

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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Home telephone ()		Work telephone ()		Alternate number ()	
Birthdate (month/day/year) / /		Age		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
				Pregnant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
				Delivery date / /	
Race (check all that apply)				Ethnicity (check one)	
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> Unknown				<input type="checkbox"/> Hispanic <input type="checkbox"/> Unknown	
<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other _____				<input type="checkbox"/> Non-Hispanic	
Was patient contacted? <input type="checkbox"/> Yes <input type="checkbox"/> Unknown <input type="checkbox"/> No					
Sensitive occupation? (Check all that apply)				Name of facility	
<input type="checkbox"/> Food handler <input type="checkbox"/> Direct patient-care					
<input type="checkbox"/> Child care attendee/staff				Address of facility	
<input type="checkbox"/> Long-term care resident/staff <input type="checkbox"/> Not applicable					
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 <input type="checkbox"/> Laboratory confirmed <input type="checkbox"/> 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 <input type="checkbox"/> Dx <input type="checkbox"/> Prenatal <input type="checkbox"/> Repeat pos		Specific type of test (e.g. smear, culture, ELISA)
Hospital discharge / /		Specimen site/type <input type="checkbox"/> Blood <input type="checkbox"/> Stool <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Cervix <input type="checkbox"/> Urethra <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____			
Date of death / /		Treatment (required for STD) <input type="checkbox"/> Treated <input type="checkbox"/> Untreated: <input type="radio"/> Will treat <input type="radio"/> Unable to contact <input type="radio"/> Referred to: _____ <input type="radio"/> Referred to: _____			
		Date treatment initiated / /		Detail drugs /dose /route	
Remarks _____					
Please submit to: _____					