

REPORTABLE DISEASES/ CONDITIONS

The following diseases are to be reported to the OSDH by PHIDDO or telephone (405-271-4060) immediately upon suspicion, diagnosis, or positive test.

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

The following diseases are to be reported to the OSDH by PHIDDO, telephone or secure electronic data transmission within one working day (Monday through Friday, State holidays excepted):

Acid Fast Bacillus (AFB) positive smear (only if no additional testing is performed or subsequent testing is indicative of <i>Mycobacterium tuberculosis</i> Complex)	Listeriosis
AIDS (Acquired Immunodeficiency Syndrome)	Lyme disease
Anaplasmosis	Malaria
Brucellosis	Mumps
California serogroup virus	Pertussis
Campylobacteriosis	Powassan virus
Congenital rubella syndrome	Psittacosis
Cryptosporidiosis	Q Fever
Dengue fever	Rocky Mountain spotted fever
Eastern equine encephalitis virus	Rubella
<i>Escherichia coli</i> O157, O157:H7 or a Shiga toxin producing <i>E. coli</i> (STEC)	Salmonellosis
Ehrlichiosis	Shigellosis
Hantavirus pulmonary syndrome	St. Louis encephalitis virus
Hemolytic uremic syndrome, postdiarrheal	<i>Staphylococcus aureus</i> (VISA or VRSA)
Hepatitis B (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) ¹	<i>Streptococcus pneumoniae</i> invasive disease, children <5 yrs.
Hepatitis C virus (in persons ≤ 40 years or in persons having jaundice or ALT ≥ 400 regardless of age with laboratory confirmation) ¹	Syphilis
Human Immunodeficiency Virus (HIV) infection	Tetanus
Influenza associated hospitalization or death	Trichinellosis
Legionellosis	Tuberculosis
Leptospirosis	Unusual disease or syndrome
	Vibriosis including cholera
	West Nile virus
	Western equine encephalitis virus
	Yellow fever

¹ with entire Hepatitis panel results

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

CD4 cell count with cell count % (by laboratories only)	Chlamydial infections (<i>C. trachomatis</i>)	Gonorrhea (<i>N. gonorrhoeae</i>)
	Creutzfeldt-Jakob disease	HIV viral load (by laboratories only)

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>Neisseria meningitidis</i> (sterile site isolates)
<i>Brucella</i> spp.	<i>Plasmodium</i> spp.
<i>Escherichia coli</i> O157, O157:H7, or a Shiga toxin producing <i>E. coli</i>	<i>Salmonella</i> spp.
<i>Francisella tularensis</i>	<i>Staphylococcus aureus</i> (VISA or VRSA)
<i>Haemophilus influenzae</i> (sterile site isolates)	<i>Vibrionaceae</i> family (<i>Vibrio</i> spp., <i>Grimontia</i> spp., <i>Photobacterium</i> spp., and other genera in the family)
<i>Listeria</i> spp. (sterile site isolates)	<i>Yersinia</i> spp.
<i>Mycobacterium tuberculosis</i>	

Acute Disease Service
(405) 271-4060 or (800) 234-5963
Available 24 Hours a Day

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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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.										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: 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? <input type="checkbox"/> YES Name and address if different from left: _____ _____ _____ _____ _____
