**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):**

[ ] 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 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**