



**COMMUNICABLE DISEASE REPORT**  
 Important Instructions - Please complete Sections 1 thru 3 for all reportable conditions. In addition, complete Section 4 for STDs and HIV/AIDS, 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 <http://siren.az.gov>.

County / IHS Number

State ID / MEDSIS ID

Date Received by County

**1. PATIENT INFORMATION**

Patient's Name (Last) (First) (Middle Initial)			Date of Birth	Race (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		Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Sex <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Female <input type="checkbox"/> Unknown		Pregnant <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes Due Date _____	
Street Address			City	State	ZIP Code	County	Reservation	Telephone #			
Patient's Occupation or School			Guardian (Not necessary for STD)		Outcome <input type="checkbox"/> Survived <input type="checkbox"/> Died Date _____		Is the patient any of the following? <input type="checkbox"/> Health care worker <input type="checkbox"/> Food worker/handler <input type="checkbox"/> Childcare worker/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 AND PROVIDER INFORMATION**

Reporting Source (Physician or other reporting source)					Facility	
Street Address		City	State	ZIP Code	Telephone #	
Provider (If different from reporter)					Facility	
Provider Street Address		City	State	ZIP Code	Telephone #	
Lab Name, Address and Telephone #						

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

<b>Diagnosis</b> <input type="checkbox"/> Syphilis (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"/> Chlamydia <input type="checkbox"/> PID <input type="checkbox"/> Gonorrhea <input type="checkbox"/> PID <input type="checkbox"/> Herpes <input type="checkbox"/> Chancroid		<input type="checkbox"/> HIV/AIDS 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> # of partners _____ # of 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)		Pos	Neg	Unk
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hepatitis B Serology Results</b> Hepatitis B surface Antigen (HBsAg) Hepatitis B core Antibody IgM (HBcAb-IgM) Hepatitis B core Antibody Total (HBcAb) Hepatitis B surface Antibody (HBsAb) Hepatitis B e Antigen (HBeAg) Symptoms consistent with acute hepatitis Jaundice Liver Function Test ALT _____ AST _____		Pos	Neg	Unk
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Hepatitis C Serology Results</b> Hepatitis C-EIA s/co ratio _____ Hepatitis C-RIBA Hepatitis C-NAT/PCR Hepatitis C-Viral Load Liver Function Test ALT _____ AST _____		Pos	Neg	Unk
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**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)	
<b>Medicine and Dosage</b> (Please enter information)	

**Comments**