DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

STATE NO:

Office Use Only

Notifiable Disease and Pregnancy Report Form

Date:

Patient Information

Last Name	First Name	DOB
Address		
City	State	Zip Code
Phone Number ( )	Emergency Contact	Phone
Race ☐ American Indian/Alaska Native ☐Asian ☐Black or African American ☐Native Hawaiian or Pacific Islander ☐White ☐ Unknown		Ethnicity ☐ Not Hispanic/Latino ☐Hispanic/Latino ☐ Unknown
Insured? ☐ No ☐ Yes – Name of Insurance		Income ☐ < $75,000 ☐ > $ 75,000 ☐ Unknown
Housing status ☐ Stable ☐ Unstable ☐ Unknown		
Ever incarcerated? ☐ No ☐ Unknown ☐ Yes – Date of entry:		Date of release:

DIAGNOSIS: ☐ HIV ☐ Hepatitis B ☐ Syphilis

(Please attach a copy of all lab reports)

Linkage to Care

Is the patient engaged in obstetrical care? ☐Yes ☐ No	EDD:
Is the patient engaged in specialist care? ☐Yes ☐ No ☐N/A	Date of Diagnosis:
Is the patient currently on treatment for the above diagnosis? ☐Yes ☐ No	
If yes, what medications?	

Provider Information

Provider Name:		Email:
Hospital/Facility Name:	Delivery Hospital (if different):	
Facility Address:		
City	State	Zip Code
Phone number ( )	Fax number ( )	
Person completing form (if different from provider)		

Do you suspect problems with any of the following in your patient (check all that apply):

☐Med Adherence ☐Substance Abuse ☐Mental Health ☐Risk of/History of falling out of care ☐ None

Are you concerned about any of the following in your patient (check all that apply):

☐Housing ☐Nutrition/Food assistance ☐Transportation ☐ None

Cases of pregnancy in women with certain notifiable diseases are reportable to DC Health, HIV/AIDS, Hepatitis, STD, and TB Administration. All cases are to be reported by name. For assistance please call (202) 671-4900 or visit our website at http://dchealth.dc.gov

Fax completed forms to CONFIDENTIAL FAX (202) 741-8720