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		Pos	Neg	Not Done		Pos	Neg	Not Done	
☐	☐	☐	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)