

COMMUNICABLE DISEASE REPORT FOR HEALTHCARE PROVIDERS

Healthcare providers are required to report selected communicable diseases, per Arizona Administrative Code R9-6-202. Report communicable diseases through MEDSIS (<https://medsisprod.azdhs.gov/medsis>) or to the local health agency (fax numbers below). Visit <http://azdhs.gov/providerreporting> for the list of reportable conditions, this form, and other communicable disease reporting information.

1. Complete the PATIENT INFORMATION

Patient's Name (Last, First, Middle)	Date of Birth	Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native _____ <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander (List tribal affiliation) <input type="checkbox"/> Asian <input type="checkbox"/> Other <input type="checkbox"/> Unknown			Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown		Sex at Birth <input type="checkbox"/> Female <input type="checkbox"/> Ambiguous <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Pregnant No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes <input type="checkbox"/> Est. due date: _____
Street Address	City	State	Zip code	County	Reservation	Telephone #	Email		

2. Complete the REPORTABLE CONDITION INFORMATION

Diagnosis or Suspect Reportable Condition	Unique ID/MRN	Illness Onset Date	DISEASE SPECIFIC INFORMATION																								
		Diagnosis Date	If chlamydia or gonorrhea: <input type="checkbox"/> with Pelvic Inflammatory Disease If chlamydia, gonorrhea, chancroid, syphilis: # Sex partners in the last 2 months _____ If HIV/AIDS: Negative HIV test in last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk Injection drug user (IDU) <input type="checkbox"/>				If syphilis: Symptoms at diagnosis <input type="checkbox"/> No symptoms <input type="checkbox"/> Chancre/lesion <input type="checkbox"/> Rash <input type="checkbox"/> Neurologic (incl. ocular, otic) <input type="checkbox"/> Other, specify _____ <input type="checkbox"/> Congenital syphilis Birth mother's name _____ Birth mother's DOB _____																				
Notes/Comments Parent/guardian information (include phone & address if different than child)			If STI/HIV/AIDS Patient had sexual contact with: <input type="checkbox"/> Females only <input type="checkbox"/> Males only <input type="checkbox"/> Both <input type="checkbox"/> Unknown																								
Treatment			<table border="1"> <tr> <td>Date</td> <td>Drug</td> <td>Dosage</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Date</td> <td>Drug</td> <td>Dosage</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> <tr> <td>Date</td> <td>Drug</td> <td>Dosage</td> </tr> <tr> <td> </td> <td> </td> <td> </td> </tr> </table>							Date	Drug	Dosage				Date	Drug	Dosage				Date	Drug	Dosage			
Date	Drug	Dosage																									
Date	Drug	Dosage																									
Date	Drug	Dosage																									
Date Collected _____ Specimen Type _____ Lab Test _____			TUBERCULOSIS:																								
Result Date _____ Lab Result _____			TB signs/symptoms <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Chest imaging <input type="checkbox"/> Consistent with TB <input type="checkbox"/> Not consistent with TB <input type="checkbox"/> Not performed		Site of disease <input type="checkbox"/> Pulmonary <input type="checkbox"/> Laryngeal <input type="checkbox"/> Other extrapulmonary		Initial Drug Regimen Start date: _____ <input type="checkbox"/> RIPE <input type="checkbox"/> Other _____																		
Date Collected _____ Specimen Type _____ Lab Test _____			TB infection in a child <6 years old (positive TST / IGRA)? <input type="checkbox"/> Yes <input type="checkbox"/> No																								
Result Date _____ Lab Result _____																											
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Result Date _____ Lab Result _____																											

3. Complete the FACILITY INFORMATION

Reporter (Person making this report or physician) Name _____ Reporting Facility _____ Reporter Address _____ City _____ State _____ Zip _____ Telephone _____ Email _____			Provider (if different from Reporter) Name _____ Provider Facility _____ Provider Address _____ Telephone _____ Email _____			Laboratory (if testing performed) Laboratory Name _____ Laboratory Address _____ Telephone _____		
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