NOTIFIABLE DISEASE CONDITION REPORTING

District Health Office Contact Information

**DISTRICT 1-1 / ROME / Northwest Health District**
PHONE: 706-295-6656; FAX: 706-802-5342
www.nwgapublichealth.org
Counties: Bartow, Catoosa, Chattooga, Dade, Floyd, Gordon, Haralson, Paulding, Polk, Walker

**DISTRICT 1-2 / DALTON / North Health District**
PHONE: 706-529-5757; FAX: 706-529-5752
EMAIL: DPHDistrict1-2EpiTeam@gets.onmicrosoft.com
http://www.nghd.org/
Counties: Cherokee, Fannin, Gilmer, Murray, Pickens, Whitfield

**DISTRICT 2 / GAINESVILLE / North Health District**
PHONE: 770-519-7661; FAX: 770-535-5848
EMAIL: dphdistrict2epi@gets.onmicrosoft.com
http://www.gnrhealth.com/
Counties: Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Tons, Union, White

**DISTRICT 3-1 / MARIETTA / Cobb/Douglas Health District**
PHONE: 770-514-2432; FAX: 770-514-2313
http://www.cobbanddouglaspublichealth.org/
Counties: Cobb, Douglas

**DISTRICT 3-2 / ATLANTA / Fulton County Board of Health**
PHONE: 404-613-1391; FAX: 404-612-3696
EMAIL: FCBOH.EPI@fultoncountyga.gov
http://www.fultoncountygahealth.org/
County: Fulton

**DISTRICT 3-3 / JONESBORO / Clayton County Health District**
PHONE: 678-610-7199; FAX: 678-610-7781
http://www.claytoncountypublichealth.org/
County: Clayton

**DISTRICT 3-4 / LAWRENCEVILLE / East Metro Health District**
PHONE: 770-339-4260; FAX: 770-339-5971
http://www.gnrhealth.com/
Counties: Gwinnett, Newton, Rockdale

**DISTRICT 3-5 / DECATUR / DeKalb Health District**
PHONE: 404-508-7870; FAX: 404-508-7813
EMAIL: dekalbepi@dph.ga.gov
http://www.dekalbhealth.net/
County: DeKalb

**DISTRICT 4 / LAGRANGE / District 4 Health Health District**
PHONE: 706-845-4035; FAX1: 706-845-4294; FAX2: 706-845-4038
http://www.district4health.org/
Counties: Butts, Carroll, Coweta, Fayette, Heard, Henry, Lamar, Meriwether, Pike, Spalding, Troup, Upson

**DISTRICT 5-1 / DUBLIN / South Central Health District**
PHONE: 478-275-6571; FAX: 478-275-6575
http://www.southcentralhealth.info/
Counties: Bleckley, Dodge, Johnson, Laurens, Montgomery, Pulaski, Telfair, Treutlen, Wheeler, Wilcox

For more information:
dph.ga.gov/disease-reporting
NOTIFIABLE DISEASE/CONDITION REPORT FORM

All Georgia physicians, laboratories, and other health care providers are required by law to report patients with conditions of public health concern listed on the reverse of the enclosed form. Both lab-confirmed and clinical diagnoses are reportable within the time interval specified.

Reporting enables appropriate public health follow-up for your patients, helps identify outbreaks, and provides a better understanding of disease trends in Georgia. For the latest information from the DPH, Department of Public Health, visit their web site at: www.health.state.ga.us.

Instructions:

1. Report cases for all diseases, except those noted below, electronically through the State Electronic Notifiable Disease Surveillance System at: http://sendss.state.ga.us
   OR
   Complete reverse of this Notifiable Disease/Condition Report Form and mail, in an envelope marked CONFIDENTIAL, to: District Health Office (see cover for contact information)
   OR
   Fax to: District Health Office (see cover for contact information).

