Nebraska Department of Health and Human Services
Division of Public Health

Cert.#__________

REPORTABLE DISEASES, POISONINGS AND ORGANISMS

Health Care Provider Confidential Communication

Provider Info.

Person Reporting:

Week Ending

Clinic/Institution:

Address/Box #

Fax #

Phone #

Town:

State

Zip Code

Patient Information

For Physician and Hospital Reporting

Today's Date ____________________ Attending Physician ____________________ Date of Onsent ____________________

Patient's Name: (Last) ____________________ (First) ____________________ (MI) ________

If <19, Parent's Name: (Last) ____________________ (First) ____________________ (MI) ________

Address: City/Town ____________________ County ____________________ State ____________________ Zip ________

Age:______ DOB:________________ Race ❑ White ❑ Black ❑ Am Indian ❑ Asian or Pacific Islander

Sex: ❑ Male ❑ Female Ethnicity ❑ Hispanic ❑ Non-Hispanic

Phone_______________ Marital Status ❑ Single ❑ Married ❑ Other

Disease: Staus: ❑ Case ❑ Suspected Case ❑ Asympt. Carrier

Check all of the following that apply

❑ Patient was hospitalized.

❑ Patient has contact with children in day care.

❑ Suspected food or waterborne illness.

❑ Patient died as a result of this illness.

❑ Patient is a foodhandler.

❑ Patient is part of an outbreak.

❑ Blood level test result________µg/dL

Treatment (drug, dosage, route, administration)

❑ **I request additional report forms. Please send __________ copies.**

Submit To: Nebraska Department of Health and Human Services
Division of Public Health
Communicable Disease
P.O Box 95026
Lincoln, Nebraska 68509-5026

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