



**Public Health**  
Prevent. Promote. Protect.

**Panhandle Health District**

# Panhandle Health District

Serving Benewah, Bonner, Boundary, Kootenai, and Shoshone Counties

## Public Health COVID-19 FAX Report Form

**24-hour COVID-19 Fax Report Line: 208-601-6129**

Only fax POSITIVE test results to PHD; aggregate testing numbers should be reported to [EpiMail@dhw.idaho.gov](mailto:EpiMail@dhw.idaho.gov).

Fax each form individually. Include a copy of lab results, if applicable.

Laboratories and health care providers are required to report infectious diseases, conditions, or syndromes listed on Idaho's reportable disease list to the local public health authority. Reportable disease reporting to the Panhandle Health District (a public health authority) is in compliance with HIPAA confidentiality regulations.

<b>Reportable Disease, Condition, or Organism:</b> <b>SARS-CoV-2 (COVID-19)</b>		<input type="checkbox"/> <b>Clinical Dx</b> <input type="checkbox"/> <b>+ Lab Result</b> <input type="checkbox"/> Antigen <input type="checkbox"/> PCR	<b>Onset Date:</b> (If known) ____/____/____	<b>Test Date:</b> (If known)	<b>Report Date:</b>
<b>Patient's Name:</b> _____ Last                                  First                                  M.I.			<b>Date of Birth:</b> ____/____/____		<input type="checkbox"/> <b>Male</b> <input type="checkbox"/> <b>Female</b>
<b>Patient's Address:</b> _____ Street                                  City                                  State                                  Zip				<b>If female, is patient pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
<b>Race:</b> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Asian <input type="checkbox"/> Am. Indian/Alaskan Native <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____			<b>Ethnicity:</b> <input type="checkbox"/> Non-hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown		
<b>Name of Parent or Guardian if Minor:</b> Guardian _____			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/>		<b>Has patient been notified?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<b>Patient's Telephone #:</b> Home/Cell: _____ Work: _____		<b>Patient Treated?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Treatment Date: _____/_____/_____ Treatment Regimen: Unknown		<b>Case is:</b> <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/>	
<b>Health Care Provider Name:</b>			<b>Telephone:</b>		
<b>Laboratory Name:</b>			<b>Telephone:</b>		
<b>Facility Name:</b>			<b>Telephone:</b>		

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