



# 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

<b>DISEASE</b> _____				<b>DATE OF ONSET OF SYMPTOMS</b> _____/_____/_____ / /	
<b>PATIENT'S NAME</b> _____				<b>DATE OF SPECIMEN COLLECTION</b> _____/_____/_____ / /	
<b>ADDRESS</b> _____				<b>DATE OF THIS REPORT</b> _____/_____/_____ / /	
<b>CITY</b> _____		<b>ZIP</b> _____		<b>DATE OF BIRTH</b> _____/_____/_____ / /	
<b>PHONE( )</b> _____					
<b>AGE</b> _____		<b>SEX</b> <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<b>RACE</b>	
<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	
				<b>HISPANIC ETHNICITY</b> <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?

- Child care                       Food handler                       Unknown  
 Nursing Home                       Other Institution

Name and location of Establishment: \_\_\_\_\_

**How was diagnosis made?**     Clinical                       Laboratory                      Name: \_\_\_\_\_

Test method & source: \_\_\_\_\_

Results of lab tests: \_\_\_\_\_

<b>Hepatitis Panel Results: Check applicable box</b> +Positive    - =Negative    ND = Not Done			<b>Comments:</b> _____ _____ _____ _____
+ - 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?**     Yes: Name of hospital \_\_\_\_\_    **Did patient die due to this disease?**  
 No                      Survived \_\_\_\_\_  
Died: Date of death \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

<b>Reporting Source:</b> <input type="checkbox"/> Physician <input type="checkbox"/> Hospital / ICP <input type="checkbox"/> Laboratory <input type="checkbox"/> Other	<b>Need more cards?</b> <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 ( ) _____	