

We want your opinion! see page 2



THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

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SPECIAL REPORTING ISSUE—2007

UPCOMING CHANGES FOR 2007 – COMING SOON

The list of reportable diseases and conditions is currently being updated by the California Department of Health Services and will be provided in an upcoming issue of The Public's Health newsletter. For immediate posted updates, please visit: www.lapublichealth.org/acd/cdrs.htm

In Los Angeles County, more than 80 diseases are reportable by law to the local health department. Since there are several different reporting forms and procedures, this special issue was designed to facilitate disease reporting during 2007. Timely and accurate reporting of communicable diseases (both confirmed and suspected cases) is a critical component of disease surveillance, prevention and control. Delay or failure to report may contribute to secondary transmission of disease and is a misdemeanor (Health and Safety Code §12095). In addition, the potential threat of emerging diseases and bioterrorist activity further increases the need for prompt and thorough disease reporting.

Regardless of the many specific diseases itemized on the current

list, any suspected unusual disease and any suspected evidence of an outbreak of disease warrants an immediate call to Acute Communicable Disease Control: (213) 240-7941.

Similarly, there are several diseases associated with potential bioterrorist activity that also warrant an immediate call—even if infection is merely suspected. These include: anthrax, botulism, brucellosis, plague, smallpox, tularemia, and the viral hemorrhagic fevers.

It is important to note that primary healthcare providers are frequently the first to recognize unusual occurrences or patterns of disease. As such, it is critical that healthcare providers be alert and quick to report all reportable diseases as well as any unusual occurrences. It is also important that these high priority diseases be reported immediately to local public health authorities, and not state or national authorities (e.g., CDC). Acute Communicable Disease Control (213-240-7941) should be the first health authority notified in cases of suspected bioterrorist activity or unusual disease since we can more readily and immediately provide guidance for testing, treatment and prophylaxis.

For questions about disease reporting, call Acute Communicable Disease Control (213-240-7941).

HIPAA: STANDARDS EXEMPT PUBLIC HEALTH AGENCIES

Many healthcare professionals remain unsure of the legality of disease reporting in light of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Congress established the HIPAA regulations to safeguard personal medical information from inappropriate disclosure and misuse, and full implementation was mandated in April 2003.

While much has been written about HIPAA, healthcare providers continue to question the legality of disease reporting without obtaining prior patient consent. HIPAA privacy regulations do not preclude sharing information with public health officials—in fact, HIPAA regulations contain specific language permitting reporting to public health agencies of diseases and conditions listed in state public health laws and regulations.

Patient authorization is NOT required when healthcare professionals or laboratory workers suspect or diagnose a disease of public health importance that is reportable by law in California or Los Angeles County. These public health reporting exceptions are described in Section 164.512b (p. 82813-4) under “permitted disclosures.”

The full HIPAA regulations, background, and technical assistance are available at www.hhs.gov/ocr/hipaa.

HIPAA regulations permit disease reporting to public health agencies.

THE PUBLIC'S HEALTH



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Readers Survey for The Public's Health

THE PUBLIC'S HEALTH is published by the Department of Public Health for all licensed physicians within Los Angeles County, other community healthcare providers and interested individuals.

The publication provides the latest information from the many programs within the department, including Acute Communicable Disease Control, Environmental Health Services, Injury and Violence Prevention, Immunizations, and Chronic Disease Prevention. Our goal is to keep health professionals abreast of the latest data and information on county health issues.

We have created this survey to learn how our readership regards TPH and as a needs assessment to learn how we can better meet our readers' needs and improve this important news vehicle.

The survey can be accessed at <https://lacws.co.la.ca.us/dhs/tphsurvey.htm>.

Please take a few moments to complete the survey. Your opinion is very important to us.

If you prefer, you may print out the survey, complete it and mail it back to:
Sheree R. Poitier, MD, Editor, The Public's Health. 313 N. Figueroa St. Ste. 227. LA, CA, 90012

HIV is Now Reportable By Name

HIV infection is now reportable in California the same way AIDS has been for 25 years—that is, by name. California Senate Bill 699, signed by Governor Schwarzenegger in April 2006, requires laboratories, physicians, allied health care providers, and HIV counseling and testing sites to report all cases of HIV to their local health department by name instead of by code.

This important change allows us to monitor the HIV epidemic in a more accurate, timely, and complete manner. And because future federal funding is now allocated according to the number of HIV cases (not just AIDS cases) reported by name, compliance with this new law will help ensure that we, as a county, receive our fair share of funding for HIV care and prevention services.

