

REPORTABLE DISEASES/ CONDITIONS

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

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> (sterile site)	Plague	Viral hemorrhagic fever
Hepatitis A (Anti-HAV-IgM+)	Poliomyelitis	

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

Acid Fast Bacillus (AFB) positive smear	Leptospirosis
AIDS (Acquired Immunodeficiency Syndrome)	Listeriosis
Arboviral infections	Lyme disease ²
Brucellosis	Malaria
Campylobacteriosis	Mumps
Congenital rubella syndrome	Pertussis
Cryptosporidiosis	Psittacosis
Cyclosporiasis	Rocky Mountain spotted fever
Dengue fever	Rubella
<i>Escherichia coli</i> O157, O157:H7 or a shiga-like toxin producing <i>E. coli</i> (EHEC)	Salmonellosis
Ehrlichiosis	Shigellosis
Giardiasis	<i>Staphylococcus aureus</i> (VISA or VRSA)
Hantavirus pulmonary syndrome	<i>Streptococcus</i> , group A (sterile site)
Hemolytic uremic syndrome, postdiarrheal	<i>Streptococcus pneumoniae</i> (sterile site), children <5 yrs.
Hepatitis B (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) ¹	Syphilis
Hepatitis C (confirmed by RIBA, NAT, HCV RNA, or s/co) ¹	Tetanus
Hepatitis, acute unspecified	Trichinosis
Human Immunodeficiency Virus (HIV) infection	Tuberculosis
Legionellosis	Unusual syndrome, or uncommon disease
Leprosy	<i>Vibrio</i> spp. infections including cholera
	Yellow fever

¹ with entire Hepatitis panel results

² *Erythema migrans* or EIA+ confirmed by western blot

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
<i>Chlamydia</i> 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>N. meningitidis</i> (sterile site isolates only)
<i>Campylobacter</i> spp.	<i>Plasmodium</i> spp.
<i>Escherichia coli</i> O157, O157:H7, or a shiga-like toxin producing <i>E. coli</i> (EHEC)	<i>Salmonella</i> spp.
<i>Francisella tularensis</i>	<i>Shigella</i> spp.
<i>H. influenzae</i> (sterile site isolates only)	<i>Staphylococcus aureus</i> (VISA or VRSA)
HIV	<i>Vibrio</i> spp.
<i>Listeria</i> spp. (sterile site isolates only)	<i>Yersinia</i> spp.

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

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

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

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 _____ / _____ / _____
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Was patient hospitalized? <input type="checkbox"/> Yes Name of Hospital: _____ <input type="checkbox"/> No	Did patient die due to this disease? <input type="checkbox"/> Survived <input type="checkbox"/> Died Date of Death _____ / _____ / _____
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How was diagnosis made? Clinical Laboratory Date of Final Result: _____ / _____ / _____

Name of Laboratory: _____

Test Method and Source: _____

Results of Lab Tests: _____

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"/>	HAVIgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HAV Total	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HCV
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBcIgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBcAb Total	HCV S/Co or Index _____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBsAb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HCV RIBA/PCR
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBeAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBeAb	HCV Viral Load _____			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBV DNA	HBV Viral Load _____			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HDV	
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: _____ _____ _____ _____ _____
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