OHIO CONFIDENTIAL REPORTABLE DISEASE FORM

Use this form to report Class A diseases to the local health department (per OAC 3701-3-02)*

DO NOT use this form to report HIV/AIDS

Class A1 diseases require immediate reporting by phone upon suspicion of a case. For evenings, weekends and holidays, please listen to the local health department's after-hours phone message for instructions on how to report.

DISEASE REPORTED:

ODRS No. (internal use only)

Patient's Last Name: First Name: Middle Name (or initial and suffix):

Address (Number and Street):

City: County: State: Zip Code:

Home Telephone: ( )

Work Telephone: ( )

Alternate Number: ( )

Birthdate (MM/DD/YYYY): / /

Age:

Sex: ☐ Female ☐ Male

Pregnant: ☐ Yes ☐ No ☐ Unk

Delivery Date: / /

Race (check one):
☐ White ☐ Asian
☐ Black ☐ Multiracial
☐ American Indian or Alaskan Native
☐ Hawaiian Native or Pacific Islander
☐ Other
☐ Unknown

Ethnicity (check one): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Patient Contacted: ☐ Yes ☐ No ☐ Unknown

Parent, Guardian, or Alternate Contact Name: Phone: ( )

Health Care Provider (Name and Address): Phone: ( )

Health Care Facility (Name and Address): Phone: ( )

Submitted By (Contact Name): Phone: ( )

Date of Report: ____/____/_____

Date of Diagnosis: ____/____/_____

Date of Onset: ____/____/_____

Hospital Admission: ____/____/_____

Hospital Discharge: ____/____/_____

Date of Death: ____/____/_____

Status: ☐ Laboratory Confirmed
☐ Clinically Diagnosed (list symptoms)_____

Laboratory (Name and Address):

Date of Specimen Collection: ____/____/_____ Reason for Test: ☐ Sick ☐ Contact ☐ Screening

Specimen Site/Type: ☐ Blood ☐ Stool ☐ CSF ☐ Urine ☐ Other _____

Test Name (e.g. smear, culture, ELISA, PCR): _____

Test Result (attach copy): ☐ Positive ☐ Negative ☐ Other (list numeric values):_____

Treatment (Required for STD): ☐ Treated ☐ Partner(s) Treated? ☐ Untreated:
☐ Will treat
☐ Unable to contact
☐ Refused treatment
☐ Referred to:

Date Treatment Initiated: ____/____/_____

(Detail Drugs/Dose/Route):_____

Remarks:_____

*Reports are to be sent to the local health jurisdiction in which the patient lives.

For local health department contact info see: http://odhlogin.sso.odh.ohio.gov/LHDdirectory/NetMgr/ODHList.aspx

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