To ensure protection of patient confidentiality, it is strongly recommended that reports not be sent by email or fax. Instead, reports should be mailed in a double-envelope to: Los Angeles County Department of Public Health, 600 S. Commonwealth Ave., Suite 1260, Los Angeles, CA 90005. Reports may also be phoned in to the County's HIV Epidemiology Program at: (213) 351-8516.

In the last 25 years, there have been over 51,000 persons reported with AIDS in the county, of which over 21,000 are now living with AIDS. From July 1, 2002, when HIV reporting by code began, to April 17, 2006, when coded reporting of HIV ended, a total of 15,275 (non-AIDS) HIV infections were reported by non-name code. We now estimate some 50—60,000 county residents are infected with HIV.

Douglas M. Frye, MD, MPH,
Director HIV Epidemiology Program

Avian Influenza: Heightened Awareness and Surveillance is Critical

As more and more countries experience animal outbreaks and human cases of avian influenza (influenza A type H5), it is critical that healthcare professionals be especially vigilant compiling a complete case history (including travel history and potential exposures) of their patients who present with flu-like symptoms. And since the epidemiologic factors that increase risk for avian influenza are frequently changing, consultation with Acute Communicable Disease Control is essential to provide advice on diagnostic testing and specimen collection.

Suspected cases of avian influenza should have:

1. Pneumonia confirmed with x-rays, acute respiratory distress syndrome (ARDS), or other severe respiratory illness for which an alternate diagnosis has not been established, **AND** history of travel within ten days of symptom onset to a country with documented H5N1 avian influenza in poultry and/or humans. Current countries of concern include: Azerbaijan, Cambodia, China, Croatia, Djibouti, Egypt,

Hong Kong, Indonesia, Japan, Kazakhstan, Korea, Laos, Malaysia, Mongolia, Romania, Russia, Thailand, Turkey, and Vietnam*.

Testing for influenza A (type H5) will be considered on a case-by-case basis for patients with:

1. Documented temperature of $>38^{\circ}\text{C}$ ($>100.4^{\circ}\text{F}$), **AND**
2. One or more of the following: cough, sore throat, shortness of breath, **AND**
3. A history of contact with poultry (e.g., visited a poultry farm or bird market, household raising poultry, etc.)
OR
4. A history of contact with a known or suspected human case of influenza A (type H5) within ten days of symptom onset.

**Countries as of January 5, 2007.*

Due to frequent changes in the global activity of avian influenza H5N1, please consult ACDC regarding suspected avian influenza cases with recent travel.

Special Cases of Influenza Are REPORTABLE in Los Angeles County

Individual cases of seasonal influenza are not routinely reportable. However, the following situations should be reported immediately by phone:

- **Outbreaks of suspected influenza or other respiratory illnesses**
Contact the Morbidity Unit: (888) 397-3993
- **Suspected cases of avian influenza**
Contact ACDC 24/7: (213) 240-7941
- **Influenza-related pediatric ICU cases and pediatric deaths**
Contact ACDC: (213) 240-7941

For more information about influenza in LA County, California, and across the Nation, go to <http://lapublichealth.org/acd/flu.htm>

For questions or additional information, contact Acute Communicable Disease Control
Phone: (213) 240-7941 E-mail: ACDC2@ph.lacounty.gov

If you would like to receive weekly reports summarizing influenza activity in Los Angeles County, sign-up at: www.ladhs.org/listserv (select "Public Health Topics" and then "FLUWATCH") or e-mail: LISTSERV@listserv.ladhs.org with **SUBSCRIBE FLUWATCH** in the body of the email.

County Seasonal Influenza Surveillance

Influenza (flu) is a vaccine preventable disease yet it is associated with approximately 36,000 deaths and 200,000 hospitalizations in the U.S. each year. Healthcare providers not only give vaccines and treat patients for flu, they also provide useful data to track the disease.

Since most flu cases are not reportable in the county (except for severe pediatric flu and suspected avian flu), flu activity is monitored by the county's Department of Public Health using several surveillance methods (Table 1). Healthcare providers, hospitals, and laboratories play an integral role in providing

flu data, including reporting laboratory tests, participating in syndromic surveillance at hospitals and physician offices, and reporting outbreaks. Without the cooperation and participation of health professionals, assessing flu in the county would be a daunting, if not impossible, task.

Beginning this year, ACDC will use collected surveillance data to produce a weekly one page newsletter ("Influenza Watch") describing influenza in the county using information as described in Table 1.

