Reset Form

CONFIDENTIAL REPORT OF COMMUNICABLE DISEASES

State Form 43823 (R7 / 6-22)
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	

Current Sex
- ☐ Male
- ☐ Female
- ☐ Unknown

Pregnant?
- ☐ Yes
- ☐ No
- ☐ Unknown

Transgender
- ☐ Cisgender / Not Transgender
- ☐ Did not ask
- ☐ Female
- ☐ Female-to-male transgender
- ☐ Genderqueer, neither exclusively male or female
- ☐ Male
- ☐ Male-to-female transgender
- ☐ Transgender unspecified
- ☐ Other
- ☐ Refused to Answer

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Race
- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hawaiian or Other Pacific Islander
- ☐ Multi-race
- ☐ Other
- ☐ Unknown
- ☐ Refused to Answer

Occupations of Interest
- ☐ Health Care Worker
- ☐ Food Service
- ☐ School (students / staff)
- ☐ Daycare (attendee / staff)

Name of Workplace or School / Daycare:

Congregate Setting
- ☐ Long Term Care Facility
- ☐ Correctional Facility
- ☐ Group Home
- ☐ Daycare (attendee / staff)

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	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 Epidemiology Resource Center at 317-233-7125.