2. Fill out the form as completely and as timely as possible, including laboratory submissions.

3. Include treatment information for sexually transmitted diseases.

4. Report symptoms and tests needed to establish the diagnosis for viral hepatitis and Lyme disease and other tick-borne diseases.

5. If you mail the form, photocopy the form as your record of reported disease/condition.

6. Report a suspect case of hearing impairment (under age 5) by completing the Children 1st Screening and Referral Form. Report a confirmed case of hearing impairment (under age 5) by completing the Surveillance of Hearing Impairment in Infants and Young Children Form (both forms available at: http://health.state.ga.us/programs/unhs/reporting.asp)


8. For Cancer and Benign Brain Tumor, DO NOT USE THIS FORM, Refer to the GCCR Policy and Procedure Manual (available at: http://health.state.ga.us/programs/gccr/reporting.asp)
   AND
   Call the Georgia Comprehensive Cancer Registry at 404-463-8919 for how and what to report.

9. For HIV infections and AIDS, DO NOT USE THIS FORM, Complete the Georgia HIV/AIDS Confidential Case Report Form (available at: http://health.state.ga.us/epi/hiv aids or by calling 1-800-827-9769) and mail in an envelope marked CONFIDENTIAL to:
   Georgia Department of Public Health, Epidemiology Section
   P.O. Box 2107
   Atlanta, GA 30301
**PATIENT DEMOGRAPHICS**

Patient’s Name

Last Name | First Name | MI

Patient’s Address

Street

City | State | Zip+4 | County

Patient’s Home Phone | Patient’s Work Phone | Patient’s Other Phone

**CLINICAL INFORMATION**

Illness Onset Date: __/__/____

Hospitalized | Emergency Rm | Outpatient

If hospitalized, complete:

Hospital Name | Admit Date | Discharge Date

**LABORATORY INFORMATION**

<table>
<thead>
<tr>
<th>Specimen Collection Date</th>
<th>Test Name</th>
<th>Specimen Type</th>
<th>Result</th>
<th>Species / Serotype</th>
<th>Lab Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>(                      )</td>
<td>(         )</td>
<td>(             )</td>
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<td>(                  )</td>
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</tbody>
</table>

**ADDITIONAL INFORMATION**

<table>
<thead>
<tr>
<th>Pregnant</th>
<th>Nursing Home or other</th>
<th>Chronic Care Facility</th>
<th>Child In Daycare</th>
<th>Daycare Worker</th>
<th>Prisoner/Detainee</th>
<th>Food Handler</th>
<th>Health Care Worker</th>
<th>Outbreak Related</th>
<th>Travel in Last 4 Weeks</th>
<th>Yes</th>
<th>No</th>
<th>UNK</th>
</tr>
</thead>
</table>

**VIRAL HEPATITIS**

<table>
<thead>
<tr>
<th>Test Results</th>
<th>Date of test(s)</th>
<th>Hepatitis A</th>
<th>Total anti-HAV</th>
<th>IgM anti-HAV</th>
<th>HBeAg</th>
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</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Hepatitis B</th>
<th>Total anti-HBc</th>
<th>IgM anti-HBc</th>
<th>anti-HCV (EIA)</th>
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<tbody>
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<tr>
<th>Hepatitis C</th>
<th>anti-HCV signal to cut-off ratio</th>
<th>RIBA</th>
<th>HCV RNA (PCR, bDNA)</th>
<th>ALT(SGPT)</th>
<th>AST (SGOT)</th>
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**REPORTER INFORMATION**

Report Date: __/__/____

Reporter Name: ____________________________

Reporter Phone ( ) __________

Reporter Institution: ____________________________

Physician Name: ____________________________

Physician Phone ( ) __________

Local Use Only: ____________________________

State Use Only: ____________________________

Comments/Symptoms/Treatment: ____________________________

Need More 3095 Forms: __________

Local Use Only: ____________________________

Name: ____________________________

Additional form completed: __________

Entered into SENDSS: __________

Form 3095 (8-09)