

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>)

Disease/Condition _____ Medical Record Number _____

PATIENT DEMOGRAPHICS

Patient's Name

Last Name _____ First Name _____ MI _____

Patient's Address

Street _____

City _____ State _____ Zip+4 _____ County _____

() _____ () _____ () _____

Patient's Home Phone _____ Patient's Work Phone _____ Patient's Other Phone _____

Date of Birth / /		Age _____	Age Type <input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Weeks <input type="checkbox"/> Days <input type="checkbox"/> Unk
Ethnicity		Sex	
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Male	<input type="checkbox"/> Female
<input type="checkbox"/> Unknown		<input type="checkbox"/> Unknown	
Race			
<input type="checkbox"/> Asian	<input type="checkbox"/> Black/African-American	<input type="checkbox"/> Native Hawaiian or Pacific Islander	
<input type="checkbox"/> Native American or Alaska Native	<input type="checkbox"/> Multiracial	<input type="checkbox"/> Other	<input type="checkbox"/> Unknown
		<input type="checkbox"/> White	

CLINICAL INFORMATION

Illness Onset Date / /	Hospitalized <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK Emergency Rm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Outpatient <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> UNK <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Died? <input type="checkbox"/> N <input type="checkbox"/> Y <input type="checkbox"/> UNK Date of Death: / /
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If hospitalized, complete: Hospital Name _____ Admit Date _____ Discharge Date _____

LABORATORY INFORMATION *Report Hepatitis information in Viral Hepatitis box below

Specimen Collection Date	Test Name (ex. Culture, IFA, IGM, EIA)	Specimen Type (ex. Stool, Blood, CSF)	Result (ex. +/-, titer, Presumptive)	Species / Serotype	Lab Name

ADDITIONAL INFORMATION

	Yes	No	UNK
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nursing Home or other Chronic Care Facility	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Child In Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daycare Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prisoner/Detainee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Handler	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Care Worker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outbreak Related	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Travel in Last 4 Weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

*VIRAL HEPATITIS

Date of test(s) _____

		Pos	Neg	UNK
Hepatitis A	Total anti-HAV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgM anti-HAV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Total anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	IgM anti-HBc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	anti-HCV (EIA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis C	anti-HCV signal to cut-off ratio	_____		
	RIBA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	HCV RNA (PCR, bDNA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All	ALT(SGPT) _____			
	AST (SGOT) _____			

REPORTER INFORMATION

Report Date / /

Reporter Name _____

Reporter Phone () _____

Reporter Institution _____

Physician Name _____

Physician Phone () _____

Comments/Symptoms/Treatment:

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 Entered into SENDSS

Local Use Only	State Use Only
<input type="checkbox"/> Additional form completed Name: _____	