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 nur	ODRS number (internal use only)	
Patient's last name		First name			Middle nego	e (ex initial and/or suffice)	
ratients last name	First name	First name			Middle name (or initial and/or suffix)		
Address (number and street)				County	y		
					ıyahoga		
City		State	ZIP		t expired?	П.	
Home telephone	1	Ohio Vork telephone		☐ Ye	es	lo 🗆 Unknown	
()	(()		()		
Birthdate (month/day/year)	Age	ex	Pregnant		Delivery date	2	
/ /		☐ Male ☐ Female	☐ Yes ☐ I	No 🗆 Unkn	own	/ /	
Race (check all that apply)				Ethnicity (check		Was patient contacted?	
American Indian or Alaskan Native Asian African American Unknown Hispanic						Yes Unknown	
□ Native Hawaiian or Pacific Islander □ White □ Other □ Non-Hispanic □ No							
Sensitive occupation? (Check all that apply) Name of facility Food handler Direct patient-care							
☐ Food handler ☐ Direct patient-care ☐ Child care attendee/staff ☐ Address of facility							
□ Long-term care resident/staff □ Not applicable							
					Lai		
Parent, guardian, or alternate contact name						Phone	
Health care provider name					Phone	Phone	
Health care provider address							
Health care facility name					Phone	Phone	
Health care facility address							
Submitted by (contact name, fa	cility)				Phone		
Date of report	Status					lt	
/ /	☐ Laboratory confirmed					, ,	
Date of onset	☐ Clinically diagnosed (list symptoms)					/ /	
/ /	Laboratory name					\	
Date of diagnosis	Laboratory address						
/ /	Date of specimen collection Reason for test Specific type of test (e.g. smear, culture, EUSA)						
Hospital admission	/ /			Repeat pos	Specific type of tes	t (e.g. sinear, culture, ELISA)	
/ /	Specimen site/type	ol 🗆 CSF 🗆 Urin	e 🗆 Cervix [Oth - :	
Hospital discharge	☐ Blood ☐ Stoo		e 🗆 Cervix i	□ Urethra	□ Sputum □	Other	
/ /		reated: O Will treat	O Unable to	contact	O Refused treat	ment	
Date of death	Date treatment initiated	O Referred t					
/ /	/ /	Betail arags/a	oserioate				
Remarks		<u>'</u>					
Class B reporting (Report num	mber of cases only)		Lsi	f cases	Medicard		
Disease			No. o	f cases	Week ending	/	
Please submit to:					l		
Central Disease Rep	orting at the Cuyah	oga County Board	of Health: Fax	216-676-13	316 / Phone 2	16-201-2080	