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 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
Health care provider name	Phone
Health care provider address	
Health care facility name	Phone
Health care 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 *(required for STD)* ☐ Treated ☐ Untreated: ○ Will treat ○ Unable to contact ○ Refused treatment ○ Referred to: _____		
	Date treatment initiated / /	Detail drugs/dose/route	

Remarks

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_____

Please submit to:

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