



REPORTABLE PATHOGENS

The following organisms are to be reported to the OSDH by any laboratory personnel by PHIDDO or telephone (405-271-4060) immediately upon suspicion, diagnosis, or positive test:

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

The following organisms 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)	Hepatitis C virus (in persons ≤ 40 years or in persons having jaundice or ALT ≥ 400 regardless of age with laboratory confirmation) ¹
<i>Anaplasma</i> spp.	Human Immunodeficiency Virus (HIV)
Arboviral infections (West Nile virus, St. Louis encephalitis virus, Eastern equine encephalitis virus, Western equine encephalitis virus, Powassan virus, California serogroup virus)	<i>Legionella</i> spp.
<i>Bordetella pertussis</i>	<i>Leptospira interrogans</i>
<i>Borrelia burgdorferi</i>	<i>Listeria monocytogenes</i> (sterile site)
<i>Brucella</i> spp.	Mumps virus
<i>Campylobacter</i> spp.	<i>Mycobacterium tuberculosis</i>
<i>Chlamydia psittaci</i>	<i>Plasmodium</i> spp.
<i>Clostridium tetani</i>	<i>Rickettsia rickettsii</i>
<i>Coxiella burnetii</i>	Rubella virus
<i>Cryptosporidium</i> spp.	<i>Salmonella</i> spp.
Dengue virus	<i>Shigella</i> spp.
<i>Ehrlichia</i> spp.	<i>Staphylococcus aureus</i> (VISA or VRSA)
<i>Escherichia coli</i> O157, O157:H7 or a Shiga toxin producing <i>E. coli</i> (STEC)	<i>Streptococcus pneumoniae</i> (sterile site), children <5 yrs.
Hantavirus	<i>Treponema pallidum</i>
Hepatitis B virus (HBsAg+, anti-HBc IgM+, HBeAg+, and/or HBV DNA+) ¹	<i>Trichinella spiralis</i>
	Unusual or uncommon pathogens
	<i>Vibrionaceae</i> family (<i>Vibrio</i> spp. including <i>V. cholerae</i> , <i>Grimontia</i> spp., <i>Photobacterium</i> spp. and other genera in the family)
	Yellow fever virus

¹ with entire Hepatitis panel results

The following organisms / test results are to be reported to the OSDH within one month:

CD4 cell count with cell count % (by laboratories only)	<i>Chlamydia trachomatis</i>	<i>Neisseria 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>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>	<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>Vibrionaceae</i> family (<i>Vibrio</i> spp., <i>Grimontia</i> spp., <i>Photobacterium</i> spp. and other genera in the family)
	<i>Yersinia</i> spp.

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: _____

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: _____

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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