CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES

State Form 43823 (R6 / 2-18)
THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.5-78

DISEASE

Fax Completed Form to: 317-234-2812

Name (*last, first, middle initial*)

If child, name of parent (*last, first, middle initial*)

Address (*number and street*)

City | ZIP code

County

Telephone

Date of birth (*MM / DD / YYYY*)

Occupations of Interest (Not Required For STD's)
Check all that apply:
- ☐ Health Care Worker
- ☐ Food Handler
- ☐ School (*student / staff*)
- ☐ Day Care (*attendee / staff*)

SEX	RACE	ETHNICITY
☐ Male ☐ Female	☐ White ☐ Black ☐ Other _____ ☐ Multiracial	☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Name of workplace or school / day care

Pregnant? ☐ Yes ☐ No ☐ Unknown

CLINICAL

Date of diagnosis (*MM / DD / YYYY*)

Symptoms

Onset date (*MM / DD / YYYY*) | Deceased ☐ Yes ☐ No | Immunocompromised ☐ Yes ☐ No

Hospitalized ☐ Yes ☐ No | Hospital Name

Admission date (*MM / DD / YYYY*) | Discharge date (*MM / DD / YYYY*)

LABORATORY

Test | Result

Specimen collection date (*MM / DD / YYYY*) | Specimen source

Laboratory Name | Laboratory Telephone

TREATMENT

Treatment (*name of antibiotic*)	Dosage	Dosage Frequency	Dosage Duration	Treatment date (*MM / DD / YYYY*)

PROVIDER

Physician name | Person reporting (*other than physician*)

Facility / Hospital Name | Person reporting telephone number

Facility / Hospital Address

Facility Telephone Number | Date of report (*MM / DD / YYYY*)

LOCAL HEALTH DEPARTMENT USE ONLY

Date of first notification (*MM / DD / YYYY*) | Follow-up initiated? ☐ Yes ☐ No

Name of investigator | Investigator telephone number