



2024 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 Sex at Birth Current Gender Identity

- | | | |
|---------------------------------------|----------------------------------|---|
| <input type="checkbox"/> Hispanic | <input type="checkbox"/> Male | <input type="checkbox"/> Male |
| <input type="checkbox"/> Non-Hispanic | <input type="checkbox"/> Female | <input type="checkbox"/> Female |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Unknown | <input type="checkbox"/> Male to Female |
| | | <input type="checkbox"/> Female to Male |

If female, pregnant?

- Yes No Unknown

Expected Due Date: _____

Expected delivery Hospital: _____

Race

- | | |
|--|----------------------------------|
| <input type="checkbox"/> American Indian/ Alaskan Native | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Black | <input type="checkbox"/> White |
| <input type="checkbox"/> Pacific Islander | <input type="checkbox"/> Unknown |

Date of diagnosis/bite: ____/____/____

Date of symptom onset: ____/____/____

Symptoms: _____

	Y	N	UNK
Hospitalized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Died	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ICU	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date of Death: ____/____/____

Treated: Yes No Unk

Date: ____/____/____

Rx: _____

If hospitalized, complete: Hospital Name Admit Date Discharge Date

LABORATORY INFORMATION

* Report Hepatitis in Viral Hepatitis box below

First Test	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
Y N UNK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
Y N UNK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						
Y N UNK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>						

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: _____

Reporting facility address: _____

Reporter name: _____

Reporter telephone: () _____ - _____

Performing lab name: _____

Ordering physician name: _____

Physician phone: () _____ - _____

RISK FACTORS: (Check all that apply)

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

Comments: _____

Mail or Call Reports: _____

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Report IMMEDIATELY By Phone	Report Within 24 Hours By Phone		
<p>! Any case that may be caused by chemical, biological, or radiological threat, novel infectious agent, or any cluster of cases, or outbreak of a disease or condition that might pose a substantial risk of human morbidity or mortality (1) (2)</p>	<ul style="list-style-type: none"> ✘ Anthrax (<i>Bacillus anthracis</i>) (2) ✘ Botulism (<i>Clostridium botulinum</i> or Botulinum toxin) Influenza, avian or other novel Measles (Rubeola) Meningococcal disease (2) (4) (8) (12) ✘ Plague (2) (<i>Yersinia pestis</i>) Poliomyelitis, Paralytic and Nonparalytic Rabies, human ✘ Smallpox (Variola) ✘ Viral Hemorrhagic Fever (e.g. Ebola, Lassa, Marburg viruses) 	<ul style="list-style-type: none"> Animal (mammal) bites ✘ Brucellosis (2) <i>Candida auris</i> or suspected (2) (3) Chikungunya (2) Ciguatera Dengue (<i>Flavivirus</i>) (2) Diphtheria (2) Eastern Equine Encephalitis (EEE) (2) <i>Escherichia coli</i>, Shiga toxin-producing (STEC) (2) <i>Haemophilus influenzae</i>, all types, invasive disease (<i>Hf lu</i>) (2) (4) (8) Hantavirus (2) Hemolytic uremic syndrome (HUS), post- diarrheal Hepatitis (acute) A, B, C, D, & E (9) Influenza associated deaths (all ages) LaCrosse Encephalitis (LAC) (2) Malaria (2) Mpox (positive, negative, and all other results) Mumps 	<ul style="list-style-type: none"> Pertussis ✘ Q fever (<i>Coxiella burnetii</i>) Rubella (includes congenital) Shiga toxin positive (2) <i>Staphylococcus aureus</i>, vancomycin- resistant or intermediate with a VA >8 MIC (VRSA/VISA) (2) (4) (13) St. Louis Encephalitis (SLE) (2) Syphilis, congenital, primary or secondary (lesion or rash) or Darkfield positive (16) Tuberculosis (2) (18) Tularemia (2) ✘ Typhoid fever (<i>Salmonella Typhi</i>) (2) (4) ✘ Typhus, epidemic (<i>Rickettsia prowazekii</i>) Varicella Vibrio - all types, including <i>V. cholerae</i> O1 & O139 (2) West Nile Virus (2) Yellow Fever (<i>Flavivirus</i>) Zika (2)

