Eastern Idaho Public Health
Prevent. Promote. Protect.

Please Print Clearly

Notifiable Disease: **Date:**

Patient Information

Name: _____

DOB: _____

Sex: _____

Phone Number: _____

Address: *Street City State Zip County*_____

Race: _____

Ethnicity: _____

Reporting Institution

Performing Facility: _____ **Ordering Provider:** _____

Performing Facility Phone: _____ **Ordering Provider Phone:** _____

Performing Facility Address: _____ **Ordering Provider Address:** _____

Laboratory Information

***Please fax lab report with this document**

Type of Test: _____ **Source:** _____

Collection Date: _____ **Result:** _____

Performed Date: _____ **Accession Number:** _____

Please attach a copy of the lab result with this form and fax to EIPH at (208) 533-3143.