

Enteric Disease Reporting Form

This form can be used to report Amebiasis, *Campylobacter* spp., *Cryptosporidium* spp., *Cyclospora* spp., *E. coli* infection, *Giardia*, *Listeria* spp., *Salmonella* spp., *Shigella* spp., Trichinosis, *Vibrio* spp., *Yersinia* spp.

› Disease Specific Information

Disease Name: _____ Onset date: _____ Reporting date: ___/___/___

› Patient Demographic Information

Last Name: _____ First Name: _____ Middle Name: _____

Date of birth: ___/___/___ Patient age: _____ Medical record #: _____

Preferred Language: English Other: _____

Country of birth: United States Other: _____ Unknown

Gender: Male Female Transgender Unknown

Address: _____ County: _____

City: _____ State: _____ Zip: _____ Address unknown Homeless

Phone: _____ Alternate phone: _____

Occupation: _____ Parent/guardian name: _____

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino Unknown

Race (check all that apply): American Indian/Alaskan Native Asian Native Hawaiian/Pacific Islander White

Black/African American Unknown Other: _____

› Hospital/Clinic Information

Reporter name: _____ Reporting institution: _____

Ordering provider: _____ Provider phone: _____

Lab: _____ Lab phone: _____

Who should MDH contact if additional information is needed:

Reporter Provider Lab Other: _____

Specimen collection date: _____ Specimen source: _____

Lab result date: _____

Hospitalized: Yes No Unknown If yes, admit date: ___/___/___ Discharge date: ___/___/___

Hospital name: _____

Patient status at time of reporting: Alive Dead Date of death: _____

Pregnant (if applicable): Yes No If yes, due date: ___/___/___

› Foodborne Disease Specific Information

Foodhandler: Yes No Unknown If yes, restaurant name: _____

Childcare attendee/worker: Yes No Unknown If yes, childcare center name: _____

Antibiotics prescribed: Yes No Unknown If yes, antibiotic name: _____

Antibiotic treatment date: ___/___/___

Did the patient travel outside the United States one week prior to illness onset: Yes No Unknown

Did the patient develop hemolytic uremic syndrome (HUS): Yes No Unknown (If yes, please complete HUS form)