OHIO CONFIDENTIAL REPORTABLE DISEASE FORM

Use this form to report infectious diseases to your local health department.
(DO NOT use this form to report HIV/AIDS)

DISEASE REPORTED:

ODRS No. **(internal use only)**

Patient's Last Name: First Name: Middle Name (or initial and suffix):

Address (Number and Street):

City: County: State: Zip Code:

Home Telephone: ( ) Work Telephone: ( ) Alternate Number: ( )

Birthdate (MM/DD/YYYY): / / Age: Sex: ☐ Female ☐ Male Pregnant: ☐ Yes ☐ No ☐ Unk Delivery Date: / /

Race (check one):
☐ White ☐ Asian
☐ Black ☐ Multiracial
☐ American Indian or Alaskan Native
☐ Hawaiian Native or Pacific Islander
☐ Other
☐ Unknown

Ethnicity (check one): ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Patient Contacted: ☐ Yes ☐ No ☐ Unknown

Parent, Guardian, or Alternate Contact Name: Phone: ( )

Health Care Provider (Name and Address): Phone: ( )

Health Care Facility (Name and Address): Phone: ( )

Submitted By (Contact Name): Phone: ( )

Date of Report: ____/____/_____

Date of Diagnosis: ____/____/_____

Date of Onset: ____/____/_____

Hospital Admission: ____/____/_____

Hospital Discharge: ____/____/_____

Date of Death: ____/____/_____

Status: ☐ Laboratory Confirmed
☐ Clinically Diagnosed (list symptoms)_____

Laboratory (Name and Address):

Date of Specimen Collection: ____/____/_____ Reason for Test: ☐ Dx ☐ Prenatal ☐ Repeat pos

Specimen Site/Type: ☐ Blood ☐ Stool ☐ CSF ☐ Urine ☐ Other _____

Specific Type of Test (e.g. smear, culture, ELISA):

Treatment (Required for STD): ☐ Treated ☐ Untreated:
☐ Will treat
☐ Unable to contact
☐ Refused treatment
☐ Referred to:

Date Treatment Initiated: ____/____/_____

(Detail Drugs/Dose/Route):_____

Remarks:_____

Class C Reporting (Report number of cases only)

Disease: No. of Cases: Week Ending: / /

Sandusky County Health Department Routine Calls Phone: (419) 334-6377 for calls concerning STD's call (419)-334-6355
2000 Countryside Drive
Fremont, OH 43420

FAX REPORTS TO # (419) 334-6380

FAX STD REPORTS TO #(419) 334-6353

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