



## NORTHEAST OHIO REPORTABLE DISEASE REPORT FORM

Patient's Last Name		First Name		MI
Address (number and street)			County	
City	State	Zip code	Patient expired? <input type="checkbox"/> No <input type="checkbox"/> Yes Date: / /	
Home telephone ( )		Work telephone ( )		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Birthday (month/day/year) / /		Age	Occupation or Job Title	
Race (check all that apply) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic	
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Hospitalized: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: / /		Medical Record Number
Discharged: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: / /		Collection Date: / /	Result Date: / /	

Hepatitis	Specimen Site/Type:	Specific type of test (mark below)			
<input type="checkbox"/> Hep A	<input type="checkbox"/> Blood	<b>Hep A</b> anti-HAV IGM	Positive <input type="checkbox"/>	Negative <input type="checkbox"/>	<b>Hep C</b> anti-HCV <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/>
<input type="checkbox"/> Hep B	<input type="checkbox"/> Serum	<b>Hep B</b> HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	RIBA <input type="checkbox"/>
<input type="checkbox"/> Hep C	<input type="checkbox"/> Other:	anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>	HCV RNA (e.g., PCR) <input type="checkbox"/>
		anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Hep D		anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep D</b> anti-HDV <input type="checkbox"/>
<input type="checkbox"/> Hep E		HBeAg	<input type="checkbox"/>	<input type="checkbox"/>	
		anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>	<b>Hep E</b> anti-HEV <input type="checkbox"/>
		HBV DNA:	<input type="checkbox"/>	<input type="checkbox"/>	

Enteric	Specimen Site/Type:	Specific type of test:	Other	Specimen Site/Type:	Specific type of test:
<input type="checkbox"/> Campylobacter	<input type="checkbox"/> Blood	<input type="checkbox"/> Culture	<input type="checkbox"/> Haemophilus influenzae	<input type="checkbox"/> Blood	<input type="checkbox"/> Culture
<input type="checkbox"/> Cryptosporidium	<input type="checkbox"/> Urine	<input type="checkbox"/> Antigen	<input type="checkbox"/> Neisseria meningitidis**	<input type="checkbox"/> Urine	<input type="checkbox"/> Antigen
<input type="checkbox"/> E.coli 0157	<input type="checkbox"/> CSF	<input type="checkbox"/> O&P Exam	<input type="checkbox"/> Meningitis, bacterial – Organism Type _____	<input type="checkbox"/> CSF	<input type="checkbox"/> PCR/RNA
<input type="checkbox"/> Giardia	<input type="checkbox"/> Stool	<input type="checkbox"/> Other:	<input type="checkbox"/> Meningitis, aseptic (viral) Type _____	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:
<input type="checkbox"/> Salmonella	<input type="checkbox"/> Other		<input type="checkbox"/> Pertussis		
<input type="checkbox"/> Shigella			<input type="checkbox"/> Legionella		
<input type="checkbox"/> Shigatoxin			<input type="checkbox"/> Other: _____		
<input type="checkbox"/> Yersinia					
<input type="checkbox"/> Other:					

STD's	Specimen Site/Type:	Specific type of test:	Treatment
<input type="checkbox"/> Chlamydia	<input type="checkbox"/> Blood	<input type="checkbox"/> IgG	<b>Syphilis</b>
<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Urine	<input type="checkbox"/> RPR Titer _____	<input type="checkbox"/> 2.4 million units Benzathine penicillin G (LA Bicillin)
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Urethra	<input type="checkbox"/> VDRL	Date given: _____
<b>NOTE: Call to report, then follow-up with report form.</b>	<input type="checkbox"/> Cervix	<input type="checkbox"/> MHATP	<input type="checkbox"/> Other Treatment: _____
<input type="checkbox"/> HIV***	<input type="checkbox"/> Other:	<input type="checkbox"/> FTA	Date given: _____
<b>***MUST BE MAILED DO NOT FAX***</b>		<input type="checkbox"/> TPPA	<input type="checkbox"/> Chlamydia/Gonorrhea Treatment: _____
		<input type="checkbox"/> DFA	Date given: _____
		<input type="checkbox"/> NAAT _____	
		<input type="checkbox"/> Culture	
		<input type="checkbox"/> Other	

Laboratory Name, Address and Phone:	Physician or Reporting Facility Name, Address and Phone:
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**\*\*MUST CALL LOCAL HEALTH DEPARTMENT ASAP**