Northeast Ohio Communicable Disease Report Form

PATIENT NAME (LAST-FIRST-MIDDLE)

ADDRESS	CITY	ZIP CODE	DATE REPORTED
COUNTY	TELEPHONE	DATE OF BIRTH	DATE COLLECTED

SEX	AGE	RACE:	ETHNICITY	REASON FOR TEST	SPECIMEN: SITE/TYPE
		☐ WHITE ☐ BLACK ☐ AMER INDIAN/AN ☐ ASIAN/PI	☐ Hispanic	PRENATAL ☐ REPEAT POS. ☐	

CHECK BLOCK FOR DISEASE SUSPECTED - INDICATE POSITIVE TEST RESULTS

HIV	SYPHILIS	CHLAMYDIA	GONORRHEA	TUBERCULOSIS
DO NOT FAX Report only repeatedly positive ELISA results confirmed by Western Blot or other confirmatory test.(Specify):	RPR/VDRL Titer FTA/MHA ____ DKFD ____	ELISA ____ F.A. ____ Culture ____	Smear ____ ELISA ____ Culture ____ PPNG/Resist. (Specify)	☐ Smear ☐ Culture Result ___/___/___ Date Reported

Other Positive Lab Findings:			
☐ CAMPYLOBACTER	☐ HepA-Ab-Total	☐ HepBc-Igm	☐ NEISSERIA meningitidis
☐ E. COLI 0157	☐ HepA Igm	☐ HepBc-T	☐ SALMONELLA
☐ GIARDIA	☐ HCV-Ab	☐ HepBeAg	☐ SHIGELLA
☐ HAEMOPHILUS Influenza	☐ HCV RIBA	☐ HepBsAb	☐ YERSINIA
		☐ HepBsAg	Other Lab:

Other reportable disease: ☐ Suspected ☐ Confirmed

Test:

HOSPITAL NAME: _____ Pt. hospital # _____

ADMISSION: IP ____ Admit Date ___/___/___ Discharge Date ___/___/___ OP ____ ED ____

TREATMENT (if given) Type/Amount

Patient's occupation if sensitive: _____

Specify day care center if patient is a child: _____

Hospital or skilled nursing facility: _____

Signs and symptoms/Related information:

Laboratory-Name/Address	Physician-Name/Address
Lab Code	Phone ___/___ _____

NAME OF CONTACT PERSON should further information be needed. Phone ___/___ _____