Table 1. Selected surveillance systems used to monitor seasonal influenza

| SURVEILLANCE SYSTEM | DESCRIPTION |
|---|---|
| Influenza and RSV Tests* | Sentinel laboratories serving Los Angeles County healthcare providers and institutions report the number of positive tests indicating influenza or respiratory syncytial virus on a weekly basis. |
| Hospitalized Adult Influenza* | In a pilot study this season, five hospitals in Los Angeles County will report all hospitalized influenza cases (lab-confirmed). |
| Severe Pediatric Influenza[†] | Children <18 years who are hospitalized in the Pediatric Intensive Care Unit (PICU) or die from laboratory confirmed influenza are reportable in the county. |
| Emergency Department Visits** | Participating emergency departments throughout the county provide initial self-reported symptoms of patients presenting to the emergency department. Influenza-like illness (ILI) is categorized by symptoms such as: fever, congestion, sneezing, sore throat, runny nose, and cough. The proportion of ILI emergency department visits for all ages and for children < 6 years of age is analyzed weekly. |

For more information and a detailed description of influenza surveillance, see:
<http://lapublichealth.org/acd/flu.htm>

* **Sentinel Surveillance**- surveillance network where a sample of selected Los Angeles County hospitals and laboratories report cases

[†] **Population Based Surveillance (passive)**- all Los Angeles County hospitals and laboratories are required to report cases

** **Syndromic Surveillance**- surveillance using health-related data (e.g. ILI data, school absenteeism) that precede diagnosis and signal a sufficient probability of a case or an outbreak to warrant further public health response

The newsletter will also include important news, announcements, and guidelines concerning influenza. We encourage you to sign up for these weekly reports at: www.ladhs.org/listserv (select "Public Health Topics" and then "FLUWATCH") or send an email to LISTSERV@listserv.ladhs.org with SUBSCRIBE FLUWATCH in the body of the email. The newsletter will be electronically distributed each week throughout the traditional influenza surveillance season, from the beginning of October to mid-May, and posted on our dedicated influenza website: <http://lapublichealth.org/acd/flu.htm>.

CDC. Prevention and Control of Influenza. MMWR 2006;55(No. RR-10):3-6.

Los Angeles County Department of Health Services Information and Reporting Phone Numbers

| | Phone Number | Hours available | Service Providers | What can be reported? |
|---|---|-------------------------------------|--|---|
| AIDS/STD | | | | |
| California AIDS Hotline | 1-800-367-2437 | 9AM-9PM M-F and 10AM-6PM Sat-Sun | General Public | Referrals for HIV/AIDS testing, case management, and services. |
| HIV/AIDS Surveillance | 213-351-8516 | 8AM-5PM M-F | Healthcare providers/labs | HIV/AIDS case reporting and HIV confirmed test results. |
| Sexually Transmitted Disease/HIV Hotline | 1-800-758-0880 | 9AM-5PM M-F; 24/hr msg. | Public and Healthcare providers | STD/HIV information line; specific information available from a Health Educator. |
| Animal Reporting | | | | |
| Animal Bites and Dead Bird Reporting | 1-877-747-2243 | 8AM-5PM M-F; 24/hr msg. | Public and Healthcare providers | Reporting of animal bites and dead birds for disease surveillance (e.g., West Nile Virus) |
| Children Services | | | | |
| California Children Services | 1-800-288-4584 | 8AM-5PM | General Public | Medical assessments and referrals. |
| LA County Child Health/Disability Prevention | 1-800-993-2437 | 8:00AM-5PM | Public and Healthcare providers | Information regarding immunizations and medical examinations. |
| LA County Child Protection Hotline | 1-800-540-4000 | 24 hours | Public, Healthcare providers, & Law enforcement. | Child abuse reporting, social workers available for information. |
| DISEASE AND ILLNESS-RELATED Information Lines | | | | |
| Communicable Disease Reporting System (CDRS) | 1-888-397-3993 or Fax 1-888-397-3778 | 24 hours | Healthcare Providers | Communicable disease reporting |
| Environmental Health Food Program | 1-888-700-9995 | 8AM-5PM M-F monitored; 24hr line | Public and Healthcare providers | Food facility complaints and suspected food-related illness. |
| Health Facilities (Complaints) | 1-800-228-1019 | 8AM-5PM M-F; 24/hr msg. | Public and Healthcare providers | Complaints about health facilities. |
| Health Services Information | 1-800-427-8700 | 8AM-5PM M-F | Public and Healthcare providers | Healthcare resource information, county facility and information numbers. |
| LA County Alcohol and Drug Programs | 1-800-564-6600 | 8AM-5PM M-F | General Public | Information regarding alcohol and drug treatment centers. |
| Lead Program: Medically elevated blood levels of lead reporting | 213-351-5086 | 8AM-5PM M-F | Healthcare providers and labs | Reporting of medically determined high levels of lead in the blood. |
| Lead Program: Unsafe work practices for those working with lead-based products | 1-800-524-5323 | 8AM-5PM M-F | General Public | Reporting unsafe methods of removing lead-based paint. |
| TB Control Program: Surveillance Unit | 213-744-6271 or Fax 213-749-0926 | 8AM-5PM M-F; 24hr/ msg. | Healthcare providers | Reporting TB cases and suspected cases. |

Reporting Cases of Vaccine-Preventable Diseases to the Health Department

Why is it important?

