Reset Form

CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES

State Form 43823 (R9 / 3-25)
THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.5-78

Fax Completed Form to:
317-234-2812

Patient Name (*last, first, middle initial*)	Date of Birth (*MM / DD / YYYY*)
If child, name of parents or guardian (*last, first, middle initial*)	
Address (*number and street)*	

City	State	ZIP Code
County	Telephone	

Sex	Ethnicity	Race
☐ Male ☐ Female ☐ Unknown	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown	☐ White ☐ Black or African American ☐ American Indian or Alaska Native ☐ Asian ☐ Hawaiian or Other Pacific Islander ☐ Multi-race ☐ Other ☐ Unknown ☐ Refused to Answer
Pregnant? ☐ Yes ☐ No ☐ Unknown		

Occupations of Interest	Congregate Setting
☐ Health Care Worker ☐ Food Service ☐ School (students / staff) ☐ Daycare (attendee / staff)	☐ Long Term Care Facility ☐ Correctional Facility ☐ Group Home ☐ Daycare (attendee / staff)
Name of Workplace or School / Daycare:	Name of Congregate Setting:
Disease	Report Date (*MM / DD / YYYY*)
Person Reporting	Person Reporting Telephone

CLINICAL

Symptoms	
Onset Date (*MM / DD / YYYY*)	Diagnosis Date (*MM / DD / YYYY*)
Deceased ☐ Yes ☐ No ☐ Unknown — Date of Death (MM/DD/YYYY)	Hospitalized ☐ Yes ☐ No ☐ Unknown
Hospital Name	
Admission Date (*MM / DD / YYYY*)	Discharge Date (*MM / DD / YYYY*)

LABORATORY

Test	Result
Specimen Collection Date (*MM / DD / YYYY*)	Specimen Source
Laboratory Name	Laboratory Telephone

TREATMENT

Treatment (*name of antibiotic*)	Dosage	Treatment Start Date (*MM / DD / YYYY*)

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.