Ohio Department of Health

Ohio Confidential Reportable Disease

Department of Health

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? ☐ Yes ☐ No ☐ Unknown
Home telephone ( )	Work telephone ( )		Alternate number ( )
Birthdate *(month / day / year)* / /	Age	Sex ☐ Male ☐ Female	Pregnant ☐ Yes ☐ No ☐ Unknown / Delivery date / /
Race *(check all that apply)* ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Unknown ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____			Ethnicity *(check one)* ☐ Hispanic ☐ Unknown ☐ Non-Hispanic / Was patient contacted? ☐ Yes ☐ Unknown ☐ No
Sensitive occupation? *(Check all that apply)* ☐ Food handler ☐ Direct patient-care ☐ Child care attendee/staff ☐ Long-term care resident/staff ☐ Not applicable			Name of facility / Address of facility

Parent, guardian, or alternate contact name	Phone
Healthcare provider name	Phone
Healthcare provider address	
Healthcare facility name	Phone
Healthcare facility address	
Submitted by *(contact name, facility)*	Phone

Date of report / /	Status ☐ Laboratory confirmed ☐ 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 ☐ Dx ☐ Prenatal ☐ Repeat pos	Specific type of test *(e.g. smear, culture, ELISA)*
Hospital discharge / /	Specimen site/type ☐ Blood ☐ Stool ☐ CSF ☐ Urine ☐ Cervix ☐ Urethra ☐ Sputum ☐ Other _____		
Date of death / /	Treatment ☐ Treated ☐ Untreated: ○ Will treat ○ Unable to contact ○ Refused treatment ○ Referred to: _____		
	Date treatment initiated / /	Detail drugs/dose/route	

Remarks

_____

_____

Please submit to: