

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	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:

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
Cyclosporiasis	Q Fever
Dengue fever	Rocky Mountain spotted fever
<i>Escherichia coli</i> O157, O157:H7 or a Shiga toxin producing <i>E. coli</i> (STEC)	Rubella
Ehrlichiosis	Salmonellosis
Giardiasis	Shigellosis
Hantavirus pulmonary syndrome	<i>Staphylococcus aureus</i> (VISA or VRSA)
Hemolytic uremic syndrome, postdiarrheal	<i>Streptococcus</i> , group A, invasive disease
Hepatitis B (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) ¹	<i>Streptococcus pneumoniae</i> invasive disease, children <5 yrs.
Hepatitis C virus (confirmed by RIBA or NAT for HCV RNA, or s/co ratio or index) ¹	Syphilis
Human Immunodeficiency Virus (HIV) infection	Tetanus
Influenza associated pediatric mortality	Trichinellosis
Legionellosis	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 %	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 test results for reportable diseases 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 _____ / _____ / _____
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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: _____

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"/>	HAV IgM	
<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"/>	HAV Total	
<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"/>	HCV	
<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"/>	HBC IgM	
<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"/>	HBC Ab Total	HCV S/Co or Index _____
<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"/>	HBsAg	HCV RIBA/PCR _____
<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"/>	HBeAg	HCV Viral Load _____
<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"/>	HBeAb	
<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"/>	HBV DNA	
<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"/>	HBV Viral Load _____	HCV 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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