

Kansas Notifiable Disease Form for Laboratory Reporting

Today's Date: ___/___/___

Laboratory Name: _____

Contact Person: _____

Address: _____

Contact Phone: _____

Patient Name: _____	
Last	First
Date of Birth: ___/___/___	Age: ___ Sex: ___
Street Address: _____	
City: _____	ST: ___ Zip Code: _____
Patient Phone: _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native <input type="checkbox"/> Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unk (Circle all that apply)	
Disease Name: _____	
Date of Test: _____	
Test Performed: _____	
Test Results: _____	
Ordering Physician/Facility: _____	
Physician Phone: _____	
Physician Street Address: _____	
City, State, Zip: _____	

Patient Name: _____	
Last	First
Date of Birth: ___/___/___	Age: ___ Sex: ___
Street Address: _____	
City: _____	ST: ___ Zip Code: _____
Patient Phone: _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unk (Circle all that apply)	
Disease Name: _____	
Date of Test: _____	
Test Performed: _____	
Test Results: _____	
Ordering Physician/Facility: _____	
Physician Phone: _____	
Physician Street Address: _____	
City, State, Zip: _____	

Patient Name: _____	
Last	First
Date of Birth: ___/___/___	Age: ___ Sex: ___
Street Address: _____	
City: _____	ST: ___ Zip Code: _____
Patient Phone: _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native <input type="checkbox"/> Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unk (Circle all that apply)	
Disease Name: _____	
Date of Test: _____	
Test Performed: _____	
Test Results: _____	
Ordering Physician/Facility: _____	
Physician Phone: _____	
Physician Street Address: _____	
City, State, Zip: _____	

Patient Name: _____	
Last	First
Date of Birth: ___/___/___	Age: ___ Sex: ___
Street Address: _____	
City: _____	ST: ___ Zip Code: _____
Patient Phone: _____	
Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unk (Circle all that apply)	
Disease Name: _____	
Date of Test: _____	
Test Performed: _____	
Test Results: _____	
Ordering Physician/Facility: _____	
Physician Phone: _____	
Physician Street Address: _____	
City, State, Zip: _____	

Mail Reports to: Office of Surveillance & Epidemiology, 1000 SW Jackson, Suite 210, Topeka, KS 66612-1274

Reports can also be *faxed toll free* to: 877-427-7318

(Rev. 02/16/2009)