**GEORGIA NOTIFIABLE DISEASE/CONDITION REPORT FORM**

**REPORT CASES BY MAIL, FAX OR PHONE TO DISTRICT HEALTH OFFICE OR TO SENDSS (http://sendss.state.ga.us)**

### PATIENT DEMOGRAPHICS

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient's Name</strong></td>
<td></td>
</tr>
<tr>
<td>Last Name</td>
<td></td>
</tr>
<tr>
<td>First Name</td>
<td></td>
</tr>
<tr>
<td>MI</td>
<td></td>
</tr>
<tr>
<td><strong>Patient's Address</strong></td>
<td></td>
</tr>
<tr>
<td>Street</td>
<td></td>
</tr>
<tr>
<td>City</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
<tr>
<td>Zip+4</td>
<td></td>
</tr>
<tr>
<td>County</td>
<td></td>
</tr>
</tbody>
</table>

**Date of Birth**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yrs</td>
<td></td>
</tr>
<tr>
<td>Mos</td>
<td></td>
</tr>
<tr>
<td>Weeks</td>
<td></td>
</tr>
<tr>
<td>Days</td>
<td></td>
</tr>
<tr>
<td>Unk</td>
<td></td>
</tr>
</tbody>
</table>

**Ethnicity**

- [ ] Hispanic
- [ ] Non-Hispanic
- [ ] Unknown

**Sex**

- [ ] Male
- [ ] Female
- [ ] Unknown

**Race**

- [ ] Asian
- [ ] Black/African-American
- [ ] Native American or Alaska Native
- [ ] Native Hawaiian or Pacific Islander
- [ ] Other
- [ ] Unknown
- [ ] Multiracial
- [ ] White

**Patient's Home Phone**

**Patient's Work Phone**

**Patient's Other Phone**

### CLINICAL INFORMATION

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Illness Onset Date</td>
<td></td>
</tr>
<tr>
<td>Hospitalized</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td></td>
</tr>
<tr>
<td>Emergency Rm</td>
<td></td>
</tr>
<tr>
<td>Died?</td>
<td></td>
</tr>
</tbody>
</table>

**Date of Death**

**If hospitalized, complete:**

- [ ] Hospital Name
- [ ] Admit Date
- [ ] Discharge Date

### LABORATORY INFORMATION

**Specimen Collection Date**

**Test Name**

- [ ] Culture
- [ ] IFA
- [ ] IGM
- [ ] EIA

**Species / Serotype**

- [ ] HAV
- [ ] HBsAg
- [ ] HBC
- [ ] HCV
- [ ] HCV RNA
- [ ] ALT
- [ ] AST

### ADDITIONAL INFORMATION

**Pregnant**

- [ ] Yes
- [ ] No
- [ ] UNK

**Nursing Home or other**

- [ ] Chronic Care Facility
- [ ] Child In Daycare
- [ ] Daycare Worker
- [ ] Prisoner/Detainee
- [ ] Food Handler
- [ ] Health Care Worker
- [ ] Outbreak Related
- [ ] Travel in Last 4 Weeks

### VIRAL HEPATITIS

**Test Results**

<table>
<thead>
<tr>
<th>Field</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Date of test(s)**

**Comments/Symptoms/Treatment:**

**Local Use Only**

**State Use Only**

**Additional form completed**

**Name:**

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Form 3095 (5-04)