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 *(required for STD)*
☐ Treated ☐ Untreated: ○ Will treat ○ Unable to contact ○ Refused treatment
○ Referred to: _____

Date treatment initiated / / | Detail drugs/dose/route

Remarks

Please submit to:

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