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: https://www.kdhe.ks.gov/1492

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 → Hospital: ______________________________ Died? □ Yes → Death date: ________

□ 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 → Treatment type, dosage, start date, and duration: ______________________________

□ No □ Unknown