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: ____________________________________________

Last  First  Middle

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  □ 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  Death date: _____________

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, start date, and duration: _____________________________

(Revised December 2020)