



SOUTH CAROLINA
DEPARTMENT OF
PUBLIC HEALTH

2026 SC DEPARTMENT OF PUBLIC HEALTH DISEASE REPORTING FORM

Disease reporting is required by SC Code of Laws Section 44-29-10, 44-1-112 and Regulation 60-20.

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:																																			
Full Name (last, first, middle):		Patient ID or last five digits of SSN:			Date of Birth:																																
Street Address:		City:	State:	Zip Code:	County:																																
Preferred Contact Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work																																					
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		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																																			
Sex at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown			Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Male to Female <input type="checkbox"/> Female to Male																																		
If female, pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Expected Due Date:		Expected Delivery Hospital:																																	
Date of Diagnosis/Bite:			Symptoms:																																		
Date of Symptom Onset:																																					
Treated: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date Treated:		Rx:																																	
Hospitalized: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			Died: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Date of Death:																																
Emergency Room: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			ICU: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown																																		
If hospitalized, complete ►		Hospital Name:		Admitted 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																															
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK																																					
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK																																					
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK																																					
PATIENT STATUS			* VIRAL HEPATITIS TEST RESULTS																																		
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: <hr/>	<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>Y</td><td>N</td><td>UNK</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>			Y	N	UNK																												Specimen Collection Date:		Result Date:	
				Y	N	UNK																															
ALT:		AST:		Jaundice: <input type="checkbox"/> Yes <input type="checkbox"/> No																																	
Hepatitis A Total anti-HAV IgM anti-HAV Hepatitis B HBsAg HBV NAT (PCR) HBeAg IgM anti-HBc Hepatitis C HCV RNA (PCR) HCV antibody (EIA) HCV Rapid Ab test		<table border="1" style="margin-left: auto; margin-right: auto;"> <tr><td>Pos</td><td>Neg</td><td>UNK</td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>		Pos	Neg	UNK																									► Value: _____						
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REPORTER INFORMATION			RISK FACTORS (check all that apply):																																		
Reporting Lab/Facility: _____			<input type="checkbox"/> Close Contact (sex, household, etc.) <input type="checkbox"/> Occupational Blood Exposure <input type="checkbox"/> Surgery/Dental <input type="checkbox"/> Dialysis <input type="checkbox"/> Exposure <input type="checkbox"/> Tattoo <input type="checkbox"/> Drug Use (injection, non-injection) <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Travel (US or outside US) <input type="checkbox"/> Homelessness <input type="checkbox"/> Piercing <input type="checkbox"/> Men Who Have Sex With Men <input type="checkbox"/> Sex with HIV+ Partner <input type="checkbox"/> Multiple Sex Partners																																		
Reporting Facility Address: _____																																					
Reporter Name: _____																																					
Reporter Phone Number: (_____) _____ - _____																																					
Performing Lab Name: _____																																					
Ordering Physician Name: _____																																					
Physician Phone Number: (_____) _____ - _____																																					
Comments:			Mail or Call Reports:																																		

