



REPORTABLE DISEASES/ CONDITIONS

The following diseases are to be reported to the OSDH by telephone, FAX, or PHIDDO immediately upon suspicion, diagnosis, or positive test.

Anthrax	Hepatitis A (Anti-HAV-IgM +)	Rabies
Bioterrorism-suspected disease	Measles (Rubeola)	Smallpox
Botulism	Meningococcal invasive disease	Tularemia
Brucellosis	Outbreaks of apparent infectious disease	Typhoid fever
Diphtheria	Plague	Viral hemorrhagic fever
<i>H. influenzae</i> invasive disease	Poliomyelitis	

The following diseases are to be reported to the OSDH within one business day

Acid Fast Bacillus (AFB) positive smear	Leptospirosis
AIDS (Acquired Immunodeficiency Syndrome)	Listeriosis
Arboviral Infections	Lyme Disease
Campylobacteriosis	Malaria
Congenital rubella syndrome	Mumps
Cryptosporidiosis	Pertussis
Cyclosporiasis	Psittacosis
Dengue Fever	Rocky Mountain Spotted Fever
<i>E. coli</i> O157, <i>E. coli</i> O157: H7 or a shiga-like toxin producing <i>E. coli</i> (EHEC)	Rubella
Ehrlichiosis	Salmonellosis
Encephalitis	Shigellosis
Giardiasis	<i>Streptococcus</i> , group A, invasive disease
Hantavirus Pulmonary Syndrome	<i>Streptococcus pneumoniae</i> invasive disease
Hemolytic Uremic Syndrome, postdiarrheal	Syphilis
Hepatitis B (acute or chronic, HBsAg+ and/or anti-HBc IgM+)	Tetanus
Hepatitis C (confirmed by RIBA or PCR only)	Trichinosis
Hepatitis, acute unspecified	Tuberculosis
Human Immunodeficiency Virus (HIV) infection	Unusual syndrome, or uncommon disease
Legionellosis	<i>Vibrio</i> spp. infections including cholera
Leprosy	Yellow Fever

The following diseases are to be reported to the OSDH within one month

CD4 Cell Count <500	Creutzfeldt-Jakob Disease	Pelvic Inflammatory Disease
<i>Chlamydia</i> infections	Gonorrhea	

Isolates of the following organisms must be sent to the OSDH Public Health Laboratory:

(1) <i>Bacillus anthracis</i>	(9) <i>N. meningitidis</i> (sterile site isolates only)	P.O. Box 24106 OKC, OK 73124
(2) <i>Brucella</i> spp.	(10) <i>Plasmodium</i> spp.	
(3) <i>Campylobacter</i> spp.	(11) <i>Salmonella</i> spp.	
(4) <i>E. coli</i> O157, O157:H7, or a shiga-like toxin producing <i>E. coli</i> (EHEC)	(12) <i>Shigella</i> spp.	
(5) <i>Francisella tularensis</i>	(13) <i>Vibrio</i> spp.	
(6) <i>H. influenzae</i> (sterile site isolates only)	(14) <i>Yersinia</i> spp.	
(7) <i>Listeria</i> (sterile site isolates only)		
(8) <i>Mycobacterium tuberculosis</i>		

Clinical specimens for Botulism testing must be sent to the OSDH Public Health Lab

HIV/STD Service

(405) 271-4636
FAX (405) 271-1187

Communicable Disease Division

(405) 271-4060
FAX (405) 271-6680
FAX (800) 898-6734

Immunization Division

(405) 271-4073
FAX (405) 271-6133

FAX machines are located in locked offices and are monitored to ensure the confidentiality of disease reports.

REPORTABLE DISEASE CARD

PLEASE ANSWER EVERY QUESTION ON THE CARD

DISEASE _____				DATE OF ONSET OF SYMPTOMS _____/_____/____	
PATIENT'S NAME _____				DATE OF SPECIMEN COLLECTION _____/_____/____	
ADDRESS _____				DATE OF THIS REPORT _____/_____/____	
CITY _____		ZIP _____		DATE OF BIRTH _____/_____/____	
PHONE() _____					
AGE _____		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RACE	
<input type="checkbox"/> YEARS <input type="checkbox"/> MONTHS <input type="checkbox"/> DAYS		<input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> AMER. IND. <input type="checkbox"/> ASIAN <input type="checkbox"/> OTHER		HISPANIC ETHNICITY	
				<input type="checkbox"/> YES <input type="checkbox"/> NO	

In the past 6 weeks, has PATIENT / HOUSEHOLD MEMBER (PLEASE CIRCLE ONE) ATTENDED, LIVED IN, or WORKED IN (PLEASE CIRCLE ONE) any of the following settings?

- | | | |
|---------------------------------------|--|----------------------------------|
| <input type="checkbox"/> Child care | <input type="checkbox"/> Food handler | <input type="checkbox"/> Unknown |
| <input type="checkbox"/> Nursing Home | <input type="checkbox"/> Other Institution | |

Name and location of Establishment: _____

How was diagnosis made? Clinical Laboratory Name: _____

Test method & source: _____

Results of lab tests: _____

Hepatitis Panel Results: Check applicable box +Positive - =Negative ND = Not Done			Comments: _____ _____ _____ _____
+ - ND	+ - ND	+ - ND	
<input type="checkbox"/> <input type="checkbox"/> HAV	<input type="checkbox"/> <input type="checkbox"/> HBcAb	<input type="checkbox"/> <input type="checkbox"/> HBeAb	
<input type="checkbox"/> <input type="checkbox"/> HAVIgM	<input type="checkbox"/> <input type="checkbox"/> HBcIgM	<input type="checkbox"/> <input type="checkbox"/> HCV	
<input type="checkbox"/> <input type="checkbox"/> HBsAg	<input type="checkbox"/> <input type="checkbox"/> HBeAg	<input type="checkbox"/> <input type="checkbox"/> HCV Riba/PCR	
<input type="checkbox"/> <input type="checkbox"/> HBsAb			
ALT _____	AST _____	Total Bili _____	

Was patient hospitalized? <input type="checkbox"/> Yes: Name of hospital _____ <input type="checkbox"/> No	Did patient die due to this disease? Survived _____ Died: Date of death _____/_____/_____
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Reporting Source: <input type="checkbox"/> Physician <input type="checkbox"/> Hospital / ICP <input type="checkbox"/> Laboratory <input type="checkbox"/> Other		Need more cards? <input type="checkbox"/> YES Name and address if different from left:
Name of person reporting _____		
Facility Name _____		
Address _____		
City _____	State _____	
Zip _____	Phone () _____	
Attending Physician _____		
City _____	State _____	
Phone () _____		