Acute Disease Service
Oklahoma State Department of Health
Creating a State of Health

# REPORTABLE DISEASES/ CONDITIONS

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

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

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

- Acid Fast Bacillus (AFB) positive smear
- AIDS (Acquired Immunodeficiency Syndrome)
- Arboviral infections
- Brucellosis
- Campylobacteriosis
- Congenital rubella syndrome
- Cryptosporidiosis
- Cyclosporiasis
- Dengue fever
- *Escherichia coli* O157, O157:H7 or a Shiga toxin producing *E. coli* (STEC)
- Ehrlichiosis
- Giardiasis
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome, postdiarrheal
- Hepatitis B (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+)[1]
- Hepatitis C virus (confirmed by RIBA or NAT for HCV RNA, or s/co ratio or index)[1]
- Human Immunodeficiency Virus (HIV) infection
- Influenza associated pediatric mortality
- Legionellosis
- Leptospirosis
- Listeriosis
- Lyme disease
- Malaria
- Mumps
- Pertussis
- Psittacosis
- Q Fever
- Rocky Mountain spotted fever
- Rubella
- Salmonellosis
- Shigellosis
- *Staphylococcus aureus* (VISA or VRSA)
- *Streptococcus*, group A, invasive disease
- *Streptococcus pneumoniae* invasive disease, children <5 yrs.
- Syphilis
- Tetanus
- Trichinellosis
- Tuberculosis
- Unusual syndrome or uncommon disease
- 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 %
- Chlamydial infections (*C. trachomatis*)
- Creutzfeldt-Jakob disease
- Gonorrhea
- HIV viral load
- Pelvic inflammatory disease

## Isolates of the following organisms must be sent to the OSDH Public Health Laboratory:

**P.O. Box 24106 OKC, OK 73214**

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

**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 test results for reportable diseases which is available through the Disease Reporting link at http://ads.health.ok.gov**

**(REV. 07/09)**

# REPORTABLE DISEASE CARD
# PLEASE ANSWER EVERY QUESTION ON THE CARD

**DISEASE** ______________________________

**PATIENT'S NAME** ______________________________

**ADDRESS** ______________________________

**CITY** ______________ **STATE** ________ **ZIP** ____________

**PHONE** ______________ **COUNTY** ______________

**AGE:** ________ ☐ Years ☐ Months ☐ Days **GENDER:** ☐ Male ☐ Female

**HISPANIC ETHNICITY:** ☐ Yes ☐ No ☐ Unk **PREGNANT:** ☐ Yes ☐ No

**RACE:** ☐ White ☐ Black ☐ American Indian ☐ Native Hawaiian / Pacific Islander ☐ Asian ☐ Other ☐ 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.

| Pos | Neg | Not Done | Test | Pos | Neg | Not Done | Test | Pos | Neg | Not Done | Test |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | ☐ | HAVIgM | ☐ | ☐ | ☐ | HAV Total | ☐ | ☐ | ☐ | HCV |
| ☐ | ☐ | ☐ | HBcIgM | ☐ | ☐ | ☐ | HBcAb Total | | | | HCV S/Co or Index ________ |
| ☐ | ☐ | ☐ | HBsAg | ☐ | ☐ | ☐ | HBsAb | ☐ | ☐ | ☐ | HCV RIBA/PCR |
| ☐ | ☐ | ☐ | HBeAg | ☐ | ☐ | ☐ | HBeAb | | | | HCV Viral Load ________ |
| ☐ | ☐ | ☐ | HBV DNA | | | | HBV Viral Load ________ | ☐ | ☐ | ☐ | HDV |

Date of Collection ____/____/____

ALT __________ AST __________ Total Bili __________

**Comments:**

**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:** ☐ Physician ☐ Laboratory ☐ Hospital/ICP ☐ Other

**Name of Person Reporting:** ______________________________

**Facility Name:** ______________________________

**Address:** ______________________________

**City:** ______________ **State:** ______ **Zip:** ________ **Phone:** ( )

**Attending Physician:** ______________________________

**City:** ______________ **State:** ______________ **Phone:** ( )

☐ Contact the physician listed above for more information

**Need more cards?** ☐ **YES**

Name and address if different from left:

**ODH FORM 295**

**(REV. 10/07)**