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: ☑ Yrs ☐ Mos ☐ Weeks ☐ Days ☐ Unk

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☑ Unknown

Sex: ☐ Male ☐ Female ☐ Unknown

Race: ☐ Asian ☐ Black/African-American ☐ Native American or Alaska Native ☐ Multiracial ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Unknown ☐ White

CLINICAL INFORMATION

Illness Onset Date: Unknown

	Y	N	UNK
Hospitalized	☐	☐	☑
Emergency Rm	☐	☐	☑
Outpatient	☐	☐	☑

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
					US BioTek Laboratories

ADDITIONAL INFORMATION

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

*VIRAL HEPATITIS Test Results

Date of test(s) _____

		Pos	Neg	UNK
Hepatitis A	Total anti-HAV	☐	☐	☐
	IgM anti-HAV	☐	☐	☐
Hepatitis B	HBsAg	☐	☐	☐
	Total anti-HBc	☐	☐	☐
	IgM anti-HBc	☐	☐	☐
Hepatitis C	anti-HCV (EIA)	☐	☐	☐
	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 US BioTek Laboratories

Physician Name _____

Physician Phone _____

☐ Need More 3095 Forms

☐ Entered into SENDSS

Comments/Symptoms/Treatment:

Local Use Only

☐ Additional form completed

Name: _____

State Use Only

Form 3095 (8-09)

CONFIDENTIAL