The Health Department plays a vital role in controlling the spread of vaccine-preventable diseases in the community. Timely reporting to the Health Department of suspected or confirmed cases is critically important for our control measures. Once a case is reported, it is not merely a statistic. Public health nurses investigate every reported case of measles, rubella, congenital rubella syndrome, pertussis, *Haemophilus influenzae* type b, hepatitis A, tetanus, diphtheria, and polio, as well as outbreaks of vaccine-preventable diseases; they implement control measures to prevent spread to family members and the community. The confidentiality of patient information is protected by law.

| DISEASE | REPORTING PROCEDURE |
|--|--|
| Diphtheria | Report immediately to Acute Communicable Disease Control (ACDC) by phone (213) 240-7941. After hours, report to (213) 974-1234 for release of anti-toxin. |
| Haemophilus influenzae, invasive disease Hepatitis A Measles (rubeola) Pertussis (whooping cough) Poliomyelitis, paralytic Rubella (German measles) Rubella syndrome, congenital | Report by mail, phone, or fax within 1 working day of identification of the case or suspected case. The Immunization Program requests an immediate phone call for measles and rubella cases (213) 351-7800. After hours, please call (213) 974-1234. |
| Hepatitis B (specify acute or chronic case) Mumps Pneumococcal, invasive disease * Tetanus | Report by mail, phone, or fax within 7 calendar days of identification of the case or suspected case. After hours, please call (213) 974-1234. |
| Outbreaks of any disease | Report immediately to the Communicable Disease Reporting System by phone (888) 397-3993. Report varicella outbreaks (5 or more cases) to the Immunization Program at (213) 351-7800. After hours, please call (213) 974-1234. |

* Required in Los Angeles County. Use the IPD report form available at www.lapublichealth.org/acd/Epiforms/New_3_29_05/InvasPneumoform.pdf.

Where and how do I report these diseases?

Health care workers and school officials are required by law to report cases of vaccine-preventable diseases. Cases can be reported to the Communicable Disease Reporting System (CDRS) by telephone or fax. The Confidential Morbidity Report (CMR) is available in this issue and can be obtained by fax from any local health center registrar, from the Morbidity Central Reporting Unit (MCRU), or from the Department of Public Health web site at www.lapublichealth.org/acd/reports/acdcmr.pdf. Cases among residents of Long Beach or Pasadena should be reported to those city health departments.

Report to:

Communicable Disease Reporting System

Hotline: (888) 397-3993

Fax: (888) 397-3778

Morbidity Central Reporting Unit

Phone: (213) 240-7821

For general information only:

For cases among residents

of Long Beach and Pasadena:

Long Beach City Health Dept.

Epidemiology

Phone: (562) 570-4301/4302

Fax: (562) 570-4374

Pasadena City Health Dept.

Public Health Nursing ^{6128/6089}

For additional information about vaccine-preventable disease reporting:

Immunization Program

Epidemiology Unit

Phone: (213) 351-7800

Fax: (213) 351-2782

Vaccine Adverse Event Reporting System (VAERS)

In order to receive and analyze reports about adverse events that may be associated with vaccines, the CDC and FDA maintain a national vaccine adverse event reporting system known as VAERS. This system allows health care providers, consumers, and vaccine manufacturers to report any clinically significant adverse event that occurs following administration of any vaccine, whether or not the vaccine is believed to be the cause of the event. VAERS reports can be made 24 hours a day by completing the VAERS form and sending it to P.O. Box 1100, Rockville MD 20849-1100 or by reporting on-line at www.vaers.hhs.gov. All health care providers that receive vaccine from the Los Angeles County Immunization Program (LACIP) should send all VAERS reports to the LACIP which will in turn forward them to the appropriate national center. Forms can be requested by calling the information line at (800) 822-7967.



LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE
CONFIDENTIAL MORBIDITY REPORT



DATE OF REPORT []-[]-[] REPORT STATUS: [] New [] Update REPORT DONE BY: []

1 PROVIDER DIAGNOSING MEDICAL PRACTITIONER (LAST NAME & FIRST NAME) TITLE ABBREVIATION
FACILITY/CLINIC NAME SUITE/UNIT NO.
FACILITY/CLINIC STREET ADDRESS
CITY/TOWN CLINIC STAMP
STATE AREA CODE OFFICE TEL
ZIP CODE AREA CODE OFFICE FAX

2 PATIENT INFORMATION PATIENT'S LAST NAME FIRST NAME MI
MEDICAL RECORD NUMBER SOCIAL SECURITY NUMBER OCCUPATION
PATIENT'S STREET ADDRESS APT/UNIT NO.
CITY/TOWN STATE ZIP CODE
AREA CODE DAY TEL AREA CODE EVENING TEL
AGE: BIRTH DATE: PREGNANT: GENDER: MARITAL STATUS: RACE: ETHNICITY: GENDER(S) of SEX PARTNERS:

3 CHLAMYDIA DIAGNOSIS: (X one): SITE / SPECIMEN: Specimen Collection Date:
Treatment Date: Medication & Dose: Partner Information:
Number partners treated: Number Partner Delivered Therapy:

GONORRHEA DIAGNOSIS: (X one): SITE / SPECIMEN: Specimen Collection Date:
Treatment Date: Medication & Dose: Partner Information:
Number partners treated: Number treated:

SYPHILIS, CONGENITAL SYPHILIS, OTHER REPORTABLE STDs AND REPORTING INFORMATION ON BACK PAGE.

PATIENT'S LAST NAME (COMPLETE SECTIONS 1 & 2 FIRST)

FIRST NAME

MI

ADULT SYPHILIS

Primary Syphilis Onset Date: LESION SITES (X all that apply): Genital, Perirectal, Oral, Other, Vagina, Rectum

Secondary Syphilis Onset Date: SYMPTOMS (X all that apply): Palmar/Plantar Rash, Other: Alopecia, Gen. Body Rash

Early Latent (< 1 Year), Late Latent (>1 Year), Latent, Unknown Duration, Late Syphilis, Neurosyphilis, DESCRIBE SYMPTOMS

Specimen Collection Date, PARTNER INFORMATION: Number elicited, Number treated

RPR or VDRL Titer, TP-PA or FTA-ABS or Other Reactive, CSF - VDRL Titer, Patient Treated: Yes/No, DATE(S) TREATED, MEDICATION / DOSE

CONGENITAL SYPHILIS (SEPARATE CMRS SHOULD BE SUBMITTED FOR MOTHER AND INFANT)

INFANT INFORMATION (complete section A and B if this is mother's CMR; complete only section B if this is infant's CMR)

INFANT'S LAST NAME, INFANT'S FIRST NAME, INFANT'S MEDICAL RECORD NUMBER

INFANT'S BIRTH DATE, GESTATION (wks), GENDER (M/F), Live/Still Birth, WEIGHT (grams), SYMPTOMS, Serum, CSF, Laboratory Test Date, RPR, VDRL, WBC, Protein, Titer, Long Bone X-rays, Infant Treated

MATERNAL INFORMATION (complete if this is infant's CMR)

MOTHER'S LAST NAME, MOTHER'S FIRST NAME, MOTHER'S MEDICAL RECORD NUMBER

MOTHER'S BIRTH DATE, MOTHER'S SEROLOGY AT DELIVERY (Lab Test Date), STAGE OF SYPHILIS AT DIAGNOSIS, RPR or VDRL Titer, TP-PA or FTA-ABS or Other Reactive, Lumbar Puncture Done, DATE(S) TREATED, MEDICATION / DOSE

OTHER REPORTABLE STDs

DIAGNOSIS: Pelvic Inflammatory Disease (Non-Chlamydial/Non-Gonococcal), Non-Gonococcal/Non-Chlamydial Urethritis (NGU), Chancroid; TREATED, DATE TREATED, MEDICATION / DOSE

4 FAX BOTH SIDES TO: (213) 749-9602 OR MAIL TO: STD PROGRAM 2615 S. GRAND AVENUE, RM. 450 LOS ANGELES, CA 90007

5 TO REQUEST CMR FORMS & ENVELOPES: Call (213) 741-8000 or DOWNLOAD at: www.lapublichealth.org/std/providers.htm FOR CASE DEFINITIONS & REPORTING QUESTIONS: Call (213) 744-3070 or visit www.lapublichealth.org/std/providers.htm FOR HIV REPORTING: Call (213) 351-8516 or visit www.lapublichealth.org/hiv