2026 SC DEPARTMENT OF PUBLIC HEALTH DISEASE REPORTING FORM

Report IMMEDIATELY By Phone		Report Within 24 Hours By Phone	
Unusual occurrence of disease of public health concern (1) OR case, cluster, or outbreak of disease that poses a potential public health threat. <ul style="list-style-type: none"> ¶ Anthrax (<i>Bacillus anthracis</i>) (3) ¶ Botulism (<i>Clostridium botulinum</i> or Botulinum toxin) Influenza, zoonotic or novel Measles (Rubeola) (13) Meningococcal disease (3) (5) (9) (14) ¶ Plague (<i>Yersinia pestis</i>) (3) Poliovirus (Poliomyelitis and non-paralytic poliovirus infection) Rabies, human ¶ Smallpox (Variola) ¶ Viral Hemorrhagic Fever (e.g. Ebola, Lassa, Marburg viruses) 	<ul style="list-style-type: none"> Animal (mammal) bites and potential rabies exposure ¶ Brucellosis (3) <i>Candida auris</i> or suspected (3) (4) Chikungunya (3) Ciguatera Dengue (<i>Flavivirus</i>) (3) Diphtheria (3) Eastern Equine Encephalitis (EEE) (3) <i>Escherichia coli</i>, Shiga toxin-producing (STEC) (3) <i>Haemophilus influenzae</i>, all types, invasive disease (H flu) (3) (5) (9) Hantavirus (3) Hemolytic uremic syndrome (HUS), post-diarrheal Hepatitis (acute) A, B, C, D, & E (10) Influenza associated deaths (all ages) LaCrosse Encephalitis (LAC) (3) Malaria 	<ul style="list-style-type: none"> Mpox (Monkeypox) (Orthopoxvirus) Mumps ¶ Q fever (<i>Coxiella burnetti</i>) Rubella (incl. Congenital) Shiga toxin positive (3) <i>Staphylococcus aureus</i>, vancomycin-resistant or intermediate with a VA ≥8 MIC (VRSA/VISA) (3) (5) (15) St. Louis Encephalitis (SLE) (3) Syphilis: congenital (18), syphilitic stillbirth (19) Tuberculosis (3) (20) Tularemia (3) ¶ Typhoid Fever (<i>Salmonella Typhi</i>) (3) (5) ¶ Typhus, epidemic (<i>Rickettsia prowazekii</i>) Vibriosis (any species of the family Vibrionaceae) to include toxicogenic <i>Vibrio cholerae</i> O1 or O139 (3) West Nile Virus (3) Yellow Fever (<i>Flavivirus</i>) Zika (3) 	
Report Within 3 Days			
Alpha-gal Syndrome (L) (2) Anaplasmosis Babesiosis Campylobacteriosis (3) Carbapenem-resistant Acinetobacter species (CRAB) (3) (5) (6) Carbapenem-resistant Enterobacteriales species (CRE) (3) (5) (6) Carbapenem-resistant <i>Pseudomonas</i> spp. (CRPA) (3) (5) (7) Chancroid <i>Chlamydia trachomatis</i> Coronavirus disease 2019 (COVID-19) (8) Cryptosporidiosis Cyclosporiasis (3) Ehrlichiosis Giardiasis	Gonorrhea (5) Hepatitis (chronic) B, C, & D (10) Hepatitis B Surface Antigen+ w/ each pregnancy HIV CD4 count/percentage in HIV+ people (L) HIV exposed infants (all results, positive and negative) HIV 1/2 AB/AG+ and/or detectable viral load with each pregnancy HIV subtype and genotype (L) HIV 1/2 Antibody and Antigen (rapid) HIV 1/2 AB/AG (confirmatory test, +/-) (L) HIV viral load (all results detectable and undetectable) (L) Inborn Errors of Metabolism & Hemoglobinopathies (11)	Influenza (8) Lead tests, all results – indicate venous or capillary specimen (12) Legionellosis Leprosy (Hansen's Disease) Leptospirosis Listeriosis (3) Lyme Disease Lymphogranuloma venereum Pertussis ¶ Psittacosis Salmonellosis (3) (5) Shigellosis (3) (5) Spotted Fever Rickettsiosis	Streptococcus group A, invasive disease (GAS) (5) (9) (16) Streptococcus pneumoniae, invasive (pneumococcal) (5) (9) (17) Syphilis, all serological tests (treponemal & nontreponemal) if at least one test is positive, CSF-VDRL or darkfield positive Tetanus Toxic Shock (specify staph. or strep.) Tuberculosis test – Positive Interferon Gamma Release Assays (IGRAs): QuantiFERON-TB Gold Plus (QFT-Plus) and T-SPOT.TB (20) (L) Varicella Yersiniosis (<i>Yersinia</i> , not <i>pestis</i>)

¶ Potential Agent of Bioterrorism (L) Only laboratories are required to report.

For footnotes, see complete list of reportable diseases at <https://dph.sc.gov/professionals/health-professionals/sc-list-reportable-conditions>

WHERE TO REPORT

HIV, AIDS, and STDs (excluding Hepatitis):
Do not fax HIV, AIDS, or STD results to DPH.
Submit electronically via SCIONx (preferred); or Mail to:
Surveillance, Assessment, and Evaluation Section
P.O. Box 2046
West Columbia, SC 29171; or Report by phone:
1-800-277-0873 to leave a detailed message.

