

Ohio Department of Health

Ohio Confidential Reportable Disease

Use this form to submit reportable infectious diseases to your local health department (**Do not** use this form to report HIV/AIDS)

Disease reported						ODRS number	
Patient's last name		First name		Middle name (or initial and/or suffix)		Medical record number	
Address (number and street)						County	
City			State	ZIP	Patient expired? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Home telephone ()		Work telephone ()			Alternate number ()		
Birthdate (month/day/year) / /		Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Delivery date / /
Race (check all that apply) <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Unknown <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____					Ethnicity (check one) <input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown <input type="checkbox"/> Non-Hispanic		Was patient contacted? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No
Sensitive occupation? (Check all that apply) <input type="checkbox"/> Food handler <input type="checkbox"/> Direct patient-care <input type="checkbox"/> Child care attendee/staff <input type="checkbox"/> Long-term care resident/staff <input type="checkbox"/> Not applicable			Name of facility				
			Address of facility				

Parent, guardian, or alternate contact name		Phone
Health care provider name		Phone
Health care provider address		
Health care facility name		Phone
Health care facility address		
Submitted by (contact name, facility)		Phone

Date of report / /	Status <input type="checkbox"/> Laboratory confirmed <input type="checkbox"/> Clinically diagnosed (list symptoms) _____		Date of result / /
Date of onset / /	Laboratory name		Phone ()
Date of diagnosis / /	Laboratory address		
Hospital admission / /	Date of specimen collection / /	Reason for test <input type="checkbox"/> Dx <input type="checkbox"/> Prenatal <input type="checkbox"/> Repeat pos	Specific type of test (e.g. smear, culture, ELISA)
Hospital discharge / /	Specimen site/type <input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____		
Date of death / /	Treatment <input type="checkbox"/> Treated <input type="checkbox"/> Untreated: <input type="radio"/> Will treat <input type="radio"/> Unable to contact <input type="radio"/> Refused treatment <input type="radio"/> Referred to: _____		
	Date treatment initiated / /	Detail drugs/dose/route	

Remarks

Please submit to:
