



Kentucky Reportable Disease Form

Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001



Kentucky Public Health
Prevent. Promote. Protect.

Disease Name _____

Fax or Mail the Completed Form to the Local Health Department

EPID 200 – 5/2025

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 <input type="checkbox"/> 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="radio"/> Yes <input type="radio"/> No If yes, Due Date (EDC): | |
| Does the patient attend/resi in a congregate living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No | Facility Name: | |
| 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 | | |
| School/Daycare Attendee? <input type="checkbox"/> Yes <input type="checkbox"/> No | Outbreak Associated? <input type="checkbox"/> Yes <input type="checkbox"/> No | Food Handler? <input type="radio"/> Yes <input type="radio"/> No |
| School/Daycare Worker? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Healthcare Worker? <input type="radio"/> Yes <input type="radio"/> No |
| Name of School/Daycare: | | |
| Did Patient travel to/arrive from another state/country in the last 30 days? <input type="radio"/> Yes <input type="radio"/> 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 |
|------|----------------------|--------------------|-----------------|---------|
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| | | | | |

ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY

| | | | | | | |
|-----------------------------------|--|--|--|---|------------|------|
| Disease: | State | Disease: | Site: (Check all that apply) | Resistance: | | |
| <input type="checkbox"/> Syphilis | <input type="radio"/> Primary (lesion) <input type="radio"/> Early Latent <input type="radio"/> Congenital <input type="radio"/> Secondary (symptoms) <input type="radio"/> Late Latent <input type="radio"/> 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 <input type="checkbox"/> 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