

REPORTABLE DISEASES/ CONDITIONS

The following diseases are to be reported to the OSDH by PHIDDO or telephone immediately upon suspicion, diagnosis, or positive test.

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|---------------------------------------|--|-------------------------|
| Anthrax | Hepatitis B during pregnancy (HBsAg+) | Rabies |
| Bioterrorism - suspected disease | Measles (Rubeola) | Smallpox |
| Botulism | Meningococcal invasive disease | Tularemia |
| Diphtheria | Outbreaks of apparent infectious disease | Typhoid fever |
| <i>H. influenzae</i> invasive disease | Plague | Viral hemorrhagic fever |
| Hepatitis A (Anti-HAV-IgM+) | Poliomyelitis | |

The following diseases are to be reported to the OSDH within one business day:

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| Acid Fast Bacillus (AFB) positive smear | Leptospirosis |
| AIDS (Acquired Immunodeficiency Syndrome) | Listeriosis |
| Arboviral infections | Lyme disease |
| Brucellosis | Malaria |
| Campylobacteriosis | Mumps |
| Congenital rubella syndrome | Pertussis |
| Cryptosporidiosis | Psittacosis |
| Dengue fever | Q Fever |
| <i>Escherichia coli</i> O157, O157:H7 or a Shiga toxin producing <i>E. coli</i> (STEC) | Rocky Mountain spotted fever |
| Ehrlichiosis | Rubella |
| Hantavirus pulmonary syndrome | Salmonellosis |
| Hemolytic uremic syndrome, postdiarrheal | Shigellosis |
| Hepatitis B (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) ¹ | <i>Staphylococcus aureus</i> (VISA or VRSA) |
| Hepatitis C virus (in persons ≤ 40 years or in persons having jaundice or ALT ≥ 400 regardless of age with laboratory confirmation) ¹ | <i>Streptococcus pneumoniae</i> invasive disease, children <5 yrs. |
| Human Immunodeficiency Virus (HIV) infection | Syphilis |
| Influenza associated pediatric mortality | Tetanus |
| Legionellosis | Trichinellosis |
| | Tuberculosis |
| | Unusual disease or syndrome |
| | Vibriosis including cholera |
| | Yellow fever |

¹ with entire Hepatitis panel results

The following diseases are to be reported to the OSDH within one month:

| | | |
|---|---------------------------|-----------------------------|
| CD4 cell count <500 with cell count % | Creutzfeldt-Jakob disease | HIV viral load |
| Chlamydial infections (<i>C. trachomatis</i>) | Gonorrhea | Pelvic inflammatory disease |

Isolates of the following organisms must be sent to the OSDH Public Health Laboratory: P.O. Box 24106 OKC, OK 73214

| | |
|--|---|
| <i>Bacillus anthracis</i> | <i>Mycobacterium tuberculosis</i> |
| <i>Brucella</i> spp. | <i>Neisseria meningitidis</i> (sterile site isolates) |
| <i>Escherichia coli</i> O157, O157:H7, or a Shiga toxin producing <i>E. coli</i> (STEC) | <i>Plasmodium</i> spp. |
| <i>Francisella tularensis</i> | <i>Salmonella</i> spp. |
| <i>Haemophilus influenzae</i> (sterile site isolates) | <i>Staphylococcus aureus</i> (VISA or VRSA) |
| <i>Listeria</i> spp. (sterile site isolates) | <i>Vibrio</i> spp. |
| | <i>Yersinia</i> spp. |

Acute Disease Service
(405) 271-4060 or (800) 234-5963
Fax (405) 271-6680 or (800) 898-6734

HIV/STD Service
(405) 271-4636
Fax (405) 271-1187

Public Health Laboratory
(405) 271-5070
Fax (405) 271-4850

Fax machines are located in locked offices and are monitored to ensure the confidentiality of disease reports.

Please refer to the Oklahoma Disease Reporting Manual for reporting guidelines and reportable test results which is available through the Disease Reporting link at <http://ads.health.ok.gov>

REPORTABLE DISEASE CARD

PLEASE ANSWER EVERY QUESTION ON THE CARD

| | |
|--|--|
| DISEASE _____ PATIENT'S NAME _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____ PHONE _____ COUNTY _____ AGE: _____ <input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days GENDER: <input type="checkbox"/> Male <input type="checkbox"/> Female HISPANIC ETHNICITY: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk PREGNANT: <input type="checkbox"/> Yes <input type="checkbox"/> No RACE: <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> American Indian <input type="checkbox"/> Native Hawaiian / Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown | DATE OF SYMPTOM ONSET _____ / _____ / _____ DATE OF SPECIMEN COLLECTION _____ / _____ / _____ DATE OF THIS REPORT _____ / _____ / _____ DATE OF BIRTH _____ / _____ / _____ |
|--|--|

Was patient hospitalized? Yes Name of Hospital: _____ No
Did patient die due to this disease? Survived Died Date of Death _____ / _____ / _____

How was diagnosis made? Clinical Laboratory Date of Final Result: _____ / _____ / _____
 Name of Laboratory: _____

| Hepatitis Panel Results: Check all applicable boxes. | | | | | | | | | | Comments: |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|-----------|
| Pos | Neg | Not Done | Pos | Neg | Not Done | Pos | Neg | Not Done | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | |
| HAVIgM | | | HAV Total | | | HCV | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HCV S/Co or Index _____ | | | | |
| HBcIgM | | | HBcAb Total | | | HCV RIBA/PCR | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HCV Viral Load _____ | | | | |
| HBsAg | | | HBsAb | | | HCV HDV | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | |
| HBeAg | | | HBeAb | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HBV Viral Load _____ | | | | | | | |
| HBV DNA | | | | | | | | | | |
| Date of Collection _____ / _____ / _____ | | | | | | | | | | |
| ALT _____ | | | AST _____ | | | Total Bili _____ | | | | |

In the past 6 weeks, has PATIENT / HOUSEHOLD MEMBER (PLEASE CIRCLE ONE) ATTENDED, LIVED IN, or WORKED IN any of the following settings?

Child Care
 Food Handler
 Nursing Home
 Other Institution
 Unknown

Name and Location of Establishment: _____

| | |
|---|---|
| Reporting Source Information: <input type="checkbox"/> Physician <input type="checkbox"/> Laboratory <input type="checkbox"/> Hospital/ICP <input type="checkbox"/> Other Name of Person Reporting: _____ Facility Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: () _____ Attending Physician: _____ City: _____ State: _____ Phone: () _____ <input type="checkbox"/> Contact the physician listed above for more information | Need more cards? <input type="checkbox"/> YES Name and address if different from left: _____ _____ _____ _____ _____ |
|---|---|