DIAGNOSIS & TREATMENT

SEND INFO

CONFIDENTIAL MORBIDITY REPORT

NOTE: This form is not intended for reporting STDs, HIV, AIDS or TB. See comments below



| DISEASE BEING REPORTED: | | | DISTRICT CODE (internal use only): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| Patient's Last Name: | | Social Security Number: | | Ethnicity (check one): <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic / Non-Latino | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Name and Middle Name (or initial): | | Birthdate (MM/DD/YYYY): | Age: | Race (check one): <input type="checkbox"/> White <input type="checkbox"/> African American / Black <input type="checkbox"/> Native American / Alaskan Native <input type="checkbox"/> Other _____ <input type="checkbox"/> Asian / Pacific Islander (check one below): <input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Address (Street and number): | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| City/Town: | | State: | Zip Code: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Home Telephone Number: () () () | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female → Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Estimated Delivery Date (MM/DD/YYYY): ____/____/____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Work Telephone Number: () () () | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Patient's Occupation or Setting: <input type="checkbox"/> Day Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Food Service: (Explain) _____ <input type="checkbox"/> Health Care <input type="checkbox"/> School <input type="checkbox"/> Other: (Explain) _____ | | | Risk Factors / Suspected Exposure Type: (check all that apply) <input type="checkbox"/> Blood transfusion <input type="checkbox"/> Needle or blood exposure <input type="checkbox"/> Child care <input type="checkbox"/> Recreational water exposure <input type="checkbox"/> Food / drink <input type="checkbox"/> Sexual activity <input type="checkbox"/> Foreign travel <input type="checkbox"/> Unknown <input type="checkbox"/> Household exposure <input type="checkbox"/> Other (specify) _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Onset (MM/DD/YYYY): ____/____/____ | | Health Care Provider: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Diagnosis (MM/DD/YYYY): ____/____/____ | | Health Care Facility: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Hospitalization (MM/DD/YYYY): ____/____/____ | | Address: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Date of Death (MM/DD/YYYY): ____/____/____ | | City: | | Type of diagnostic specimen: (check all that apply) <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Stool <input type="checkbox"/> Urine <input type="checkbox"/> Clinical <input type="checkbox"/> No test <input type="checkbox"/> Other _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Telephone: | | FAX: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Submitted by: | | Date CMR submitted (MM/DD/YYYY): ____/____/____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hepatitis Diagnosis: <input type="checkbox"/> Hep A, acute <input type="checkbox"/> Hep B, acute <input type="checkbox"/> Hep B, chronic <input type="checkbox"/> Hep C, acute <input type="checkbox"/> Hep C, chronic <input type="checkbox"/> Hep D <input type="checkbox"/> Other Hepatitis _____ | | Type of Hepatitis Testing (check all that apply): <table border="1"><thead><tr><th></th><th>Pos.</th><th>Neg.</th><th>Pend.</th><th>Not Done</th></tr></thead><tbody><tr><td>anti-HAV IgM</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>HBsAg</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>anti-HBc (total)</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>anti-HBc IgM</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>anti-HBs</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>anti-HCV</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td colspan="5">- anti-HCV signal to cut-off ratio = _____</td></tr><tr><td>PCR-HCV</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>anti-Delta</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td>other test</td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td><td><input type="checkbox"/></td></tr><tr><td colspan="5">specify _____</td></tr></tbody></table> | | | Pos. | Neg. | Pend. | Not Done | anti-HAV IgM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | HBsAg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | anti-HBc (total) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | anti-HBc IgM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | anti-HBs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | anti-HCV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | - anti-HCV signal to cut-off ratio = _____ | | | | | PCR-HCV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | anti-Delta | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | other test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | specify _____ | | | | | <p>DO NOT use this form to report HIV/AIDS, chancroid, chlamydia infections, gonorrhea, non-gonococcal urethritis, pelvic inflammatory disease, syphilis, or tuberculosis.</p> <p>For HIV and AIDS : report to the HIV Epidemiology Program. Reporting information and forms are available by phone (213-351-8516) or at: www.lapublichealth.org/hiv/index.htm</p> <p>For Pediatric AIDS : report to the Pediatric HIV/AIDS Reporting Program. Reporting information is available by calling 213-250-8666.</p> <p>For Tuberculosis : report cases and suspected cases to the TB Control Program within 24 hours of identification. Reporting information is available by phone (213-744-6160) or at: www.lapublichealth.org/tb/index.htm Fax reports to: 213-744-0926.</p> <p>For STDs: The STDs that are reportable to the STD Program include: chlamydial infections, syphilis, gonorrhea, chancroid, non-gonococcal urethritis (NGU), and pelvic inflammatory disease. Reporting information is available by phone (213-744-3070) or at: www.lapublichealth.org/std/index.htm</p> | | | |
| | Pos. | Neg. | Pend. | Not Done | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| anti-HAV IgM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| HBsAg | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| anti-HBc (total) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| anti-HBc IgM | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| anti-HBs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| anti-HCV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| - anti-HCV signal to cut-off ratio = _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PCR-HCV | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| anti-Delta | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| other test | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| specify _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Elevated LFTs? <input type="checkbox"/> No <input type="checkbox"/> Yes → ALT _____ AST _____ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Jaundiced? <input type="checkbox"/> No <input type="checkbox"/> Yes | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| REMARKS: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <p align="center">FAX THIS REPORT TO: 888-397-3778</p> <p align="center">For assistance, please call the Morbidity Unit at 888-397-3993, or mail to Morbidity Unit, 313 N. Figueroa St. #117, Los Angeles, CA 90012.</p> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR), § 2500