Report Within 3 Days

<ul style="list-style-type: none"> Anaplasmosis Babesiosis Campylobacteriosis (2) Carbapenem-resistant <i>Enterobacteriales</i> (CRE) and <i>Acinetobacter</i> species (2) (4) (5) Carbapenem-resistant <i>Pseudomonas</i> spp. (CRPA) (2) (4) (6) Chancroid Chlamydia trachomatis Coronavirus Disease 2019 (COVID-19) (7) Cryptosporidiosis Cyclosporiasis (2) Ehrlichiosis Giardiasis Gonorrhea (4) Hepatitis (chronic) B, C, & D (9) 	<ul style="list-style-type: none"> Hepatitis B Surface Antigen+ w/each pregnancy HIV and AIDS clinical diagnosis HIV exposed infants (all results, positive and negative) HIV 1/2 AB/AG+ and/or detectable viral load with each pregnancy HIV CD4 test (all CD4 T lymphocyte results) (L) HIV subtype, genotype, and phenotype (L) HIV 1/2 Antibody and Antigen (rapid) HIV 1/2 AB/AG (confirmatory tests, +/-) (L) HIV viral load (all results detectable and undetectable) (L) Influenza <ul style="list-style-type: none"> • Lab-confirmed cases (eg. culture, RT-PCR, DFA, Molecular assay) (10) • Influenza associated hospitalizations (10) 	<ul style="list-style-type: none"> Lead tests, all results – indicate venous or capillary specimen (11) Legionellosis Leprosy (Hansen’s Disease) Leptospirosis Listeriosis (2) Lyme disease Lymphogranuloma venereum Psittacosis Salmonellosis (2) (4) Shigellosis (2) (4) 	<ul style="list-style-type: none"> Spotted Fever Rickettsiosis Streptococcus group A, invasive disease (GAS) (4) (8) (14) <i>Streptococcus pneumoniae</i>, invasive (pneumococcal) (4) (8) (15) Syphilis, early latent, latent, tertiary or positive serologic test (17) Tetanus Tuberculosis test - Positive Interferon Gamma Release Assays (IGRAs): QuantiFERON-TB Gold Plus (QFT-Plus) and T-SPOT.TB (18) (L) Toxic Shock (specify staph. or strep.) Yersiniosis (<i>Yersinia</i>, not <i>pestis</i>)
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✘ Potential Agent of Bioterrorism (L) Only laboratories are required to report.
 For notes 1–7, see complete list of reportable diseases at <https://scdhec.gov/health-professionals/south-carolina-list-reportable-conditions>

HOW TO REPORT

<p>HIV, AIDS, and STDs (excluding Hepatitis): Do not fax HIV, AIDs or STD results to DHEC Submit electronically via SCIONx (preferred); or Mail to: Division of Surveillance, Assessment, and Evaluation Mills/Jarrett Complex 2100 Bull Street, Columbia SC 29201; or Call 1-800-277-0873</p>	<p>LEAD: Submit electronically via SCIONx; or Email: scionlead@dhec.sc.gov to establish electronic reporting; or Mail to: Lead Surveillance Mills/Jarrett Complex 2100 Bull Street, Columbia, SC 29201; or Fax Lead reports to (803) 898-3236</p>	<p>POTENTIAL RABIES EXPOSURE: Fill out and submit the D-1799 Animal Incident Report Form within 24 hours online at https://www.scdhec.gov/rabies. For questions & concerns, call 1-888-847-0902. (option 2)</p>
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HOW TO REPORT TUBERCULOSIS

<p>Lowcountry Berkeley, Charleston, Dorchester Office: (843) 719-4612 Fax: (843) 308-0324</p>	<p>Midlands Chester, Kershaw, Lancaster, Newberry, Saluda, York Office: (803) 909-7358 Fax: (803) 327-9847</p>	<p>Pee Dee Dillon, Georgetown, Horry, Marion Office: (843) 915-8798 Fax: (843) 915-6504</p>	<p>Upstate Cherokee, Oconee, Pickens, Spartanburg, Union Office: (864) 596-2227 ext. 108 Fax: (864) 596-3340</p>
<p>Allendale, Bamberg, Beaufort, Calhoun, Colleton, Hampton, Jasper, Orangeburg Office: (843) 549-1516 ext. 222 Fax: (843) 308-0324</p>	<p>Aiken, Barnwell, Edgefield, Fairfield, Lexington, Richland Office: (803) 576-2870 Fax: (803) 576-2880</p>	<p>Chesterfield, Clarendon, Darlington, Florence, Lee, Marlboro, Sumter, Williamsburg Office: (843) 673-6693 Fax: (843) 673-6670</p>	<p>Abbeville, Anderson, Greenwood, Greenville, Laurens, McCormick Office: (864) 372-3198 Fax: (864) 282-4294</p>

Nights/Weekends/Holidays: (803) 898-0558 **Fax:** (803) 898-0685

TO REPORT ALL OTHER CONDITIONS: Contact the health department office in the region in which the patient resides. (See reportable list for contact info)

DHEC Bureau of Disease Control
 Division of Acute Disease Epidemiology
 2100 Bull St · Columbia, SC 29201
 Phone: (803) 898-0861 · Fax: (803) 898-0897 Nights/Weekends: 1-888-847-0902

For information on reportable conditions and daytime & after-hours phone numbers, see scdhec.gov/health-professionals/south-carolina-list-reportable-conditions
 To learn about DHEC’s web-based reporting system, call 1-800-917-2093.

