

GEORGIA NOTIFIABLE DISEASE/CONDITION REPORT FORM

REPORT CASES BY MAIL, FAX OR PHONE TO DISTRICT HEALTH OFFICE
OR TO SENDSS (<http://sendss.state.ga.us>)

Disease/Condition _____ Medical Record Number _____

PATIENT DEMOGRAPHICS

Patient's Name

Last Name _____ First Name _____ MI _____

Patient's Address

Street _____

City _____ State _____ Zip+4 _____ County _____

() _____ () _____ () _____

Patient's Home Phone _____ Patient's Work Phone _____ Patient's Other Phone _____

Date of Birth ____/____/____	Age ____	Age Type <input type="checkbox"/> Yrs <input type="checkbox"/> Mos <input type="checkbox"/> Weeks <input type="checkbox"/> Days <input type="checkbox"/> Unk
Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	
Race <input type="checkbox"/> Asian <input type="checkbox"/> Black/African-American <input type="checkbox"/> Native American or Alaska Native <input type="checkbox"/> Multiracial		
<input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> White		

CLINICAL INFORMATION

Illness Onset Date
____/____/____

Hospitalized	Y N UNK	Outpatient	Y N UNK
Emergency Rm	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Died? Y ☐ N ☐ UNK ☐
Date of Death: ____/____/____

If hospitalized, complete: Hospital Name _____ Admit Date _____ Discharge Date _____

LABORATORY INFORMATION

**Report Hepatitis information in Viral Hepatitis box below*

Specimen Collection Date	Test Name (ex. Culture, IFA, IGM, EIA)	Specimen Type (ex. Stool, Blood, CSF)	Result (ex. +/-, titer, Presumptive)	Species / Serotype	Lab Name

ADDITIONAL INFORMATION

Yes | No | UNK

Pregnant ☐ Yes ☐ No ☐ UNK
Nursing Home or other Chronic Care Facility ☐ Yes ☐ No ☐ UNK
Child In Daycare ☐ Yes ☐ No ☐ UNK
Daycare Worker ☐ Yes ☐ No ☐ UNK
Prisoner/Detainee ☐ Yes ☐ No ☐ UNK
Food Handler ☐ Yes ☐ No ☐ UNK
Health Care Worker ☐ Yes ☐ No ☐ UNK
Outbreak Related ☐ Yes ☐ No ☐ UNK
Travel in Last 4 Weeks ☐ Yes ☐ No ☐ UNK

*VIRAL HEPATITIS

Date of test(s) _____

Test Results

Pos | Neg | UNK

Hepatitis A ☐ Total anti-HAV ☐ ☐ ☐
IgM anti-HAV ☐ ☐ ☐
HBsAg ☐ ☐ ☐
Hepatitis B ☐ Total anti-HBc ☐ ☐ ☐
IgM anti-HBc ☐ ☐ ☐
anti-HCV (EIA) ☐ ☐ ☐
Hepatitis C ☐ anti-HCV signal to cut-off ratio _____
RIBA ☐ ☐ ☐
HCV RNA (PCR, bDNA) ☐ ☐ ☐
All ALT(SGPT) _____ AST (SGOT) _____

REPORTER INFORMATION

Report Date ____/____/____
Reporter Name _____
Reporter Phone () _____
Reporter Institution _____
Physician Name _____
Physician Phone () _____

Comments/Symptoms/Treatment:

Local Use Only

State Use Only

Additional form completed

☐ Name: _____

☐ Need More 3095 Forms

☐ Entered into SENDSS