KANSAS REPORTABLE DISEASE FORM

Fax this form to your local health department or KDHE: 877-427-7318
Please include disease-specific laboratory results, if available
To report urgent diseases, call the KDHE Epidemiology Hotline: 877-427-7317
This form is available at: http://www.kdheks.gov/epi/disease_reporting.html

Today’s date: ____________________________

PATIENT INFORMATION

Name: ____________________________________________________________

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<th>Last</th>
<th>First</th>
<th>Middle</th>
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Mobile phone: ____________________________  Home phone: ____________________________

Residential address: _________________________________________________________________

City: ____________________________  State: __________  Zip: ______

Date of Birth (if unknown, provide age): ____________________________

Race: □ White  □ Black  □ Asian  □ American Indian / Alaska Native  □ Native Hawaiian / Pacific Islander

Ethnicity: □ Hispanic  □ Non-Hispanic

Sex: □ Male  □ Female  □ Yes  □ No  □ Unknown

Pregnant? □ Yes  □ No  □ Unknown

Associated with high-risk setting or institution? □ Daycare  □ Nursing Home  □ Health Care  □ Food Handler  □ School

□ Correctional  □ Shelter  □ Other

Name and city of high-risk setting or institution: ____________________________

DISEASE OR CONDITION INFORMATION

Disease or condition suspected: __________________________________________________

Symptom onset date: ____________________________

Hospitalized? □ Yes  □ No  □ Unknown

Hospital: __________________________________________________  Died? □ Yes  □ No  □ Unknown

Laboratory name: ____________________________  Specimen collection date: ____________________________

Test(s) performed: ____________________________  Test result(s): ____________________________

FACILITY AND PHYSICIAN INFORMATION

Facility name: ________________________________________________  Facility city: ____________________________

Physician name: ____________________________________________  Phone #: ____________________________

Name of person reporting: ____________________________  Phone #: ____________________________

TREATMENT INFORMATION

Treated? □ Yes  □ No  □ Unknown

Treatment type, dosage, and duration: ____________________________

(Revised 05/2018)