



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:** _____
Sex: 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 ☐ 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 ☐	LFT collection date: ____/____/____ Total bilirubin: _____ SGOT (AST): _____ SGPT (ALT): _____ Was patient jaundiced Yes ☐ No ☐ Was patient symptomatic Yes ☐ No ☐
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 ☐		

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:** ____/____/____