

Wyoming Department of Health - Confidential Disease Report

A report is required by state law from **both** the attending health care provider/hospital **and** the laboratory performing diagnostic testing. Information will be held in confidence and will be used for public health epidemiological purposes only.

Patient Information

Send Reports To:

Last Name:	First Name: Gender M F
Address:	City: State: Zip:
Phone: (Home) Phone: (Work)	Date of Birth: Age:
Occupation:	Hispanic:
☐ White ☐ Black ☐ Asian	American Indian/Alaskan Native Pacific Islander
Unknown Other	
Provider and Laboratory Information	
Disease:	Laboratory Findings:
Specimen Source: Onset Date:	Specimen Collection Date: Result Date:
Laboratory Name:	
Physician: Phon	ne: Physician City:
Physician Institution/Clinic:	
Person Reporting:	Phone:
Was Patient Hospitalized? Yes No Unknown	Where?
If Yes, Admission Date:	Discharge Date:
Check All That Apply: Healthcare Worker	Food Service Worker Daycare Worker/Attendee
Name of Facility:	
Treatment:	Pregnant: Yes No Unknown
If this is a report of an STD, were any partners provided treatment? Yes No Number:	
Other Comments:	

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Secure Fax: (307) 777-5573 / Phone: (307) 777-7953 Epidemiology Section Toll-Free, 24 Hour Hotline: 1-888-996-9104 Thank You for Your Cooperation With Disease Reporting!!!