



NOTIFIABLE DISEASE/CONDITION REPORT FORM

To report a disease to Deschutes County Health Services, please complete the information below

Patient Information	
Patient Name: _____	Date of Birth: ____ / ____ / ____
Patient's Street: _____	City: _____ State: ____ Zip: ____
Patient's Phone: _____	Other patient phone: _____
Preferred Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____	<i>**Can attach demographics if preferred</i>
Pregnant? <input type="checkbox"/> No <input type="checkbox"/> Yes – EDD: ____ / ____ / ____	
Diagnostic Information	
Diagnosis: _____	
<input type="checkbox"/> Clinical Dx or Suspect only OR <input type="checkbox"/> Lab Confirmed –	Specimen date: ____ / ____ / ____
Signs/Symptoms: _____	Symptom onset: ____ / ____ / ____
Patient Notified of Results? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes – Name of Hospital: _____	
Admit Date: ____ / ____ / ____	Discharge Date: ____ / ____ / ____
Treatment Information	
If sexually transmitted disease, give specific treatment details.	
Date patient treated: ____ / ____ / ____	Treatment provided for partner? <input type="checkbox"/> Yes <input type="checkbox"/> No
Medication(s): _____	
Dosage: _____	Duration: _____
Details: _____	
Reporter Information	
Reporter Name: _____	Phone: _____
Reporting Facility: _____	City, State, Zip: _____
Provider Name: _____	Phone: _____
FAX COMPLETED REPORT TO (541) 322-7618	
NOTE: Attaching lab results will expedite processing.	
Please call (541) 322-7418 if you have any questions about the reporting process or requirements.	