SUMMIT COUNTY PUBLIC HEALTH

1867 WEST MARKET STREET • AKRON, OHIO 44313 • 330-923-4891

NORTHEAST OHIO REPORTABLE DISEASE REPORT FORM

Patient's Last Name	First Name		MI
Address (number and street)			County
City	State	Zip code	Patient expired? ☐ No ☐ Yes Date: / /
Home telephone ( )	Work telephone ( )		Pregnant ☐ Yes ☐ No ☐ Unknown
Birthday (month/day/year) / /	Age	Occupation or Job Title	
Race (check all that apply) ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other ☐ Unknown		Ethnicity (check one) ☐ Hispanic ☐ Unknown ☐ Non-Hispanic	Sex ☐ Male ☐ Female
Hospitalized: ☐ No ☐ Yes Date: / / Discharged: ☐ No ☐ Yes Date: / /	Collection Date: / /	Result Date: / /	Medical Record Number

Hepatitis	**Specimen Site/Type:**	**Specific type of test (mark below)**				
☐ **Hep A** ☐ **Hep B** ☐ **Hep C** ☐ **Hep D** ☐ **Hep E**	☐ Blood ☐ Serum ☐ Other:	**Hep A** anti-HAV IGM **Hep B** HBsAg anti-HBc total anti-HBc IgM anti-HBs HBeAg anti-HBe HBV DNA:	Positive ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	Negative ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	**Hep C** anti-HCV RIBA HCV RNA (e.g., PCR) **Hep D** anti-HDV **Hep E** anti-HEV	Positive ☐ Negative ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Enteric	**Specimen Site/Type:**	**Specific type of test:**	**Other**	**Specimen Site/Type:**	**Specific type of test:**
☐ **Campylobacter** ☐ **Cryptosporidium** ☐ **E.coli 0157** ☐ **Giardia** ☐ **Salmonella** ☐ **Shigella** ☐ **Shigatoxin** ☐ **Yersinia** ☐ **Other:**	☐ Blood ☐ Urine ☐ CSF ☐ Stool ☐ Other	☐ Culture ☐ Antigen ☐ O&P Exam ☐ Other:	☐ **Haemophilus influenzae** ☐ **Neisseria meningitidis**** ☐ **Meningitis, bacterial – Organism Type** _____ ☐ **Meningitis, aseptic (viral) Type** _____ ☐ **Pertussis** ☐ **Legionella** ☐ **Other:** _____	☐ Blood ☐ Urine ☐ CSF ☐ Other:	☐ Culture ☐ Antigen ☐ PCR/RNA ☐ Other:

STD's	**Specimen Site/Type:**	**Specific type of test:**	**Treatment**
☐ Chlamydia ☐ Gonorrhea ☐ **Syphilis** **NOTE: Call to report, then follow-up with report form.** ☐ **HIV***** ******MUST BE MAILED DO NOT FAX******	☐ Blood ☐ Urine ☐ Urethra ☐ Cervix ☐ Other:	☐ IgG ☐ RPR Titer _____ ☐ VDRL ☐ MHATP ☐ FTA ☐ TPPA ☐ DFA ☐ NAAT _____ ☐ Culture ☐ Other	**Syphilis** ☐ 2.4 million units Benzathine penicillin G (LA Bicillin) Date given: _____ ☐ Other Treatment: _____ Date given: _____ ☐ Chlamydia/Gonorrhea Treatment: _____ Date given: _____

Laboratory Name, Address and Phone:	**Physician or Reporting Facility Name, Address and Phone:**

*****MUST CALL LOCAL HEALTH DEPARTMENT ASAP***