2020 SC DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL DISEASE REPORTING FORM

Disease reporting is required by SC Code of Laws Section 44-29-10, 44-53-1380, 44-1-110, and 44-1-140 and Regulation 61-20.
See other side for list of reportable diseases.
Federal HIPAA legislation allows disclosure of protected health information, without consent of the individual, to public health authorities for the purpose of preventing or controlling disease. (45 CFR §164.512)

Disease/Condition (include stage, if appropriate): _____ Today's Date_____

Last Name _____ First Name _____ Middle Name _____

Patient ID or last five digits of SSN: _____ DOB: _____/_____/_____

Street Address _____

City _____ State _____ Zip _____ County _____

Preferred Contact Number ( ) _____-_____ ☐ Home ☐ Cell ☐ Work

Ethnicity
☐ Hispanic
☐ Non-Hispanic
☐ Unknown

Sex at Birth
☐ Male
☐ Female
☐ Unknown

Current Gender Identity
☐ Male
☐ Female
☐ Male to Female
☐ Female to Male

If female, pregnant?
☐ Yes ☐ No ☐ Unknown
Expected Due Date: _____
Expected delivery Hospital: _____

Race
☐ American Indian/ Alaskan Native
☐ Black
☐ Pacific Islander
☐ Asian
☐ White
☐ Unknown

Date of diagnosis/bite: _____/_____/_____

Date of symptom onset: _____/_____/_____

Symptoms:

	Y	N	UNK
Hospitalized	☐	☐	☐
Emergency Room	☐	☐	☐
Died	☐	☐	☐

Date of Death: _____/_____/_____

Treated: ☐ Yes ☐ No ☐ Unk
Date: _____/_____/_____
Rx: _____

For Rabies PEP:
Animal species: _____
Initial date of administration: / /

If hospitalized, complete: Hospital Name | Admit Date | Discharge Date

LABORATORY INFORMATION * *Report Hepatitis in Viral Hepatitis box* below

Specimen Collection Date	Result Date	Lab Test Name (ex. Culture, IFA, IGM, PCR, Susceptibility)	Specimen Source (ex. Stool, Blood, CSF) Lead: specify venous or cap	Result (ex. +/-, titer)	Species/Serotype
		BD veritor SARS-CoV-2 nucleocapsid antigen	nasal swab		

PATIENT STATUS

	Y	N	UNK
In childcare	☐	☐	☐
Food handler	☐	☐	☐
Healthcare worker	☐	☐	☐
Daycare Worker	☐	☐	☐
Nursing home or other chronic care facility	☐	☐	☐
Incarcerated/detainee	☐	☐	☐
Outbreak related	☐	☐	☐
Travel in last 4 weeks	☐	☐	☐
Other:			

***VIRAL HEPATITIS TEST RESULTS** Specimen collection date: _____/_____/_____
ALT _____ AST _____ Result date: _____/_____/_____

Jaundice: ☐ Yes ☐ No

		Pos	Neg	UNK
Hepatitis A	Total anti-HAV	☐	☐	☐
	IgM anti-HAV	☐	☐	☐
Hepatitis B	HBsAg	☐	☐	☐
	HBV NAT (PCR)	☐	☐	☐
	HBeAg	☐	☐	☐
	IgM anti-HBc	☐	☐	☐
				Value:_____
Hepatitis C	HCV RNA (PCR)	☐	☐	☐
	HCV antibody (EIA)	☐	☐	☐
	HCV Rapid Ab test	☐	☐	☐
				Value:_____

REPORTER INFORMATION

Reporting lab/facility: My Pharmacy
Reporting facility address: 808 Hwy 378 Ste B Lexington, SC 29072
Reporter name: Christopher Munnerlyn, PHARMD
Reporter telephone: (803) 756 - 3460
Performing lab name: My Pharmacy
Ordering physician name: Christopher Munnerlyn, PHARMD
Physician phone: (803) 756 - 3460

RISK FACTORS: (Circle all that apply)

Close contact (type: sex, household other)
Dialysis
Drug Use (type: injection, non-injection)
Homelessness
Men who Have Sex with Men
Multiple Sex Partners
Occupational blood exposure
Organ Transplant
Piercing
Sex with HIV+ Partner
Surgery/Dental
Tattoo
Travel (US or outside US)

Comments:

Mail or Call Reports:

Reporting required by attending physician/designee and laboratory except where lab only (L) reporting is indicated.