



CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES

State Form 43823 (R2 / 11-96)

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 3.1-2-18.

DISEASE

Name (last, first, m.i.)							
If child, name of parent (last, first, m.i.)							
Address (number and street)		Telephone number ()					
City, ZIP code		<p>(Not Required For STD's) Check all that apply:</p> <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Food Service <input type="checkbox"/> School (student / staff) <input type="checkbox"/> Day Care (attendee / staff)					
County							
Date of birth (month, day, year)	Age						
<table border="1"> <tr> <th>SEX</th> <th>RACE</th> <th>ETHNICITY</th> </tr> <tr> <td> <input type="checkbox"/> Male <input type="checkbox"/> Female Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown </td> <td> <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> Multi-Racial </td> <td> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown </td> </tr> </table>	SEX		RACE	ETHNICITY	<input type="checkbox"/> Male <input type="checkbox"/> Female Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____ <input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown
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Etiologic agent		Site of infection					
Date of diagnosis (month, day, year)		Stage (syphilis only)					
Symptoms associated with infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown							
IF YES	(Not Required for STD's) Onset date (month, day, year)	Died? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	Pertinent symptoms, signs:						
Lab test(s) and result(s)		Date(s)					
Treatment (name of antibiotic)		Dosage					
Antibiotic resistance? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NOT DONE		Date initiated					
If Yes, what antibiotic?							

Reporting Facility Code (see other side for codes)	If hospital, name of hospital
Name of physician and address	Record number
	Person reporting (other than physician)
Telephone number ()	Telephone number ()
Date of report	Check here if you need more cards <input type="checkbox"/>

LOCAL HEALTH DEPARTMENT USE ONLY	
Date received (month, day, year)	Follow-up initiated? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of investigator	

REPORTING FACILITY CODE	(Type of facility reporting the case to the local health department or State Department of Health)		
	LETTER CODE	LETTER CODE	
Private Medical Practice / HMO	PHY	Clinics:	
Hospital:		Prenatal	PRN
Outpatient	OUT	School / Student Health	SCH
Inpatient	INP	Reproductive Health	
ER	ER	(Family Planning, Abortion)	FAM
Lab (Hospital, Private, or Other)	LAB	Adult / Adolescent Health Clinic	ADU
Mental Health Facility	MEN	STD Clinic	SO1 13
Nursing Home	NUR	Free Standing Facilities:	
Drug / Alcohol Rehab Center (free standing)	REH	Ambulatory Surgery Center	ASC
Correctional Facility	COR	Blood Bank / Plasma Center	BLO
		Other	OTH
For any questions or emergencies, call (317) 233-7665 8:15 AM 4:45 PM OR (317) 383-6144 ALL OTHER			
Reportable Diseases (for reporting requirements, see sections 6(b) and 6(c) found in code 410 IAC 2.1)	Legionellosis Leptospirosis Listeriosis Lymphogranuloma Venereum Malaria Meningitis, Aseptic (Viral) Mumps Ophthalmia Neonatorum Pelvic Inflammatory Disease Pertussis Poliomyelitis Psittacosis Rocky Mountain Spotted Fever Rubella Congenital Syndrome Salmonellosis Syphilis Trichinosis Tularemia Typhoid Fever, Cases and Carriers Typhus, Endemic (flea borne) Yellow Fever Yersiniosis		
Diseases reported on a DIFFERENT form			
Acquired Immunodeficiency Syndrome			
Animal Bites			
Human Immunodeficiency Virus Infection			
Tuberculosis, Cases and Reactors			
Diseases reported on THIS form			
Diseases to be reported immediately (following probable diagnosis)			
Anthrax			
Botulism (foodborne)			
Cholera			
Diphtheria			
Haemophilus Infuenza Invasive Disease (including meningitis)			
Measles (Rubeola)			
Meningitis, Bacterial (see Meningococcal and Haemophilus)			
Meningococcal Infections (all)			
Plague			
Q Fever			
Rabies in Humans			
Rubella (German Measles) ** see below for congenital syndrome			
Shigellosis (immediate reporting requested)			
Typhus, Epidemic (louse borne)			
Disease to be reported within 72 hours			
Amebiasis			
Brucellosis			
Campylobacter Enteritis			
Chancroid			
Chlamydial Infections			
Cryptosporidiosis			
Dengue Fever			
Encephalitis, Acute, Infectious			
Eschericia coli, Diarrhea Associated			
Giardiasis			
Gonorrhea			
Granuloma Inguinale			
Hepatitis, Viral (A,B,Delta, Non A Non B, Unspecified)			
Herpes Neonatal			
Histoplasmosis			
Diseases to be reported within 1 week			
Botulism (infant and wound)			
Human Bites			
HIV Infection, Including AIDS			
Lyme Disease			
Tetanus			
Toxic Shock Syndrome			
Non communicable diseases which have public health significance (to be reported within 1 week)			
Angiosarcoma of the liver			
Carcinoma of the Bladder			
Coal Worker's Pneumoconiosis			
Hepatitis, Chemically Induced			
Kawasaki's Disease			
Reye's Syndrome			
Rheumatic Fever			
Silicosis			
Spinal Cord Injuries			