It shall be the duty of every healthcare provider, knowing of or in attendance on a case or suspected case of any diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no healthcare provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report. "Healthcare provider" encompasses physicians, surgeons, veterinarians, podiatrists, nurse practitioners, physician assistants, registered nurses, nurse midwives, school nurses, infection control practitioners, medical examiners, coroners, dentists and chiropractors.

Urgency Reporting Requirements:

- ☎ = Report immediately by telephone.
- ✉ = Report by mailing, telephoning or electronically transmitting a report within 1 working day of identification of the case or suspected case.
- ☎ = Report by telephone within 1 hour followed by a written report submitted by facsimile or electronic mail within 1 working day.
- 📧 = Report within 7 calendar days from the time of identification by mail, telephone or electronic report.

REPORTABLE DISEASES

- | | | |
|---|--|---|
| <ul style="list-style-type: none"> 📧 Acquired Immune Deficiency Syndrome (AIDS) * ✉ Amebiasis ✉ Anisakiasis ☎ Anthrax ☎ Babesiosis ☎ Botulism: Infant, Foodborne, or Wound ☎ Brucellosis ✉ Campylobacteriosis 📧 Chancroid * 📧 Chlamydial Infections * ☎ Cholera ☎ Ciguatera Fish Poisoning 📧 Coccidioidomycosis ✉ Colorado Tick Fever ✉ Conjunctivitis, Acute Infections of the Newborn, specify etiology ✉ Cryptosporidiosis 📧 Cysticercosis ☎ Dengue ☎ Diarrhea of the Newborn, outbreaks only ☎ Diphtheria ☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning) 📧 Echinococcosis (Hydatid Disease) 📧 Ehrlichiosis ✉ Encephalitis, specify etiology: Viral, Bacterial, Fungal, Parasitic ☎ <i>Escherichia coli</i> O157:H7 Infections ✉ Foodborne Disease: <ul style="list-style-type: none"> ☎ 2 or more cases from separate households with same suspected source 📧 Giardiasis 📧 Gonococcal Infections * ✉ <i>Haemophilus influenzae</i> Invasive Disease ☎ Hantavirus Infections ☎ Hemolytic Uremic Syndrome ☎ Hemorrhagic Fevers, Viral (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) | <ul style="list-style-type: none"> <u>Hepatitis:</u> ✉ Hepatitis A 📧 Hepatitis B, specify Acute or Chronic 📧 Hepatitis C, specify Acute or Chronic 📧 Hepatitis D (Delta) 📧 Hepatitis Other, Acute 📧 Human Immunodeficiency Virus (HIV) * 📧 Influenza, pediatric—ICU cases or deaths only 📧 Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome) 📧 Legionellosis 📧 Leprosy (Hansen's Disease) 📧 Leptospirosis ✉ Listeriosis 📧 Lyme Disease ✉ Lymphocytic Choriomeningitis ✉ Malaria ✉ Measles (Rubeola) ✉ Meningitis, specify etiology: Viral, Bacterial, Fungal, or Parasitic ☎ Meningococcal Infections 📧 Mumps 📧 Non-Gonococcal Urethritis (report laboratory confirmed Chlamydia as Chlamydia) * ☎ Paralytic Shellfish Poisoning 📧 Pelvic Inflammatory Disease (PID) * 📧 Pertussis (Whooping Cough) ☎ Plague, Human or Animal ✉ Poliomyelitis, Paralytic ✉ Psittacosis ✉ Q Fever ☎ Rabies, Human or Animal ✉ Relapsing Fever 📧 Rye Syndrome 📧 Rheumatic Fever, Acute 📧 Rocky Mountain Spotted Fever <u>Rubella:</u> 📧 Acute Rubella (German Measles) 📧 Congenital Rubella Syndrome | <ul style="list-style-type: none"> ✉ Salmonellosis (other than Typhoid Fever) ☎ SARS (Severe Acute Respiratory Syndrome) ☎ Scabies (Atypical or Crusted) * ☎ Scombroid Fish Poisoning ✉ Shigellosis ☎ Smallpox <u>Streptococcal Infections:</u> ✉ Outbreaks of any type ✉ Individual case in a food handler ✉ Individual case in a dairy worker ✉ Invasive Group A Streptococcal Infections including Streptococcal Toxic Shock Syndrome and Necrotizing Fasciitis * (Do <u>not</u> report individual cases of pharyngitis or scarlet fever.) 📧 <i>Streptococcus pneumoniae</i> Invasive * ✉ Swimmer's Itch (Schistosomal Dermatitis) ✉ Syphilis * 📧 Tetanus 📧 Toxic Shock Syndrome 📧 Toxoplasmosis ✉ Trichinosis ✉ Tuberculosis * ☎ Tularemia ✉ Typhoid Fever, cases and carriers 📧 Typhus Fever <u>Varicella:</u> ☎ Varicella, Fatal Cases 📧 Varicella, Hospitalized Cases (Do <u>not</u> report cases of herpes zoster/shingles.) ✉ <i>Vibrio</i> Infections ✉ Water-associated Disease ✉ West Nile Virus ☎ Yellow Fever ☎ Yersiniosis ☎ OCURRENCE OF ANY UNUSUAL DISEASE ☎ OUTBREAKS OF ANY DISEASE |
|---|--|---|

