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: (____) ____-__________

Reported by: ________________________________ Phone: (____) ____-__________

Date of onset: _____/____/____

Patient Last name: ___________________________ First: __________________________ Date of birth: _____/____/____
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 test name ___________________ 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 □
Is this part of an outbreak/cluster?: Yes □ No □ Unknown □ Number of cases linked to this case: __________

Was the patient hospitalized? Yes □ No □ Unknown □
Admission date: _____/____/____ Discharge date: _____/____/____
Reason seen: __________________________________________ Died: Yes □ No □

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 04/28/22