**DC Health**

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 Other Pacific Islander White  Unknown | | | Ethnicity: Hispanic/Latino  Not Hispanic/Latino  Unknown | | | |

**INSURANCE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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):**

HousingNutrition/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 OR**

Mail completed reports in a doubled sealed envelope marked “**CONFIDENTIAL**” to:

**CONFIDENTIAL MAILING ADDRESS:**

**DC Health**

**Box 19**

**899 North Capitol Street, NE**

**Washington, DC 20002**