



# Kentucky Reportable Disease Form

Department for Public Health  
Division of Epidemiology and Health Planning  
275 East Main St., Mailstop HS2W-C  
Frankfort, KY 40621-0001



KentuckyPublicHealth  
Prevent. Promote. Protect.

Disease Name \_\_\_\_\_

Fax or Mail the Completed Form to the Local Health Department

EPID 200 – 7/2024

DEMOGRAPHIC DATA					
Patient's Last Name		First	M.I.	Date of Birth (MM/DD/YYYY) / /	Age
If Patient <18y, Parent or Guardian Name			Preferred Language		
Address		City	State	ZIP Code	County of Residence
Patient Occupation			Employer Name		
Phone Number	Ethnic Origin <input type="checkbox"/> Hisp. <input type="checkbox"/> Non-Hisp.	Race <input type="checkbox"/> W <input type="checkbox"/> B <input type="checkbox"/> Asian <input type="checkbox"/> NH/PI <input type="checkbox"/> Am. Ind./Alaska Native <input type="checkbox"/> Other			
Sex assigned at birth: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Unk.	Current gender identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender male-to-female <input type="checkbox"/> Transgender female-to-male <input type="checkbox"/> Unknown Additional gender identity (specify) _____				

DISEASE INFORMATION				
Disease/Organism		Date of Onset / /		Date of Diagnosis / /
List Symptoms/Comments			Highest Temperature	
			Days of Diarrhea	
Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Admission Date / /	Discharge Date / /	Died? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk.	Date of Death / /
Hospital Name:		Is Patient Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Due Date (EDC): / /		
Does the patient attend/reside in a congregate living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please select the type of facility. <input type="checkbox"/> Assisted Living/Long-Term Care/Nursing Home <input type="checkbox"/> Correctional <input type="checkbox"/> Shelter <input type="checkbox"/> Other If Other, please specify _____			Facility Name:	
School/Daycare Attendee? <input type="checkbox"/> Yes <input type="checkbox"/> No Outbreak Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No School/Daycare Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of School/Daycare: _____			Food Handler? <input type="checkbox"/> Yes <input type="checkbox"/> No Healthcare Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Did Patient travel to/arrive from another state/country in the last 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, please provide travel details including where, when, mode of travel, etc.)				
Person or Agency Completing form: Name: _____ Agency: _____			Attending Physician: Name: _____	
Address: _____			Address: _____	
Phone: _____		Date of Report: / /	Phone: _____	

LABORATORY INFORMATION				
Date	Name or Type of Test	Name of Laboratory	Specimen Source	Results

ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY				
Disease: Stage		Disease: Site: (Check all that apply)		Resistance:
<input type="checkbox"/> Syphilis	<input type="checkbox"/> Primary (lesion) <input type="checkbox"/> Secondary (symptoms) <input type="checkbox"/> Early Latent <input type="checkbox"/> Late Latent <input type="checkbox"/> Congenital <input type="checkbox"/> Other	<input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Chancroid	<input type="checkbox"/> Genital, uncomplicated <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Anorectal <input type="checkbox"/> Other _____	<input type="checkbox"/> Ophthalmic <input type="checkbox"/> PID/Acute Salpingitis <input type="checkbox"/> Penicillin <input type="checkbox"/> Tetracycline <input type="checkbox"/> Other _____

Date of Spec. Collection	Laboratory Name	Type of Test	Results	Treatment Date	Medication	Dose

If syphilis, was previous treatment given for this infection? ☐ Yes ☐ No

If yes, give approximate date and place \_\_\_\_\_

**Please use the following information and fax numbers (when relevant) for reporting:**

**HIV/AIDS Cases:**

Forms other than the EPID 200 are required for reporting HIV/AIDS cases in children and adults. Obtain those forms by calling [866-510-0008](tel:866-510-0008), or those forms can be downloaded from the DPH Website, <https://www.chfs.ky.gov/agencies/dph/dehp/hab/Pages/reportsstats.aspx>. Contact information for telephoning case reports and addresses for mailing case reports are on that Website.

**Reports for HIV/AIDS cases should not be faxed.**

**Pediatric Confidential Case Form** (Rev 11/2019)

(for patients younger than 13 at time of diagnosis)

Fillable HIV/AIDS Case Report Forms are available [here](#)

**Adult Confidential Form** (Rev 11/2019)

(for patients 13 or older at time of diagnosis)

**Sexually Transmitted Disease Cases:**

Confidential reports for STD cases can be submitted on the EPID 200 form.

**Fax a completed form for STD Cases, only, to 502-564-5715. Or, mail to:**

**Kentucky Department for Public Health  
STD Prevention and Control Program  
275 E Main St, MS: HS2CC  
Frankfort, KY 40621**

**Reporting All Other Diseases and Conditions Listed in 902 KAR 2:020 (Reportable Disease Surveillance) or in any Public Health Advisory (PHA) Issued per that KAR that Requires Using the EPID 200 Form for Reporting:**

Reports, depending upon the notification classification described in 902 KAR 2:020 or in a PHA, shall be submitted by phone, by electronic submission, or by fax or mail submission on an EPID 200 form to the

**Local Health Department (LHD) serving the county in which the patient resides.**

If submitted by telephone, an electronic or fax submission shall be made within one business day to the LHD serving the county in which the patient resides.

**Kentucky Department for Public Health in Frankfort  
Telephone 502-564-3418 or 888-9REPORT (888-973-7678)  
SECURE FAX 502-696-3803**