Print Form

Patient name (last–first–middle)	County	Telephone	Date reported
Address	City	ZIP	Date collected

Sex	D.O.B.	Race ☐ White ☐ Black ☐ American Indian/AN ☐ Asian/PI	Ethnicity ☐ Hispanic	Reason for test ☐ Prenatal ☐ Repeat pos	Specimen Site/Type

Check block for disease suspected — Indicate positive test results

☐ **HIV**	☐ **Syphilis**	☐ **Chlamydia**	☐ **Gonorrhea**	**Tuberculosis**
Report only repeatedly positive Elisa results; confirmed by Western Blot or other confirmatory test *(specify)*	RPR/VDRL Titer	Elisa	Smear	☐ Smear ☐ Culture
	FTA/MHA	F.A.	Elisa / Culture	Result
	DKFD	Culture	PPNG/Resist, (specify)	Date Reported

Other positive lab findings			Other disease suspected
☐ Campylobacter	☐ Salmonella	☐ Hepatitis A IgM	
☐ Neisseria meningitidis	☐ Shigella	☐ HBc Ab-IgM	Test
☐ Haemophilus influenzae	☐ Giardia	☐ HBs Ag	
Treatment date	Type/Amount		Result

Laboratory—name/address	Physician—name/address
Lab code	Phone ( )

Positive Laboratory Findings for Reportable Diseases

Form no. 3833.11 (Rev. 8/05)

HEA 3333 (Rev. 8/05) per Ohio Admin. Code 3701-3-02 and 3701-3-12