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

4815 West Markham Street,
Slot #32
Little Rock, AR 72205

Please Print Legibly

Reporting facility: _____ Address: _____

City: _____ State: _____ Zip Code: _____ Phone: _____

Reporter name: _____ Reporter Phone: _____

Physician Last name: _____ First: _____ Physician Phone:_____

Disease or Condition: _____ Date of onset: _____/_____/_____

Patient Last name: _____ First: _____ Date of birth: ____/____/_____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____ County: _____

Gender: Male ☐ Female ☐
Ethnicity: Hispanic ☐ Not Hispanic ☐

Race: American Indian/Alaskan ☐ Asian ☐ Black ☐
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 ☐
Healthcare worker: Yes ☐ No ☐ Unknown ☐
Nursing home: Yes ☐ No ☐ Unknown ☐

Child/worker in a daycare: Yes ☐ No ☐
Pregnant: Yes ☐ No ☐ Due Date: ___/___/____
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: _____/_____/_____
Reason seen: _____

Discharge date: _____/_____/_____
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 ☐
Hep B IgM antibody: Positive ☐ Negative ☐ Not Done ☐
Hep B surface antigen: Positive ☐ Negative ☐ Not Done ☐
Hep C antibody: Positive ☐ Negative ☐ Not Done ☐
(Signal to cut off ratio: _____)
Does patient have previous diagnosis of Hepatitis Yes ☐ No ☐

LFT collection date: ____/____/_____
Total bilirubin: _____
SGOT (AST): _____
SGPT (ALT): _____
Was patient jaundiced 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: _____/_____/_____