GEORGIA NOTIFIABLE DISEASE/CONDITION REPORT FORM

REPORT CASES BY MAIL, FAX OR PHONE TO DISTRICT HEALTH OFFICE
OR TO SENDSS (http://sendss.state.ga.us)

Disease/Condition ______________________ Medical Record Number ______________________

PATIENT DEMOGRAPHICS

Patient's Name

Last Name ______ First Name ______ MI ______

Patient's Address

Street ______

City ______ State ______ Zip+4 ______ County ______

( ) ______ Patient's Home Phone ( ) ______ Patient's Work Phone ( ) ______ Patient's Other Phone ______

Date of Birth __/__/__ Age ______

Age Type: ☐ Yrs ☐ Mos ☐ Weeks ☐ Days ☐ Unk

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Sex: ☐ Male ☐ Female ☐ Unknown

Race: ☐ Asian ☐ Black/African-American ☐ Native American or Alaska Native ☐ Multiracial ☐ Native Hawaiian or Pacific Islander ☐ Other ☐ Unknown ☐ White

CLINICAL INFORMATION

Illness Onset Date __/__/__

	Y	N	UNK
Hospitalized	☐	☐	☐
Emergency Rm	☐	☐	☐
Outpatient	☐	☐	☐

Died? Y ☐ N ☐ UNK ☐
Date of Death: __/__/__

If hospitalized, complete:

Hospital Name	Admit Date	Discharge Date

LABORATORY INFORMATION

Report Hepatitis information in Viral Hepatitis box below

Specimen Collection Date	Test Name (ex. Culture, IFA, IGM, EIA)	Specimen Type (ex. Stool, Blood, CSF)	Result (ex. +/-, titer, Presumptive)	Species / Serotype	Lab Name

ADDITIONAL INFORMATION

	Yes	No	UNK
Pregnant	☐	☐	☐
Nursing Home or other Chronic Care Facility	☐	☐	☐
Child In Daycare	☐	☐	☐
Daycare Worker	☐	☐	☐
Prisoner/Detainee	☐	☐	☐
Food Handler	☐	☐	☐
Health Care Worker	☐	☐	☐
Outbreak Related	☐	☐	☐
Travel in Last 4 Weeks	☐	☐	☐

*VIRAL HEPATITIS Test Results

Date of test(s) ______

	Test	Pos	Neg	UNK
Hepatitis A	Total anti-HAV	☐	☐	☐
	IgM anti-HAV	☐	☐	☐
Hepatitis B	HBsAg	☐	☐	☐
	Total anti-HBc	☐	☐	☐
	IgM anti-HBc	☐	☐	☐
Hepatitis C	anti-HCV (EIA)	☐	☐	☐
	anti-HCV signal to cut-off ratio	______		
	RIBA	☐	☐	☐
	HCV RNA (PCR, bDNA)	☐	☐	☐
All	ALT(SGPT) ______ AST (SGOT) ______			

REPORTER INFORMATION

Report Date __/__/__

Reporter Name ______

Reporter Phone ( ) ______

Reporter Institution ______

Physician Name ______

Physician Phone ( ) ______

☐ Need More 3095 Forms

☐ Entered into SENDSS

Comments/Symptoms/Treatment:

Local Use Only

☐ Additional form completed
Name: ______

State Use Only

Form 3095 (8-09)

CONFIDENTIAL