



Acute Communicable Disease Control  
 313 N. Figueroa St., Rm. 212, Los Angeles, CA 90012  
 213-240-7941 (phone) 213-482-4856 (facsimile)  
 www.lapublichealth.org/acd

## PATIENT INFORMATION

Patient Name - Last	First	Middle	Date of Birth	IRIS Incident ID
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**During the exposure and infectious periods (from 50 days before until 7 days after jaundice or symptom onset, if not jaundice):**  
**If additional space is needed to record any named locations, comment in REMARKS section or on a separate page.**

Did the patient work for or volunteer at a place that serves homeless persons?  Yes  No  Unknown

Did they work in food service (preparing, serving, cleaning)?  Yes  No  Unknown

If Yes to either question above,

Specify Location Name & Address: \_\_\_\_\_

Describe role and duties? \_\_\_\_\_

Dates worked? \_\_\_\_\_

Where did the patient use the bathroom? (check all that apply and list specific locations/cross streets)

- Public bathroom    
  Portable restroom (porta-potty)    
  Outside (alley, street, etc.)  
 Shelter    
  Institution    
  Other: Specify. \_\_\_\_\_

Name	Address/Cross Streets	Type of Facility	Date(s)	Did this location have...	
				A sink?	Soap?
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk

Did the patient use public transportation?  Yes  No  Unknown

If Yes, what modes (taxi/uber, bus, train)? (check all that apply)  Taxi, Uber, Lyft, etc.  Bus  Train

If Bus or Train, what locations travelled during the infectious period?

Bus or Train?	Location	Date(s)

Patient Name (Last, First) \_\_\_\_\_ Date of Birth \_\_\_\_\_ IRIS ID: \_\_\_\_\_

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**During the INFECTIOUS PERIOD (from 14 days before until 7 days after jaundice or symptom onset, if not jaundice):**  
***If additional space is needed to record any named locations, comment in REMARKS section or on a separate page.***

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What restaurants/food establishments did the patient visit during the infectious period?

Restaurant/Location Name	Location (Address, City)	Date(s)

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**REMARKS** *(Please record any additional locations reported and/or additional case notes.)*

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Investigator's name (print)	Investigator's signature	Date	Telephone number
Health District	Supervisor signature	Area Medical Director's signature	

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