Instructions for Completing DHEC 1129 - Disease Reporting Form

Purpose: To report diseases and positive laboratory tests designated as reportable by DHEC's Director in accordance with Section 61-20 of the Rules and Regulations of the state of South Carolina.

Item by Item Instructions:

Explanation and Definition: The reporter must complete all items on the front of the form. Reportable diseases are listed on the reverse side of the form.

Disease/Condition - Enter the disease diagnosed and the complete diagnosis. Enter the stage of the disease, if appropriate.

Today's Date - Enter the date that the form is completed.

Patient Name - Enter the last name, first name and middle name of the patient.

Patient ID or SSN - Enter the patient ID number or the last five digits of the SSN if available.

Date of Birth - Enter the numerical month, day, and year of birth.

Street Address - Enter the street address of the patient's residence.

City, State, Zip - Enter the city, state, and zip code where the patient resides.

County - Enter the county where the patient resides.

Preferred Contact Number - Enter the area code and phone number of the patient. Select whether the preferred number is a home, cellular, or work telephone number.

Ethnicity - Check the appropriate box for the ethnicity of the patient.

Sex at Birth - Check the appropriate box for the sex of the patient at birth.

Current Gender Identity - Check the appropriate box for the patient's current gender identity.

Pregnant - Check the appropriate box (yes, no, unknown) for "if female, pregnant", depending on the patient's pregnancy status.

Race - Check the appropriate box(es) for the race of the patient.

Date of Diagnosis/Bite - Enter the date of diagnosis. If animal bite, enter the date of the bite.

Date of Symptom Onset - If patient has symptoms, enter the month, day and year the symptoms of the disease appeared.

Symptoms - Enter patient symptoms if applicable.

Hospitalized/Emergency Room/Died - Check yes, no, or unknown for patient hospitalization status, emergency room visit status, and death status.

Date of Death - If patient died, enter numerical month, day, and year of death.

Treated - Check the appropriate box for whether the patient was treated. Date - If patient was treated, enter date treatment was received by patient. Rx - Enter treatment received by patient.

For Rabies PEP - If rabies post-exposure prophylaxis (PEP) was administered following a bite, enter the species of animal and the numerical date the first dose of PEP was administered.

Hospitalized - If patient was hospitalized enter hospital name, admit date, and discharge date.

First Test - If patient has been tested for coronavirus disease 2019 (COVID-19), check the appropriate box.

Specimen Collection Date - Enter month, day, and year specimen was collected.

Result Date - Enter date of lab result.

Lab Test Name - Enter type of test.

Specimen Source - Enter the specimen source, as appropriate. Result - Enter any laboratory results that support the diagnosis.

Species/Serotype - Enter species or serotype if applicable.

Patient Status - Check the appropriate box for whether the patient was in childcare, was a food handler, was a healthcare worker, was a daycare worker, was in a nursing home or other chronic care facility, was a prisoner or detainee, was a part of an outbreak, or traveled during the previous four weeks. Use the space next to "other" for additional information pertinent to patient status, for example, where patient traveled.

Viral Hepatitis Test Results (Specimen Collection Date) - Enter month, day, and year specimen was collected for hepatitis testing.

ALT, AST, Result Date - Enter any liver enzyme results and date of test.

Jaundice - Check appropriate box for presence of jaundice.

Hepatitis Results - Check box for appropriate test results if the patient has been tested for hepatitis A, B, or C. Enter value for HCV RNA, if applicable.

Reporting Laboratory/Facility - Enter the name of the reporting laboratory or facility.

Reporting Facility Address - Enter the address of the reporting laboratory or facility.

Reporter Name - Enter the name of the person reporting.

Reporter Telephone - Enter the phone number of the person who completed the DHEC 1129 form.

Performing Lab Name - Enter name of lab which performed the test.

Ordering Physician Name - Enter the name of the ordering physician.

Physician Phone - Enter the phone number of the ordering physician.

Comments - Enter any additional information deemed pertinent.

Risk Factors - Check all of the Risk Factors that apply.

Mail or Call Reports To - The regional/county health department phone number and address to which private providers should call/send reports are entered or stamped in this space.

Side Two

List of reportable diseases or conditions and the timeframes for reporting to DHEC and instructions for how/where to report.

Office Mechanics/Filing-

The reporting person will submit these forms to the regional/county health department or enter this information electronically. Depending on the disease reported on the form, 1) the county health department or DHEC Central Office will enter the information in the electronic reporting system (SCION), or 2) the county health department will forward the forms to the appropriate Division in DHEC's Bureau of Communicable Disease Prevention and Control in Columbia. The completed forms will be filed and retained for six months after the calendar year. The forms will then be destroyed.