Arkansas Department of Health
Communicable Disease Reporting Form

Fax reports to (501) 661-2428

IT IS VERY IMPORTANT THAT YOU PRINT LEGIBLY

Reporter name _____ Reporter phone (_____) _____-_____

Facility name _____ Facility city _____

Report #1

Disease name _____ Onset Date _____

Patient first name _____ Patient last name _____ Date of Birth _____

Patient address _____ City _____

State ____ Zip _____ Patient Phone (_____) _____-_____ Sex ___ Race ___

Physician first name _____ Physician last name _____

Physician city _____ Physician phone (_____) _____-_____

Reason patient seen _____

Lab results and clinical comments (Please include test name, body source, result and date of testing)

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Report #2

Disease name _____ Onset Date _____

Patient first name _____ Patient last name _____ Date of Birth _____

Patient address _____ City _____

State ____ Zip _____ Patient Phone (_____) _____-_____ Sex ___ Race ___

Physician first name _____ Physician last name _____

Physician city _____ Physician phone (_____) _____-_____

Reason patient seen _____

Lab results and clinical comments (Please include test name, body source, result and date of testing)

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