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 / /

Date of onset / /

Date of diagnosis / /

Hospital admission / /

Hospital discharge / /

Date of death / /

Status
☐ Laboratory confirmed
☐ Clinically diagnosed *(list symptoms)*_____

Date of result / /

Laboratory name

Phone ( )

Laboratory address

Date of specimen collection / /

Reason for test ☐ Dx ☐ Prenatal ☐ Repeat pos

Specific type of test *(e.g. smear, culture, ELISA)*

Specimen site/type
☐ Blood ☐ Stool ☐ CSF ☐ Urine ☐ Cervix ☐ Urethra ☐ Sputum ☐ Other _____

Treatment
☐ Treated ☐ Untreated: ○ Will treat ○ Unable to contact ○ Refused treatment
○ Referred to: _____

Date treatment initiated / /

Detail drugs/dose/route

Remarks

_____

_____

Please submit to: