Arkansas Department of Health
Communicable Disease Reporting Form
Fax Reports to (501) 661-2428

Please Print Legibly

Reporting facility: ___________________________ Address: ___________________________
City: __________________ State: ______ Zip Code: ______ Phone: (___) ____-_______
Reporter name: _______________________________ Reporter phone: (___) ____-_______
Physician Last name: __________________ First: ___________________ phone: (___) ____-_______

Disease or Condition: __________________________ Date of onset: ___/____/____

Patient Last name: __________________ First: __________________ Date of birth: ___/____/____
Address: ____________________________________ Phone: (___) ____-_______
City: __________________ State: _____ Zip: ______ County: ______________
Gender: Male ☐ Female ☐ Race: American Indian/Alaskan ☐ Asian ☐ Black ☐
Ethnicity: Hispanic ☐ Not Hispanic ☐ Hawaiian/Pac Islander ☐ White ☐ Other ☐

Method of diagnosis: clinical ☐ laboratory ☐ Specific name of test & Result: ______________
Specimen (blood, CSF, sputum, stool, etc.): ___________ Date lab specimen collected: ___/____/____

Food handler: Yes ☐ No ☐ Unknown ☐ Child/worker in a daycare: Yes ☐ No ☐
Healthcare worker: Yes ☐ No ☐ Unknown ☐ Pregnant: Yes ☐ No ☐ Due Date: ___/____/____
Nursing Home: Yes ☐ No ☐ Unknown ☐ Jail: Yes ☐ No ☐

Was the patient hospitalized Yes ☐ No ☐ Unknown ☐
Admission date: ___/____/____ Discharge date: ___/____/____
Reason seen: __________________________________ Died: Yes ☐ No ☐ Unknown ☐

Other Lab Results, Treatments or Additional Comments: (Please include test name, source, result and dates)
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Disease or Condition-Specific Information (Please complete if appropriate)

If Hepatitis:
Hep A IgM antibody: Positive ☐ Negative ☐ Not Done ☐ LFT collection date: ___/____/____
Hep B IgM antibody: Positive ☐ Negative ☐ Not Done ☐ Total bilirubin: _____________
Hep B surface antigen: Positive ☐ Negative ☐ Not Done ☐ SGOT (AST): _____________
Hep C antibody: Positive ☐ Negative ☐ Not Done ☐ SGPT (ALT): _____________
(Signal to cut off ratio: __________________________) Was patient jaundiced Yes ☐ No ☐
Does patient have previous diagnosis of Hepatitis Yes ☐ No ☐ Was patient symptomatic Yes ☐ No ☐

If Tickborne Disease:
Diagnostic Tests: IgG titer: ___________ IgM titer: ___________ PCR: ___________
Symptoms: Fever ☐ Rash ☐ Myalgia ☐ Headache ☐ Anemia ☐ Leukopenia ☐ Thrombocytopenia ☐
Elevated hepatic transaminases ☐ Other: ______________________________________________________________________

If Influenza: please report online at: https://FluReport.ADH.Arkansas.gov
Test Performed: Rapid antigen: ______ PCR result: ______ Other: ___________
Vaccinated this season Yes ☐ No ☐ Unknown ☐ If yes, Date: ___/____/____

Revised 4/1/2016