



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 to the local health agency (fax numbers below) or through MEDSIS (<https://my.health.azdhs.gov/>). Visit <http://azdhs.gov/providerreporting> for the list of reportable conditions, this form, and other communicable disease reporting information.

1. Complete the PATIENT INFORMATION

Patient's Name (Last, First, Middle)	Date of Birth	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> Native American (list tribal affiliation) _____ <input type="checkbox"/> Black <input type="checkbox"/> Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Gender <input type="checkbox"/> Male <input type="checkbox"/> Unknown <input type="checkbox"/> Female <input type="checkbox"/> Transgender	Parent/guardian (of minors) (Not necessary for STDs)
Street Address	City	State	Zip code	County	Reservation	Telephone #	Email	

2. Complete the REPORTABLE CONDITION INFORMATION

Diagnosis or Suspect Reportable Condition	Illness Onset Date	Diagnosis Date	
Risk & outcome information: Patient's School or Occupation *Write the school/facility/employer name in the Notes if any of these are checked. <input type="checkbox"/> *Healthcare worker <input type="checkbox"/> *Food worker/handler <input type="checkbox"/> *School/childcare worker <input type="checkbox"/> *School/childcare attendee Other occupation (specify) _____	Outcome <input type="checkbox"/> Survived <input type="checkbox"/> Died, date: _____ <input type="checkbox"/> Injection drug user (IDU)	If STDs, Hepatitis or HIV/AIDS: Patient had sexual contact with: <input type="checkbox"/> Males only <input type="checkbox"/> Females only <input type="checkbox"/> Both <input type="checkbox"/> Unknown	
Notes/Comments (including school/facility/ employer name if above boxes are checked)	If SEXUALLY TRANSMITTED DISEASES (STD) or HIV/AIDS: If chlamydia or gonorrhea: <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		
L Date Collected _____ Specimen Type _____ Lab Test _____ <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> NP swab A Result Date _____ <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Other swab _____ Lab Result _____ <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____ R Date Collected _____ Specimen Type _____ Lab Test _____ <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> NP swab S Result Date _____ <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Other swab _____ Lab Result _____ <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____ U Date Collected _____ Specimen Type _____ Lab Test _____ <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> NP swab L Result Date _____ <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Other swab _____ Lab Result _____ <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____ T Date Collected _____ Specimen Type _____ Lab Test _____ <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> NP swab S Result Date _____ <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Other swab _____ Lab Result _____ <input type="checkbox"/> Sputum <input type="checkbox"/> Other _____	STD Treatment		
	If HEPATITIS: Acute hepatitis symptoms <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 values (with units) ALT: _____ AST: _____		Hepatitis Test Results A Hepatitis A antibody (IgM anti-HAV) <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 surface antigen (HBsAg) <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk B Hepatitis B e antigen (HBeAg) <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Hepatitis B DNA/NAT <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Hepatitis C-EIA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk C Hepatitis C-NAT/PCR <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Unk Hepatitis C-Viral Load _____
	If TUBERCULOSIS: TB signs/symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Chest imaging <input type="checkbox"/> Consistent with TB <input type="checkbox"/> Not consistent with TB <input type="checkbox"/> Not performed Site of disease <input type="checkbox"/> Pulmonary <input type="checkbox"/> Laryngeal <input type="checkbox"/> Other extrapulmonary Initial Drug Regimen Start date: _____ <input type="checkbox"/> RIPE <input type="checkbox"/> Other _____		ST Date _____ Drug _____ Dosage _____ U Date _____ Drug _____ Dosage _____ S Date _____ Drug _____ Dosage _____
TB infection in a child <6 years old (positive TST / IGRA)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

3. Complete the FACILITY INFORMATION

Person making this report (Reporter) (Physician or other reporting source) 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 _____
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Fax numbers for local health departments: Apache (866) 804-8449; Cochise (520) 432-9479; Coconino (928) 679-7351; Gila (928) 425-0794; Graham (928) 428-8074; Greenlee (928) 865-1929; La Paz (928) 669-6703; Maricopa non-STDs (602) 372-8935; Maricopa STDs (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

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