/> Chancroid <input type="checkbox"/> Primary genital herpes infection <input type="checkbox"/> Other STD Salpingitis (PID)		
	Has patient been treated? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date(s) of Treatment (mm/dd/yyyy)				
ENTERIC DISEASES AND HEPATITIS	Amebiasis, Campylobacter, Cryptosporidia, E. coli, Giardia, Hepatitis A, Salmonella, Shigella, and Yersinia			Hepatitis B and C Laboratory Results			
	Check below if patient: Yes No Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> is a food handler. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> attends or works at a day care center. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> is a health care worker. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> is in contact with animals. Specify animal: _____ <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> drinks unpasteurized milk. <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> travelled out-of-state. Location / dates: _____			HBsAg <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HBs <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HBc <input type="checkbox"/> Positive <input type="checkbox"/> Negative anti-HBc-IgM <input type="checkbox"/> Positive <input type="checkbox"/> Negative HepC-EIA <input type="checkbox"/> Positive <input type="checkbox"/> Negative HepC-RIBA <input type="checkbox"/> Positive <input type="checkbox"/> Negative HepC-PCR <input type="checkbox"/> Positive <input type="checkbox"/> Negative			
TUBERCULOSIS	Mycobacteriology		X-ray		Mantoux Tuberculin Test	Treatment	
	Specimen type and date collected (mm/dd/yyyy)		<input type="checkbox"/> Not done <input type="checkbox"/> No comparison film available <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Date: _____		<input type="checkbox"/> Not Done Date Done (mm/dd/yyyy)	<input type="checkbox"/> Isoniazid <input type="checkbox"/> Rifampin <input type="checkbox"/> Pyrazinamide <input type="checkbox"/> Ethambutol <input type="checkbox"/> Other, specify: _____	
	Smear <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not done		Check one: <input type="checkbox"/> Stable <input type="checkbox"/> Cavitory <input type="checkbox"/> Worsening <input type="checkbox"/> Noncavitory		Result (w / mm induration) <input type="checkbox"/> Positive _____ mm <input type="checkbox"/> Negative _____ mm		Date started (mm/dd/yyyy)
	Culture <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending <input type="checkbox"/> Not done		Report Date (mm/dd/yyyy)		If negative, anergic? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If culture positive <input type="checkbox"/> <i>M. tuberculosis</i> complex <input type="checkbox"/> Atypical Mycobacteria, Specify: _____		Previously diagnosed with TB <input type="checkbox"/> Yes, Year: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown		Patient's country of origin		Date arrived in U.S.	
WEEKLY REPORTABLE & COMMENTS	Weekly Reportable Diseases Category II (Saturday through Friday)		Varicella (Chickenpox) Number of cases: _____		Week ending / Date (mm/dd/yyyy) : _____		
	Comments:				Date rec'd by LHD	Date sent to DPH	
REPORTING SOURCE (REQUIRED)	Agency Reporting (Name & Address)		Date reported	Telephone No. ()			
	Attending Physician (Name & Address)		Interviewer Initials	Date of Interview			

Information for Completing ACUTE AND COMMUNICABLE DISEASE CASE REPORT

WISCONSIN STATUTE CHAPTER 252.05 AND ADMINISTRATIVE RULE CHAPTER HFS 145 REQUIRE REPORTING OF COMMUNICABLE DISEASES.

Persons required to report include any person licensed under ch. 441 and 448, Wis. Stats., or any other person having knowledge that a person has a communicable disease such as:

- A person in charge of infection control at a health care facility
- School nurses, principals of schools and day care center directors
- Laboratory directors

For further information see Wisconsin Administrative Rule HFS 145.

Diseases listed under categories I, II are to be reported to the local city or county health officer located in the local public health department of the patient's place of residence. The category III disease must be reported directly to the state epidemiologist. Complete Demographic and Morbidity Data for diseases in categories I, II, and III. For diseases preceded by an asterisk (*), give vaccination history. Follow-up epidemiologic information may be requested by local or state public health officials. Complete "Reporting Source" for ALL categories. Send copy "A" and copy "B" to the local health officer. Copy "C" may be retained with the patient's record.

REPORT THE FOLLOWING DISEASES TO YOUR LOCAL HEALTH AGENCY

CATEGORY I:

The following diseases are of urgent health importance and shall be reported **IMMEDIATELY BY TELEPHONE** to the patient's local health officer upon identification of a case or suspected case. Complete and mail an Acute and Communicable Disease Case Report (DPH 4151) to the local health officer within 24 hours. Public health intervention is expected as indicated. See s. HFS 145.04 (3) (a).

