ARIZONA DEPARTMENT OF HEALTH SERVICES

COMMUNICABLE DISEASE REPORT FOR HEALTHCARE PROVIDERS

Healthcare providers are required to report selected communicable diseases, per Arizona Administrative Code R9-6-202.
Report communicable diseases through MEDSIS (https://medsisprod.azdhs.gov/medsis) or to the local health agency (fax numbers below).
Visit http://azdhs.gov/providerreporting for the list of reportable conditions, this form, and other communicable disease reporting information.

Clear Form

1. Complete the PATIENT INFORMATION

Patient's Name (Last, First, Middle)

Date of Birth

Race (check all that apply):
☐White ☐American Indian/Alaskan Native _____
☐Black ☐Native Hawaiian/Pacific Islander (List tribal affiliation)
☐Asian ☐Other ☐Unknown

Ethnicity
☐Hispanic
☐Non-Hispanic
☐Unknown

Sex at Birth
☐Female ☐Ambiguous
☐Male ☐Other
☐Unknown

Pregnant No ☐
Unknown ☐ Yes ☐
Est. due date:

Street Address | **City** | **State** | **Zip code** | **County** | **Reservation** | **Telephone #** | **Email**

2. Complete the REPORTABLE CONDITION INFORMATION

Diagnosis or Suspect Reportable Condition

Unique ID/MRN

Illness Onset Date

Diagnosis Date

Notes/Comments

Parent/guardian information (include phone & address if different than child)

Date Collected	Specimen Type	Lab Test
Result Date		Lab Result
Date Collected	Specimen Type	Lab Test
Result Date		Lab Result
Date Collected	Specimen Type	Lab Test
Result Date		Lab Result
Date Collected	Specimen Type	Lab Test
Result Date		Lab Result
Date Collected	Specimen Type	Lab Test
Result Date		Lab Result

DISEASE SPECIFIC INFORMATION

If chlamydia or gonorrhea:
☐ with Pelvic Inflammatory Disease

If chlamydia, gonorrhea, chancroid, syphilis:
Sex partners in the last 2 months _____

If HIV/AIDS: Negative HIV test in last 6 months?
☐Yes ☐No ☐Unk

Injection drug user (IDU) ☐

If syphilis: Symptoms at diagnosis
☐No symptoms
☐Chancre/lesion
☐Rash
☐Neurologic (incl. ocular, otic)
☐Other, specify _____

☐Congenital syphilis

Birth mother's name _____

Birth mother's DOB _____

If STI/HIV/AIDS

Patient had sexual contact with: ☐Females only ☐Males only ☐Both ☐Unknown

Treatment

Date	Drug	Dosage
Date	Drug	Dosage
Date	Drug	Dosage

TUBERCULOSIS:

TB signs/symptoms
☐Yes
☐No
☐Unk

Chest imaging
☐ Consistent with TB
☐ Not consistent with TB
☐ Not performed

Site of disease
☐Pulmonary
☐Laryngeal
☐Other extrapulmonary

Initial Drug Regimen
Start date: _____
☐RIPE
☐Other _____

TB infection in a child <6 years old (positive TST / IGRA)? ☐Yes ☐No

3. Complete the FACILITY INFORMATION

Reporter (Person making this report or physician)
Name _____ Reporting Facility _____
Reporter Address _____
City _____ State _____ Zip _____
Telephone _____ Email _____

Provider (if different from Reporter)
Name _____
Provider Facility _____
Provider Address _____
Telephone _____ Email _____

Laboratory (if testing performed)
Laboratory Name _____
Laboratory Address _____
Telephone _____

Fax numbers for local health departments:

Apache (866) 804-8449; **Cochise non-STIs** (520) 432-9479; **Cochise STIs** (520) 384-0309; **Coconino** (928) 447-4187; **Gila** (928) 220-8618; **Graham** (928) 428-8074; **Greenlee** (928) 865-1929; **La Paz** (928) 669-6703; **Maricopa non-STIs** (602) 372-8935; **Maricopa STIs** (602) 506-6916; **Mohave** (928) 718-1579; **Navajo** (928) 532-6054; **Pima** (520) 838-7538; **Pinal** (520) 866-2929; **Santa Cruz** (520) 375-7624; **Yavapai** (866) 271-9773; **Yuma** (928) 317-4620