



# Kentucky Reportable Disease Form

Department for Public Health  
Division of Epidemiology and Health Planning  
275 East Main St., Mailstop HS2E-A  
Frankfort, KY 40621-0001



Kentucky Public Health  
Prevent. Promote. Protect.

EPID 200 – 6/2016

Disease Name \_\_\_\_\_

**Fax or Mail the Completed Form to the Local Health Department**

| DEMOGRAPHIC DATA   |                       |   |   |  |   |  |  |   |  |
|--|-----------------------|---|---|--|---|--|--|---|--|
| Patient's Last Name  | First                 | M.I.  | Date of Birth<br>/ /  | Age  | Gender<br><input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk. |  |  |   |  |
| Address  |                       | City  | State   | ZIP Code   | County of Residence   |  |  |   |  |
| Phone Number   | Patient ID Number     | Ethnic Origin<br><input type="checkbox"/> Hisp. <input type="checkbox"/> Non-Hisp.  |   | Race<br><input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> A/PI <input type="checkbox"/> Am. Ind. <input type="checkbox"/> Other |   |  |  |   |  |
| DISEASE INFORMATION  |                       |   |   |  |   |  |  |   |  |
| Disease/Organism   |                       |   | Date of Onset<br>/ /  | Date of Diagnosis<br>/ /   |   |  |  |   |  |
| List Symptoms/Comments   |                       |   |   | Highest Temperature  |   |  |  |   |  |
|  |                       |   |   | Days of Diarrhea   |   |  |  |   |  |
| Hospitalized?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  | Admission Date<br>/ / | Discharge Date<br>/ /   |   | Died?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.  | Date of Death<br>/ /  |  |  |   |  |
| Hospital Name:   |                       |   | Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Due Date (EDC): / / |  |   |  |  |   |  |
| School/Daycare Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No                                    |                       |   |   | Outbreak Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |   |  |
| Name of School/Daycare:  |                       |   |   | Food Handler? <input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |   |  |
| Person or Agency Completing form:  |                       |   |   | Attending Physician:   |   |  |  |   |  |
| Name:  |                       | Agency:   |   | Name:  |   |  |  |   |  |
| Address:   |                       |   |   | Address:   |   |  |  |   |  |
| Phone:   |                       | Date of Report: / /   |   | Phone:   |   |  |  |   |  |
| LABORATORY INFORMATION   |                       |   |   |  |   |  |  |   |  |
| Date   | Name or Type of Test  | Name of Laboratory  | Specimen Source   | Results  |   |  |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
| ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY  |                       |   |   |  |   |  |  |   |  |
| Disease:   |                       | Stage   |   | Disease:   |   | Site: (Check all that apply)   |  | Resistance:   |  |
| <input type="checkbox"/> Syphilis  |                       | <input type="checkbox"/> Primary (lesion) <input type="checkbox"/> Secondary (symptoms)<br><input type="checkbox"/> Early Latent <input type="checkbox"/> Late Latent<br><input type="checkbox"/> Congenital <input type="checkbox"/> Other |   | <input type="checkbox"/> Gonorrhea<br><input type="checkbox"/> Chlamydia<br><input type="checkbox"/> Chancroid   |   | <input type="checkbox"/> Genital, uncomplicated<br><input type="checkbox"/> Pharyngeal<br><input type="checkbox"/> Anorectal<br><input type="checkbox"/> Other _____ |  | <input type="checkbox"/> Ophthalmic<br><input type="checkbox"/> PID/Acute Salpingitis<br><input type="checkbox"/> Penicillin<br><input type="checkbox"/> Tetracycline<br><input type="checkbox"/> Other _____ |  |
| Date of Spec. Collection   | Laboratory Name       | Type of Test  | Results   | Treatment Date   | Medication  | Dose   |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
|  |                       |   |   |  |   |  |  |   |  |
| If syphilis, was previous treatment given for this infection? <input type="checkbox"/> Yes <input type="checkbox"/> No |                       |   |   |  |   |  |  |   |  |
| If yes, give approximate date and place _____  |                       |   |   |  |   |  |  |   |  |

Please use the following information and fax numbers (when relevant) for reporting:

### HIV/AIDS Cases:

Forms other than the EPID 200 are required for reporting HIV/AIDS cases in children and adults. Obtain those forms by calling [866-510-0008](tel:866-510-0008), or those forms can be downloaded from the DPH Website, <http://chfs.ky.gov/dph/epi/HIVAIDS/surveillance.htm>. Contact information for telephoning case reports and addresses for mailing case reports are on that Website.

**Reports for HIV/AIDS cases should not be faxed.**

[Pediatric Confidential Case Form](#) (PDF, 451k)  
(for patients younger than 13 at time of diagnosis)

[Adult Confidential Form](#) (PDF, 441k)  
(for patients 13 or older at time of diagnosis)

### Sexually Transmitted Disease Cases:

Confidential reports for STD cases can be submitted on the EPID 200 form.

**Fax a completed form for STD Cases, only, to 502-564-5715. Or, mail to:**

Kentucky Department for Public Health  
STD Prevention and Control Program  
275 E Main St, MS: HS2CC  
Frankfort, KY 40621

### Animal Bite Reports:

Healthcare providers and healthcare facilities should fax reports about animal bites directly to the **Local Health Department (LHD) serving the county in which the patient resides.** Please do not fax reports about animal bites to the Kentucky Department for Public Health.

### Reporting All Other Diseases and Conditions Listed in 902 KAR 2:020 (Reportable Disease Surveillance) or in any Public Health Advisory (PHA) Issued per that KAR that Requires Using the EPID 200 Form for Reporting:

Reports, depending upon the notification classification described in 902 KAR 2:020 or in a PHA, shall be submitted by phone, by electronic submission, or by fax or mail submission on an EPID 200 form to the **Local Health Department (LHD) serving the county in which the patient resides.**

If submitted by telephone, an electronic or fax submission shall be made within one business day to the LHD serving the county in which the patient resides.

Kentucky Department for Public Health in Frankfort  
Telephone 502-564-3418 or 888-9REPORT (888-973-7678)  
SECURE FAX 502-696-3803