

State of Connecticut
Reportable Disease Confidential Case Report Form PD-23 (rev. 01/01/2015)

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

Date Completed: _____ *Check this box to request additional PD-23 forms, or call 860-509-7994.*

For information or weekday disease reporting, call 860-509-7994. For reporting on evenings, weekends, and holidays, call 860-509-8000.

Patient Name (Last)	(First)	(MI)	Parent or Guardian Name	Age	Birth Date	Patient's Telephone	Home Work Cell
Address (No. and Street)		(Apt. #)	(City or Town)	(State)	(Zip Code)	(Primary Language Spoken) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	

Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other specify: _____ <input type="checkbox"/> Unknown	Is patient a (please check): <input type="checkbox"/> Health care worker <input type="checkbox"/> Student/Day care attendee <input type="checkbox"/> Day care worker <input type="checkbox"/> Food handler <input type="checkbox"/> LTC facility resident
Race <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other specify: _____ <input type="checkbox"/> Unknown	Name and address of workplace, school, day care or other facility: _____

Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Due date: _____	Did patient die of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Viral Hepatitis
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Disease Name _____	Onset Date _____	Diagnosis Date _____	Symptoms: <input type="checkbox"/> Jaundice <input type="checkbox"/> Flu-like <input type="checkbox"/> Discrete Onset <input type="checkbox"/> Fatigue ALT: _____ AST: _____
Is this condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, occupation: _____	IgM anti-HAV: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done HBsAg: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done IgM anti-HBc: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done Anti-HCV: Method: <input type="checkbox"/> Rapid <input type="checkbox"/> Serology <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Done HCV confirmed by: <input type="checkbox"/> Signal to cut off value: _____ <input type="checkbox"/> RNA <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Value: _____		

Did patient have recent international travel? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, country visited: _____	Dates visited: _____	Risk Factors: <input type="checkbox"/> IDU (<input type="checkbox"/> present <input type="checkbox"/> past) <input type="checkbox"/> Blood Transfusion < July 1992 <input type="checkbox"/> Hemodialysis <input type="checkbox"/> Multiple sex partners <input type="checkbox"/> Perinatal (infected mom to baby) <input type="checkbox"/> Contact w/ infected person (<input type="checkbox"/> household <input type="checkbox"/> sexual) <input type="checkbox"/> Incarcerated (<input type="checkbox"/> present <input type="checkbox"/> past) <input type="checkbox"/> MSM (men who have sex with men)
Confirmatory information: If specimen obtained, collection date: _____		Vaccine: Completed hepatitis A vaccine series <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Completed hepatitis B vaccine series <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Laboratory data, immunization status, dates, and comments (be specific). _____

Physician's name and address: _____ Direct telephone: _____	Lyme disease surveillance case definition signs and symptoms
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If hospitalized, hospital:	Date Admitted _____	Date Discharged _____	Physician diagnosed EM rash \geq 5cm <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Name _____	Patient ID # _____		Arthritis (objective joint swelling) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
City _____			Bell's palsy or other cranial neuritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
State _____			Radiculoneuropathy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			Lymphocytic meningitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			Encephalomyelitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			If yes, is antibody to <i>B. burgdorferi</i> higher in CSF than serum <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			Myocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			2nd or 3rd degree atrioventricular block <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
			Was patient diagnosed with Lyme disease in current year? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Lyme disease laboratory results	
EIA/IFA <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Culture <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
Western Blot: IgM <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Western Blot: IgG <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown

(Please print)