



# 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 [siren.az.gov](http://siren.az.gov).

|                     |                      |                         |
|---------------------|----------------------|-------------------------|
| County / IHS Number | State ID / MEDSIS ID | Date Received by County |
|---------------------|----------------------|-------------------------|

## 1. PATIENT INFORMATION

|  |  |  |  |   |  |   |                    |
|--|--|--|--|---|--|---|--------------------|
| <b>Patient's Name (Last)</b><br>Middle | <b>(First)</b>                           | <b>Date of Birth</b>   | <b>Race</b> (check all that apply):<br><input type="checkbox"/> White <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Unknown<br><input type="checkbox"/> Black <input type="checkbox"/> Native American<br><input type="checkbox"/> Asian <input type="checkbox"/> Other | <b>Ethnicity:</b><br><input type="checkbox"/> Hispanic<br><input type="checkbox"/> Non-Hispanic<br><input type="checkbox"/> Unknown | <b>Gender:</b><br><input type="checkbox"/> Male <input type="checkbox"/> Unknown<br><input type="checkbox"/> Female <input type="checkbox"/> Transgender | <b>Pregnant:</b><br><input type="checkbox"/> No <input type="checkbox"/> Unknown<br><input type="checkbox"/> Yes<br>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><br><input type="checkbox"/> Survived<br><input type="checkbox"/> Died Date: ____ | Is the patient any of the following?<br><input type="checkbox"/> Healthcare worker <input type="checkbox"/> Food worker/handler <input type="checkbox"/> School or childcare worker or attendee<br>Facility Name & Address: ____   |   |  |   |                    |

## 2. REPORTABLE CONDITION INFORMATION / LAB RESULTS

| Diagnosis or Suspect Reportable Condition  | Onset Date     | Diagnosis Date  |   |            |            |
|--|----------------|---|---|------------|------------|
| <b>L</b><br><b>A</b><br><b>B</b><br><br><b>A</b><br><b>R</b><br><b>E</b><br><b>S</b><br><b>U</b><br><b>L</b><br><b>T</b><br><b>S</b> | Date Collected | Date Finalized  | Specimen Type<br><input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine<br><input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum<br><input type="checkbox"/> Other ____ | Lab Test   | Lab Result |
| Date Collected   | Date Finalized | Specimen Type<br><input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine<br><input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum<br><input type="checkbox"/> Other ____ | Lab Test  | Lab Result |            |
| Date Collected   | Date Finalized | Specimen Type<br><input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Urine<br><input type="checkbox"/> Stool <input type="checkbox"/> NP Swab <input type="checkbox"/> Sputum<br><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)<br><input type="checkbox"/> Primary<br><input type="checkbox"/> Secondary<br><input type="checkbox"/> Early Latent (<1 year)<br><input type="checkbox"/> Late (< 1 year)<br><input type="checkbox"/> Congenital<br>Mother's Name: _____<br>Mother's DOB: _____<br><input type="checkbox"/> Other Syphilis<br><input type="checkbox"/> Neurological symptoms: _____ | <input type="checkbox"/> <b>Chlamydia</b><br><input type="checkbox"/> PID<br><input type="checkbox"/> <b>Gonorrhea</b><br><input type="checkbox"/> PID<br><input type="checkbox"/> <b>Herpes</b><br><input type="checkbox"/> <b>Chancroid</b> | <input type="checkbox"/> <b>HIV/AIDS</b><br>Risk Factors<br><input type="checkbox"/> IDU<br><input type="checkbox"/> Sex with IDU<br><input type="checkbox"/> Sex with males<br><b>Date of Last Negative HIV Test:</b> ____ | <b>Site of Infection</b><br><input type="checkbox"/> Genitalia <input type="checkbox"/> Rectum<br><input type="checkbox"/> Throat <input type="checkbox"/> Other<br><b>Patient had Sexual Contact with:</b><br><input type="checkbox"/> Males only <input type="checkbox"/> Refused<br><input type="checkbox"/> Females only <input type="checkbox"/> Unknown<br><input type="checkbox"/> Both<br><b>Marital Status</b><br><input type="checkbox"/> Married <input type="checkbox"/> Single<br><input type="checkbox"/> Divorced <input type="checkbox"/> Widowed<br><input type="checkbox"/> Separated <input type="checkbox"/> Domestic partner<br><b>Sex Partners:</b><br># Sex partners ____<br># 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><br><input type="checkbox"/> Pulmonary<br><input type="checkbox"/> Laryngeal<br><input type="checkbox"/> Extrapulmonary |
| <input type="checkbox"/> TB Infection in a Child 5 and Under (Positive TB skin test result)   |
| Medicine and Dosage   |