



CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES

State Form 43823 (R8 / 6-24)

THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.5-78

Fax Completed Form to:
317-234-2812

Patient Name (<i>last, first, middle initial</i>)		Date of Birth (<i>MM / DD / YYYY</i>)	
If child, name of parents or guardian (<i>last, first, middle initial</i>)			
Address (<i>number and street</i>)			
City		State	ZIP Code
County		Telephone	
Current Sex <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Transgender <input type="checkbox"/> Cisgender / Not Transgender <input type="checkbox"/> Did not ask <input type="checkbox"/> Female <input type="checkbox"/> Female-to-male transgender <input type="checkbox"/> Genderqueer, neither exclusively male or female <input type="checkbox"/> Male <input type="checkbox"/> Male-to-female transgender <input type="checkbox"/> Transgender unspecified <input type="checkbox"/> Other <input type="checkbox"/> Refused to Answer	Ethnicity <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown	Race <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hawaiian or Other Pacific Islander <input type="checkbox"/> Multi-race <input type="checkbox"/> Other <input type="checkbox"/> Unknown <input type="checkbox"/> Refused to Answer
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Occupations of Interest <input type="checkbox"/> Health Care Worker <input type="checkbox"/> Food Service <input type="checkbox"/> School (students / staff) <input type="checkbox"/> Daycare (attendee / staff)		Congregate Setting <input type="checkbox"/> Long Term Care Facility <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Group Home <input type="checkbox"/> Daycare (attendee / staff)
Name of Workplace or School / Daycare:		Name of Congregate Setting:	
Disease		Report Date (<i>MM / DD / YYYY</i>)	
Person Reporting		Person Reporting Telephone	

CLINICAL	
Symptoms	
Onset Date (<i>MM / DD / YYYY</i>)	Diagnosis Date (<i>MM / DD / YYYY</i>)
Deceased <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Hospital Name	
Admission Date (<i>MM / DD / YYYY</i>)	Discharge Date (<i>MM / DD / YYYY</i>)

LABORATORY	
Test	Result
Specimen Collection Date (<i>MM / DD / YYYY</i>)	Specimen Source
Laboratory Name	Laboratory Telephone

TREATMENT		
Treatment (<i>name of antibiotic</i>)	Dosage	Treatment Start Date (<i>MM / DD / YYYY</i>)

PROVIDER	
Physician Name	Facility / Hospital Name
Facility / Hospital Address	Facility Telephone Number

For questions or emergencies, call the Infectious Disease Epidemiology & Prevention Division at 317-233-7125.