LEAD:
Submit electronically via SCIONx; or email: scionlead@dph.sc.gov to establish electronic reporting; or Mail to: Lead Surveillance
P.O. Box 2046
West Columbia, SC 29171; or
Fax lead reports to: (803) 898-3236

ANIMAL BITES / POTENTIAL RABIES EXPOSURE

(report within 24 hrs):

Report online by completing the 1799-ENG-DPH Animal Incident Report Form.

See: https://liquidoffice.dhec.sc.gov/lserver/Animal_Incident_Report when a person is exposed to an animal suspected of rabies.

See: https://dph.sc.gov/Rabies_Person_Flowchart

For questions or concerns, call (888) 847-0902 (Option 2), 24/7

WHERE TO REPORT TUBERCULOSIS

Lowcountry
Berkeley, Charleston, Dorchester
Office: (843) 209-8435
Fax: (843) 308-0324

Allendale, Bamberg, Beaufort, Calhoun, Colleton, Hampton, Jasper, Orangeburg
Office: (843) 209-8435
Fax: (843) 308-0324

Midlands
Chester, Kershaw, Lancaster, Newberry, Saluda, York
Office: (803) 909-7358
Fax: (803) 327-9847

Aiken, Barnwell, Edgefield, Fairfield, Lexington, Richland
Office: (803) 576-2870
Fax: (803) 576-2880

Pee Dee
Dillon, Georgetown, Horry, Marion
Office: (843) 915-8798
Fax: (843) 915-6504

Chesterfield, Clarendon, Darlington, Florence, Lee, Marlboro, Sumter, Williamsburg
Office: (843) 673-6693
Fax: (843) 673-6670

Upstate
Cherokee, Oconee, Pickens, Spartanburg, Union
Office: (864) 596-2227 ext. 108
Fax: (864) 596-3340

Abbeville, Anderson, Greenwood, Greenville, Laurens, McCormick
Office: (864) 372-3198
Fax: (864) 282-4294

After-Hours/Holiday: (803) 898-0558 • Fax: (803) 898-0685

WHERE TO REPORT ALL OTHER CONDITIONS

Contact the health department office in the region in which the patient resides. (See: https://dph.sc.gov/sites/scdph/files/Library/00167-ENG-CR_2025.pdf)

DPH Communicable Disease Bureau of Prevention and Control

Communicable Disease Epidemiology Section

P.O. Box 2046, West Columbia, SC 29171

Phone: (803) 898-0861 • Fax: (803) 898-0897 • After-Hours/Holidays: 1-888-847-0902

To learn about DPH's web-based reporting system or electronic notifications, call 1-800-917-2093 or email SCIONHelp@dph.sc.gov.

Do not use these to report any conditions.

Disease Reporting Form

Instructions for Completing 1129-ENG-DPH

PURPOSE

To report diseases and positive laboratory tests designated as reportable by DPH's Director in accordance with Section 60-20 of the Rules and Regulations of the state of South Carolina.

INSTRUCTIONS

Disease/Condition: Enter the disease diagnosed and the complete diagnosis. Enter the stage of 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: Enter the patient ID number.

Date of Birth: Enter the numerical month, day, and year of the patient's birth.

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

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.

If female, pregnant? Check the appropriate box 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 an 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 the patient's symptoms, if applicable.

Hospitalized/Emergency Room/Died: Check the appropriate box for patient hospitalization, emergency room visit, and death status.

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

Treated: Check the appropriate box for whether the patient was treated. If patient was treated, enter date (Date) treatment was received by patient and the treatment (Rx) received by the patient.

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

Hospitalized: If patient was hospitalized, enter the hospital name, admitted 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 the month, day, and year the specimen was collected.

Result Date: Enter the date of the lab result.

Lab Test Name: Enter the 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 as applicable. Use the space below "Other" for additional information pertinent to patient status; for example, where the patient traveled.

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

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

Jaundice: Check the appropriate box for presence of jaundice.

Hepatitis Results: Check the 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 Phone Number: Enter the phone number of the person who completed the 1129-ENG-DPH form.

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

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

Physician Phone Number: Enter the phone number of the ordering physician.

Risk Factors: Check all of the risk factors that apply.

Comments: Enter any additional information deemed pertinent.

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

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 DPH 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 Section in DPH'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.