ERIE COUNTY DEPARTMENT OF HEALTH

General Communicable Disease Referral
Phone: 814-451-6711 FAX: 814-451-6767

Disease/Condition: _____

Reported By: _____ Agency: _____ Phone: _____

PATIENT INFORMATION

Name: _____ DOB: _____ Sex: _____

Race: _____ Ethnicity: _____ Age: _____ Pregnant: ☐Y ☐ N EDC: _____

Parent/Guardian: _____

Address: _____

Phone: _____ Work/Cell/Alternate phone: _____

Insurance: _____

Employer/Occupation: _____

School/Grade: _____

If Long Term Care Facility: Total # Residents_____ Total # Employees_____ Total # Other Staff_____

PHYSICIAN INFORMATION

Physician Name: _____Phone: _____

LABORATORY INFORMATION

Lab Name: _____

Source of Specimen: _____ Date Collected: _____ Date Final: _____

Results: _____

OTHER

Onset of Illness: Date_____ Time_____

Duration of Illness: Date_____ Time_____

Symptoms: _____ Still sick? ☐ Y ☐ N

Treatment: _____

EPI INVESTIGATION

Contact to Known Case: Name-_____

Anyone Besides Client Sick? Y / N Name(s): _____

Suspect or Common Source of Infection: _____

COMMENTS

_____

_____

_____

_____

ECDH Use Only:
Intake Nurse: _____ Date: _____