

# 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)

<b>Disease reported</b>				<b>ODRS number</b> <i>(internal use only)</i>	
Patient's last name		First name		Middle name (or initial and/or suffix)	
Address <i>(number and street)</i>				County <b>Cuyahoga</b>	
City		State <b>Ohio</b>	ZIP	Patient expired? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Home telephone (    )		Work telephone (    )		Alternate number (    )	
Birthdate <i>(month/day/year)</i> / /	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 <i>(check all that apply)</i> <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 <i>(check one)</i> <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? <i>(Check all that apply)</i> <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		
<b>Submitted by</b> <i>(contact name, facility)</i>		Phone

Date of report / /	Status <input type="checkbox"/> Laboratory confirmed <input type="checkbox"/> Clinically diagnosed <i>(list symptoms)</i> _____		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 <i>(e.g. smear, culture, ELISA)</i>
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 <i>(required for STD)</i> <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
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<b>Class B reporting</b> <i>(Report number of cases only)</i>		
Disease	No. of cases	Week ending / /
Please submit to: <b>Central Disease Reporting at the Cuyahoga County Board of Health: Fax 216-676-1316 / Phone 216-201-2080</b>		