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

<table>
<thead>
<tr>
<th>Disease</th>
<th>Reporting Code</th>
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<tbody>
<tr>
<td>Anthrax</td>
<td>Hepatitis B during pregnancy (HBsAg+)</td>
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<tr>
<td>Bioterrorism - suspected disease</td>
<td>Poliomyelitis</td>
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<td>Botulism</td>
<td>Rabies</td>
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<tr>
<td>Diptheria</td>
<td>Smallpox</td>
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<tr>
<td>Free-living amebae infections causing primary amebic meningoencephalitis</td>
<td>Typhoid fever</td>
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</tbody>
</table>

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 Mycobacterium tuberculosis Complex)
- AIDS (Acquired Immunodeficiency Syndrome)
- Anaplasmosis
- Brucellosis
- California serogroup virus infection
- Campylobacteriosis
- Chikungunya virus infection
- Congenital rubella syndrome
- Cryptosporidiosis
- Dengue fever
- Eastern equine encephalitis virus infection
- Escherichia coli O157, O157:H7 or a Shiga toxin producing E. coli (STEC)
- Ehrlichiosis
- Haemophilus influenzae invasive disease
- Hantavirus infection, without pulmonary syndrome
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome, postdiarrheal
- Hepatitis A (Anti-HAV-IgM+)
- Hepatitis B (HBsAg+, anti-HBC IgM+, HBeAg+, and/or HBV DNA+)
- Hepatitis C virus (having jaundice or ALT ≥ 200 with laboratory confirmation)
- Human Immunodeficiency Virus (HIV) infection
- Influenza associated hospitalization or death
- Legionellosis
- Leptospirosis
- Listeriallosis
- Lyme disease
- Malaria
- Mumps
- Pertussis
- Powassan virus infection
- Psittacosis
- Q Fever
- Rocky Mountain Spotted Fever
- Rubella
- Salmonellosis
- Shigelllosis
- St. Louis encephalitis virus infection
- Streptococcal disease, invasive, Group A (GAS)
- Streptococcus pneumoniae invasive disease, children <5 yrs.
- Syphilis (Nontreponemal and treponemal tests are reportable. If any syphilis test is positive, then all syphilis test results on the panel must be reported. For infants ≤12 months, all syphilis tests ordered, regardless of test result, must be reported.)
- Tetanus
- Trichinellosis
- Tuberculosis
- Unusual disease or syndrome
- Vibrio cholera
- West Nile virus infection
- Western equine encephalitis virus infection
- Yellow fever
- Zika virus infection

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

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

Isolates of the following organisms must be sent to the OSDH Public Health Laboratory:

- Bacillus anthracis
- Brucella spp.
- Carbapenem-resistant Enterobacteriaceae
- Escherichia coli O157, O157:H7, or a Shiga toxin producing E. coli
- Francisella tularensis
- Haemophilus influenzae (sterile site isolates)
- Listeria spp. (sterile site isolates)
- Mycobacterium tuberculosis
- Neisseria meningitidis (sterile site isolates)
- Plasmidium spp.
- Salmonella spp.
- Vibrio cholerae (Vibrio spp., Gramontia spp., Photobacterium spp., and other genera in the family)
- Yersinia spp.
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

Was patient hospitalized? [ ] Yes Name of Hospital: ____________________________ [ ] Survived

[ ] No [ ] Died Date of Death __________/________/________

How was diagnosis made? [ ] Clinical [ ] Laboratory Date of Final Result: __________/________/________

Name of Laboratory:

Hepatitis Panel Results: Check all applicable boxes.

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<tr>
<th>Pos</th>
<th>Neg</th>
<th>Not Done</th>
<th>Pos</th>
<th>Neg</th>
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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

ODH FORM 295
(REV. 10/07)