Anthrax ^{1,4,5}	Foodborne or waterborne outbreaks ^{1,2,3,4}	*Hepatitis A ^{1,2,3,4,5}	Plague ^{1,4,5}	Rubella (congenital syndrome) ^{1,2,5}
Botulism ^{1,4}		Hantavirus ^{1,2,4,5}	*Poliomyelitis ^{1,4,5}	Smallpox ^{1,4,5}
Botulism, infant ^{1,2,4,5}	* <i>Haemophilus influenzae</i> invasive disease, (including epiglottitis) ^{1,2,3,5}	*Measles ^{1,2,3,4,5}	Rabies (human) ^{1,4,5}	Tuberculosis ^{1,2,3,4,5}
Cholera ^{1,3,4,5}		Meningococcal disease ^{1,2,3,4,5}	Ricin toxin ^{4,5}	Yellow Fever ^{1,4}
*Diphtheria ^{1,3,4,5}		Pertussis (whooping cough) ^{1,2,3,4,5}	*Rubella ^{1,2,4,5}	

CATEGORY II:

The following diseases shall be reported to the local health officer on an Acute and Communicable Disease Case Report (DPH 4151) or by other means within 72 hours of the identification of a case or suspect case. Public health intervention is expected as indicated. See s. HFS 145.04 (3) (b).

Amebiasis ^{1,3,4}	*Hepatitis B ^{1,2,3,4,5}	Psittacosis ^{1,2,4}	Streptococcus group B invasive disease ^{1,5}
Arboviral infection (encephalitis/meningitis) ^{1,2,4}	Hepatitis C ^{1,2}	Q fever ^{4,5}	<i>Streptococcus pneumoniae</i> (pneumococcus) invasive disease ²
Babesiosis ^{4,5}	Hepatitis non-A, non-B, (acute) ^{1,2}	Reye syndrome ²	*Tetanus ^{1,2}
Blastomycosis ⁵	Hepatitis D ^{2,3,4,5}	Rheumatic fever (newly diagnosed and meeting the Jones criteria) ⁵	Toxic shock syndrome ^{1,2}
Brucellosis ⁴	Hepatitis E ^{3,4}	Rocky Mountain spotted fever ^{1,2,4,5}	Toxic substance related diseases: Infant methemoglobinemia
Campylobacter ^{3,4}	Histoplasmosis ⁵	Salmonellosis ^{1,3,4}	Lead intoxication (specify Pb levels)
Cat Scratch Disease (Bartonella species) ⁵	Kawasaki disease ²	Sexually transmitted diseases: Chancroid ^{1,2,4,5}	Other metal and pesticide poisonings
Cryptosporidiosis ^{1,2,3,4}	Legionellosis ^{1,2,4}	<i>Chlamydia trachomatis</i> infection ^{1,2,4,5}	Toxoplasmosis ^{1,2,4}
Cyclosporiasis ^{1,4,5}	Leptospirosis ⁴	Genital herpes infection (1 st episode identified by health provider) ²	Trichinosis ^{1,2,4}
<i>E. coli</i> 0157:H7 ^{1,2,3,4} and other enterohemorrhagic <i>E. coli</i> , enteropathogenic <i>E. coli</i> , enteroinvasive <i>E. coli</i> enterotoxigenic <i>E. coli</i> ^{1,2,3,4}	Lyme disease ^{1,2}	Gonorrhea ^{1,2,4,5}	Tularemia ^{1,4}
Encephalitis, viral (other than arboviral)	Malaria ^{1,2,4}	Pelvic inflammatory disease ^{1,2,5}	Typhoid fever ^{1,2,3,4}
Ehrlichiosis ^{1,5}	Meningitis, bacterial (other than <i>Haemophilus influenzae</i> or meningococcal) ^{2,5}	Syphilis ^{1,2,5}	Typhus fever ^{4,5}
Giardiasis ^{3,4}	Meningitis, viral (other than arboviral)	Shigellosis ^{1,3,4}	Varicella (chickenpox) – report by number of cases only
Hemolytic uremic syndrome ^{1,2,4}	*Mumps ^{1,2,4,5}	Streptococcus group A invasive disease ^{1,5}	Yersiniosis ^{3,4}
	Mycobacterial disease (nontuberculous)		

For diseases preceded by an asterisk (*), give vaccination history.

Also report any suspected outbreaks of other acute or occupationally-related diseases

CATEGORY III:

The following diseases shall be reported to the state epidemiologist on an AIDS case report (DPH 4264) or a Wisconsin Human Immunodeficiency Virus (HIV) Infection Confidential Case Report (DPH 4338) or by other means within 72 hours after identification of a case or suspected case. See s. 252.15 (7) (b), Stats., and s. HFS 145.04 (3) (b).

Acquired Immune Deficiency Syndrome (AIDS)^{1,2,4}
Human immunodeficiency virus (HIV) infection^{2,4}
CD4+ T-lymphocyte <200/uL, or CD4+ T-lymphocyte percentage of total lymphocytes <14

KEY:

- ¹Infectious diseases designated as notifiable at the national level.
- ²Wisconsin or CDC follow-up form is required. Local health departments have templates of these forms in the Epinet manual.
- ³High-risk assessment by local health department is needed to determine if patient or member of patient's household is employed in food handling, day care or health care.
- ⁴Source investigation by local health department is needed.
- ⁵Immediate treatment is recommended, i.e., antibiotic or biologic for the patient or contact or both.