Colorado Department of Health
Disease Reporting Form
(Please Print Clearly)

Patient Information	**Name:**			**Phone#:**
	Address:			
	City:		**State:**	**Zip:**
	DOB:	**Age:**	**Patient ID#**	**Sex:** M F (circle choice)
	Is Patient Pregnant: □Yes □ No □Unknown If **Yes**, what is EDD date: Delivery Hospital:			
	Born in USA: □Yes □ No □Unknown		**Birth Country:**	
(Check Choice of Race)	**Race:** American Indian/Alaskan Native □ Asian □ Black □ Multi Racial □ Other □ Pacific/Hawaiian □ Unknown □ White □			
(Check Choice of Ethnicity)	**Ethnicity:** Hispanic □ Non Hispanic □ Unknown □			
Physician Information	**Name:**			**Phone#:**
	Address:			
	City		**State:**	**Zip:**
Disease Reporting	**Disease:**			

(Mark the positive or negative result with an X)	**Collection Date:**	**Date of Death:**		**Report Date:**	
	IgM anti-HAV	Pos:		Neg:	
	IgM anti-HBc	Pos:		Neg:	
	anti-HBc Total	Pos:		Neg:	
	anti-Hbe (HBeAb)	Pos:		Neg:	
	anti-HBs (HBsAb)	Pos:		Neg:	
	HBeAg	Pos:		Neg:	
	HBsAg	Pos:	Pos Neut:	Neg Neut:	Not Done:
	HBV DNA Result	iu/ml		copys/ml	
≥11	HCV by Bayer Centaur	Pos:	Neg:	S/Co Ratio:	
≥8	HCV by CIA	Pos:	Neg:	S/Co Ratio:	
≥5	HCV CMIA	Pos:	Neg:	S/Co Ratio:	
≥3.8	HCV EIA/ELISA	Pos:	Neg:	S/Co Ratio:	
≥10	HCV MEIA	Pos:	Neg:	S/Co Ratio:	
	HCV NAT	Pos:	Neg:	Write s/co value (ex:>11, >8, or value	
	HCV RIBA	Pos:	Neg:		
	HCV Genotype:				
	HCV DNA by PCR:	iu/ml		copys/ml	

Did patient have a Negative HBsAg or anti-HCV test within the past six months: □Yes; □No; □Unknown
(If **Yes,** □HBsAg or □anti-HCV; collection date :____/____/______)

Vaccination History:	Hepatitis A ever given: □Yes □No □Unknown; Date of Last Dose:________________ Hepatitis B ever given: □Yes □No □Unknown; Date of Last Dose:________________
Symptom:(Check all that apply)	Abdominal Pain □ Dark Urine □ Fatigue □ Jaundice □ Loss of appetite □ Nausea □
Risk Factors: (Check all that apply)	Born/Immigrant from endemic country □ Diabetic □ IVDU □ Sex w/Men □ Prison Tattoos □ Any Other Tattoos □ Street Drugs □ Surgery □

Reporting Facility Info.	**Agency:**			
	Address:		**Phone#:**	
	Person Reporting:	**City:**	**State:**	**Zip:**

Fax Reports to the Viral Hepatitis Program's Fax: 303-759-5257 or Communicable Disease's Fax: 303-782-0338

http://www.cdphe.state.co.us/dc/hepatitis

For Questions in completing form for Hepatitis A call: Lavelle Fernandez 303-692-2627
For Questions in completing form for Hepatitis B/C call: Donna Cordova 303-692-2616 or Vanessa Willis 303-692-2622

ALERT: ENSURE THAT CORRECT FAX NUMBER IS INPUT WHEN FAXING CASES

Thank You!