

# Ohio Department of Health

## Ohio Confidential Reportable Disease

Use this form to submit reportable infectious diseases to your local health department (**Do not use this form to report HIV/AIDS**)

<b>Disease reported</b>						<b>ODRS number</b> <i>(internal use only)</i>	
Patient's last name			First name			Middle name (or initial and/or suffix)	
Address <i>(number and street)</i>					County		
City			State	ZIP	Patient expired? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Home telephone (    )		Work telephone (    )			Alternate number (    )		
Birthdate <i>(month/day/year)</i> / /		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Delivery date / /
Race <i>(check all that apply)</i> <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____					Ethnicity <i>(check one)</i> <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic		Was patient contacted? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No
Sensitive occupation? <i>(Check all that apply)</i> <input type="checkbox"/> Food handler <input type="checkbox"/> Direct patient-care <input type="checkbox"/> Child care attendee/staff <input type="checkbox"/> Long-term care resident/staff <input type="checkbox"/> Not applicable			Name of facility				
			Address of facility				

Parent, guardian, or alternate contact name						Phone	
Health care provider name						Phone	
Health care provider address							
Health care facility name						Phone	
Health care facility address							
<b>Submitted by</b> <i>(contact name, facility)</i>						Phone	

<b>Date of report</b> / /		Status <input type="checkbox"/> Laboratory confirmed <input type="checkbox"/> Clinically diagnosed <i>(list symptoms)</i> _____				Date of result / /	
Date of onset / /		Laboratory name				Phone (    )	
Date of diagnosis / /		Laboratory address					
Hospital admission / /		Date of specimen collection / /		Reason for test <input type="checkbox"/> Dx <input type="checkbox"/> Prenatal <input type="checkbox"/> Repeat pos		Specific type of test <i>(e.g. smear, culture, ELISA)</i>	
Hospital discharge / /		Specimen site/type <input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____					
Date of death / /		Treatment <i>(required for STD)</i> <input type="checkbox"/> Treated <input type="checkbox"/> Untreated: <input type="radio"/> Will treat <input type="radio"/> Unable to contact <input type="radio"/> Refused treatment <input type="radio"/> Referred to: _____					
		Date treatment initiated / /		Detail drugs/dose/route			

Remarks							

**Class B reporting** (Report number of cases only)

Disease			No. of cases		Week ending / /		
Please submit to:							