Kentucky Reportable Disease Form

Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001

EPID 200 – 9/2014

Disease Name_____

Mail Form to Local Health Department

DEMOGRAPHIC DATA

Patient's Last Name	First	M.I.	Date of Birth / /	Age	Gender ☐ M ☐ F ☐ Unk
Address	City	State	Zip		County of Residence
Phone Number	Patient ID Number	Ethnic Origin ☐ His. ☐ Non-His.	Race ☐ W ☐ B ☐ A/PI ☐ Am.Ind. ☐ Other		

DISEASE INFORMATION

Disease/Organism	Date of Onset / /	Date of Diagnosis / /
List Symptoms/Comments	Highest Temperature Days of Diarrhea	

Hospitalized? ☐ Yes ☐ No	Admission Date / /	Discharge Date / /	Died? ☐ Yes ☐ No ☐ Unk	Date of Death / /

Hospital Name: | Is Patient Pregnant? ☐ Yes ☐ No If yes, # wks_____

School/Daycare Associated? ☐ Yes ☐ No
Name of School/Daycare:

Outbreak Associated? ☐ Yes ☐ No
Food Handler? ☐ Yes ☐ No

Person or Agency Completing form: Name: Agency:	Attending Physician: Name:
Address:	Address:
Phone: Date of Report: / /	Phone:

LABORATORY INFORMATION

Date	Name or Type of Test	Name of Laboratory	Specimen Source	Results

ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY

Method of case detection: ☐ Prenatal ☐ Community & Screening ☐ Delivery ☐ Instit. Screening ☐ Reactor ☐ Provider Report ☐ Volunteer

Disease: ☐ Syphilis
Stage: ☐ Primary (lesion) ☐ Secondary (symptoms) ☐ Early Latent ☐ Late Latent ☐ Congenital ☐ Other

Disease: ☐ Gonorrhea ☐ Chlamydia ☐ Chancroid
Site: (Check all that apply) ☐ Genital, uncomplicated ☐ Pharyngeal ☐ Anorectal ☐ Other_____ ☐ Ophthalmic ☐ PID/Acute Salpingitis
Resistance: ☐ Penicillin ☐ Tetracycline ☐ Other _____

Date of spec. Collection	Laboratory Name	Type of Test	Results	Treatment Date	Medication	Dose

If syphilis, was previous treatment given for this infection? ☐ Yes ☐ No
If yes, give approximate date and place_____