NORTHEAST OHIO REPORTABLE DISEASE REPORT FORM

Patient's Last Name	First Name	MI

Address (number and street)	County

City	State	Zip code	Patient expired? ☐ No ☐ Yes Date: / /

Home telephone ( )	Work telephone ( )	Pregnant ☐Yes☐ No ☐Unknown

Birthday (month/day/year) / /	Age	Occupation or Job Title

Race (check all that apply)	Ethnicity (check one)	Sex
☐American Indian or Alaskan Native ☐ Asian ☐ African American ☐Native Hawaiian or Pacific Islander ☐ White☐ Other ☐ Unknown	☐Hispanic ☐Unknown ☐Non-Hispanic	☐Male ☐ Female

Hospitalized: ☐No ☐ Yes Date: / / Discharged: ☐ No ☐ Yes Date: / /	Collection Date: / /	Result Date: / /	Medical Record Number

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

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

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

Laboratory Name, Address and Phone:	**Physician or Reporting Facility Name, Address and Phone:**

*****MUST CALL LOCAL HEALTH DEPARTMENT ASAP***