

Ohio Department of Health

Use this form to submit reportable infectious diseases to your local health department (**Do not** use this form to report HIV/AIDS)

Disease reported						ODRS number	
Patient's last name		First name		Middle name (or initial and/or suffix)		Medical record number	
Address (number and street)						County	
City		State		ZIP		Patient expired? ☐ Yes ☐ No ☐ Unknown	
Home telephone ()		Work telephone ()			Alternate number ()		
Birthdate (month/day/year) / /		Age	Sex ☐ Male ☐ Female		Pregnant ☐ Yes ☐ No ☐ Unknown		Delivery date / /
Race (check all that apply) ☐ American Indian or Alaskan Native ☐ Asian ☐ African American ☐ Unknown ☐ Native Hawaiian or Pacific Islander ☐ White ☐ Other _____					Ethnicity (check one) ☐ Hispanic ☐ Unknown ☐ Non-Hispanic		Was patient contacted? ☐ Yes ☐ Unknown ☐ No
Sensitive occupation? (Check all that apply) ☐ Food handler ☐ Direct patient-care ☐ Child care attendee/staff ☐ Long-term care resident/staff ☐ Not applicable			Name of facility				
			Address of facility				

Parent, guardian, or alternate contact name	Phone
Health care provider name	Phone
Health care provider address	
Health care facility name	Phone
Health care facility address	
Submitted by (contact name, facility)	Phone

Date of report / /	Status ☐ Laboratory confirmed ☐ Clinically diagnosed (list symptoms) _____		Date of result / /
Date of onset / /	Laboratory name		Phone ()
Date of diagnosis / /	Laboratory address		
Hospital admission / /	Date of specimen collection / /	Reason for test ☐ Dx ☐ Prenatal ☐ Repeat pos	Specific type of test (e.g. smear, culture, ELISA)
Hospital admission / /	Specimen site/type ☐ Blood ☐ Stool ☐ CSF ☐ Urine ☐ Cervix ☐ Urethra ☐ Sputum ☐ Other _____		
Hospital discharge / /	Treatment ☐ Treated ☐ Untreated: ☐ Will treat ☐ Unable to contact ☐ Refused treatment ☐ Referred to: _____		
Date of death / /	Date treatment initiated / /	Detail drugs /dose/route	

Remarks

Please submit to: