



# COMMUNICABLE DISEASE REPORT

Important Instructions: Please complete sections 1-3 for all reportable conditions. In addition, complete Section 4 for STDs and HIV/AIDS cases, Section 5 for hepatitis, and Section 6 for tuberculosis. Once completed, return to your county or tribal health agency. If reporting through MEDSIS, go to <https://my.health.azdhs.gov/>.

County / IHS Number	State ID / MEDSIS ID	Date Received by County
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## 1. PATIENT INFORMATION

<b>Patient's Name (Last, First, Middle)</b>	<b>Date of Birth</b>	<b>Race</b> (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Asian <input type="checkbox"/> Other	<b>Ethnicity:</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<b>Pregnant:</b> <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes Due date ____	
<b>Street Address:</b>	<b>City:</b>	<b>State:</b>	<b>Zip code:</b>	<b>County:</b>	<b>Reservation:</b>	<b>Telephone#:</b>
<b>Patient's Occupation or School:</b>	<b>Guardian:</b> (not necessary for STD)	<b>Outcome:</b> <input type="checkbox"/> Survived <input type="checkbox"/> Died Date: ____	Is the patient any of the following? <input type="checkbox"/> Healthcare worker <input type="checkbox"/> Food worker/handler <input type="checkbox"/> School or childcare worker or attendee Facility Name & Address: ____			

## 2. REPORTABLE CONDITION INFORMATION / LAB RESULTS

Diagnosis or Suspect Reportable Condition		Onset Date	Diagnosis Date
LAB RESULTS	Date Collected: _____ Date Finalized: _____ Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Other: _____	Lab Test	Lab Result
	Date Collected: _____ Date Finalized: _____ Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Other: _____	Lab Test	Lab Result
	Date Collected: _____ Date Finalized: _____ Specimen Type: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum <input type="checkbox"/> Other: _____	Lab Test	Lab Result

## 3. REPORTER & PROVIDER INFORMATION

<b>Reporting Source</b> (Physician or other reporting source)	Facility
Street Address	City State Zip code Telephone#
<b>Provider</b> (if different from Reporter)	Facility
Provider Street Address	City State Zip code Telephone#
<b>Laboratory Name, Address and Telephone#</b>	

## 4. SEXUALLY TRANSMITTED DISEASES (STD) AND HIV/AIDS

<b>Diagnosis</b>			
<input type="checkbox"/> <b>Syphilis</b> (specify below) <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Early Latent (<1 year) <input type="checkbox"/> Late (> 1 year) <input type="checkbox"/> Congenital Mother's Name: _____ Mother's DOB: _____ <input type="checkbox"/> Other Syphilis <input type="checkbox"/> Neurological symptoms: _____	<input type="checkbox"/> <b>Chlamydia</b> <input type="checkbox"/> PID <input type="checkbox"/> <b>Gonorrhea</b> <input type="checkbox"/> PID <input type="checkbox"/> <b>Herpes</b> <input type="checkbox"/> <b>Chancroid</b>	<input type="checkbox"/> <b>HIV/AIDS</b> Risk Factors <input type="checkbox"/> IDU <input type="checkbox"/> Sex with IDU <input type="checkbox"/> Sex with males <b>Date of Last Negative HIV Test:</b> _____	<b>Site of Infection</b> <input type="checkbox"/> Genitalia <input type="checkbox"/> Rectum <input type="checkbox"/> Throat <input type="checkbox"/> Other <b>Patient had Sexual Contact with:</b> <input type="checkbox"/> Males only <input type="checkbox"/> Refused <input type="checkbox"/> Females only <input type="checkbox"/> Unknown <input type="checkbox"/> Both <b>Marital Status</b> <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Domestic partner <input type="checkbox"/> Unknown <b>Sex Partners:</b> # Sex partners: _____ # Sex partners treated: _____
<b>Treatment</b>			
Date	Drug	Dosage	
Date	Drug	Dosage	
Date	Drug	Dosage	

## 5. HEPATITIS PANEL

<b>Hepatitis A Serology Results</b>	
Hepatitis A Antibody (acute IgM anti-HAV)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
<b>Hepatitis B Serology Results</b>	
Hepatitis B surface Antigen (HBsAg)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis B core Antibody IgM (HBcAb-IgM)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis B core Antibody Total (HBcAb)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis B surface Antibody (HBsAb)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis B e Antigen (HBeAg)	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Symptoms consistent with acute hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk
Liver Function Test ALT: _____	AST: _____
<b>Hepatitis C Serology Results</b>	
Hepatitis C-EIA	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk s/co ratio: _____
Hepatitis C-RIBA	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis C-NAT/PCR	<input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk
Hepatitis C-Viral Load	_____
Liver Function Test ALT: _____	AST: _____

## 6. TUBERCULOSIS (TB)

<b>Site of Disease</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Laryngeal <input type="checkbox"/> Extrapulmonary
<input type="checkbox"/> TB Infection in a Child 5 and Under (Positive TB skin test result)
Medicine and Dosage