



Communicable Disease Reporting Form



Disease reported:

Patient Demographics

First Name: Last Name: Patient I.D./MR #:
 Address: Date of birth:
(xx/xx/xxxx)
 City: ZIP code: County: Phone:
(xxx-xxx-xxxx)

SEX: Male Female Female to Male Male to Female

IS PATIENT PREGNANT? Yes No Unk

RACE: American Indian / Alaskan Native White Pacific / Hawaiian Asian Other

ETHNICITY: Hispanic Non Hispanic Unknown

HOSPITALIZED? Yes No

Physician Information

Physician Name/Practice: Phone:
(xxx-xxx-xxxx)
 Address of Practice: Fax:
(xxx-xxx-xxxx)
 City: ZIP Code: County:

Laboratory Information (check all that apply)

Lab Accession #: Testing Lab:
 Collection Date: Test Result Date: Originating Lab:
(xx/xx/xxxx) (xx/xx/xxxx)

SPECIMEN TYPE: blood CSF NP swab stool bone nasal wash urine other:

TESTING PERFORMED: Culture: pos neg O & P: pos neg IgM: pos neg EIA: pos neg

PCR: pos neg Rapid Antigen: pos neg Other: pos neg

Hepatitis Testing ONLY

A IgM anti-HAV: pos neg

B HBsAg: pos neg
 HBeAg: pos neg
 IgM anti-HBc: pos neg
 HBV: DNA NAT Quantitative Value:

LFTs: SGOT/AST: Alk Phosphate:
 SGPT/ALT: Total Bilirubin:

DONOR CENTERS: Secondary NAT test: pos neg

HCV Ab: pos neg Signal to cut-off Value:

Please select test

C EIA: pos neg
 CIA: pos neg
 Siemen Centaur: pos neg
 Elisa: pos neg
 Rapid HCV antibody: pos neg
 Other: pos neg

HCV RNA by: PCR NAT Quantitative Value:

SYMPTOMS:
 COMMENTS:

Reporter Information

Agency: Person Reporting:
 Address: Phone:
(xxx-xxx-xxxx)

RETURN REPORT TO: Colorado Dept of Public Health and Environment | FAX: 303-782-0338 | ALTERNATE FAX: 303-691-7753

For questions about completing this form, please call:
 LaVelle Fernandez 303-692-2627 | LeAnna Kent 303-692-6445 | Susma Dahal 303-692-2659