



# REPORTABLE PATHOGENS

The following organisms are to be reported to the OSDH by any laboratory personnel by PHIDDO or telephone immediately upon suspicion, diagnosis, or positive test:

<i>Bacillus anthracis</i> Bioterrorism - suspected organism	Hepatitis A virus (anti-HAV IgM+)	Rabies virus
<i>Clostridium botulinum</i>	Hepatitis B virus during pregnancy (HBsAg+)	Rubeola virus (Measles)
<i>Corynebacterium diphtheriae</i>	<i>Neisseria meningitidis</i> (sterile site)	<i>Salmonella</i> Typhi
<i>Francisella tularensis</i>	Outbreaks of apparent infectious organism	Variola virus (Smallpox)
<i>Haemophilus influenzae</i> (sterile site)	Poliovirus	Viral hemorrhagic fever
		<i>Yersinia pestis</i>

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

Acid Fast Bacillus (AFB) positive smear	Human Immunodeficiency Virus (HIV)
<i>Anaplasma</i> spp.	<i>Legionella</i> spp.
Arboviral infections	<i>Leptospira interrogans</i>
<i>Bordetella pertussis</i>	<i>Listeria monocytogenes</i> (sterile site)
<i>Borrelia burgdorferi</i>	Mumps virus
<i>Brucella</i> spp.	<i>Mycobacterium tuberculosis</i>
<i>Campylobacter</i> spp.	<i>Plasmodium</i> spp.
<i>Chlamydia psittaci</i>	<i>Rickettsia rickettsii</i>
<i>Clostridium tetani</i>	Rubella virus
<i>Coxiella burnettii</i>	<i>Salmonella</i> spp.
<i>Cryptosporidium</i> spp.	<i>Shigella</i> spp.
Dengue virus	<i>Staphylococcus aureus</i> (VISA or VRSA)
<i>Ehrlichia</i> spp.	<i>Streptococcus pneumoniae</i> (sterile site), children <5 yrs.
<i>Escherichia coli</i> O157, O157:H7 or a Shiga toxin producing <i>E. coli</i> (STEC)	<i>Treponema pallidum</i>
Hantavirus	<i>Trichinella spiralis</i>
Hepatitis B virus (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) <sup>1</sup>	Unusual or uncommon pathogens
Hepatitis C virus (in persons ≤ 40 years or in persons having jaundice or ALT ≥ 400 regardless of age with laboratory confirmation) <sup>1</sup>	<i>Vibrio</i> spp. including <i>Vibrio cholerae</i>
	Yellow fever virus

<sup>1</sup> with entire Hepatitis panel results

The following organisms / test results 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 trachomatis</i>	<i>Neisseria gonorrhoeae</i>	

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 _____ / _____ / _____
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<b>Was patient hospitalized?</b> <input type="checkbox"/> Yes Name of Hospital: _____ <input type="checkbox"/> No	<b>Did patient die due to this disease?</b> <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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HCV Viral Load	_____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBV DNA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	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: \_\_\_\_\_

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