STATE NO:
Office Use Only

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

DC Health
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	

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
Government of the District of Columbia
Box 19
899 North Capitol Street, NE
Washington, DC 20002