Notification Required of Laboratories (CCR § 2505)

- | | | |
|---|---|--|
| <ul style="list-style-type: none"> 📧 Anthrax +■ 📧 Botulism ■ 📧 Brucellosis +■ ✉ Chlamydial Infections * ✉ Cryptosporidiosis ✉ Diphtheria + ✉ Encephalitis, arboviral 📧 <i>Escherichia coli</i> O157:H7 or Shiga toxin-producing <i>E. coli</i> O157:NM + ✉ Gonorrhea * ✉ Hepatitis A, Acute Infections, by IgM antibody test or positive viral antigen test | <ul style="list-style-type: none"> <u>Hepatitis B:</u> ✉ Acute Infections, by IgM anti-HBc antibody test ✉ Surface Antigen Positivity (specify gender) 📧 Hemorrhagic Fevers, Viral (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses) ■ 📧 Human Immunodeficiency Virus (HIV) * ✉ Listeriosis + ✉ Lyme Disease ✉ Malaria + ✉ Measles (Rubeola), Acute Infections, by IgM antibody test or positive viral antigen test | <ul style="list-style-type: none"> 📧 Plague, Animal or Human +■ ✉ Rabies, Animal or Human ✉ Salmonella + 📧 Smallpox ■ 📧 <i>Streptococcus pneumoniae</i> Invasive * ✉ Syphilis * ✉ Tuberculosis +■ 📧 Tularemia +■ ✉ Typhoid and other <i>Salmonella</i> Species + ✉ <i>Vibrio</i> Species Infections + ✉ West Nile Virus |
|---|---|--|

* Reportable to the Los Angeles County Department of Health Services.
 + Bacterial isolates and malarial slides must be forwarded to the Los Angeles County DHS Public Health Laboratory for confirmation. Healthcare providers must still report all such cases separately.
 ■ Laboratories receiving specimens for the diagnosis of these diseases must immediately contact the California Department of Health Services; for bacterial testing call 510-412-3700, for viral testing call 510-307-8575. For botulism testing, contact Acute Communicable Disease Control at 213-240-7941.

Non-communicable Diseases or Conditions

- 📧 Alzheimer's Disease and Related Conditions (CCR § 2802, § 2806, § 2810)
- 📧 Disorders Characterized by Lapses of Consciousness (CCR § 2806, § 2810)
- ✉ Pesticide-Related Illnesses (Health and Safety Code, § 105200)

* For questions regarding the reporting of HIV/AIDS, STDs, or TB, contact their respective programs:

HIV Epidemiology Program
 213-351-8516
www.lapublichealth.org/hiv/index.htm

STD Program
 213-744-3070
www.lapublichealth.org/std/index.htm

TB Control Program
 213-744-6271 (for reporting) 213-744-6160 (general)
www.lapublichealth.org/tb/index.htm

To report a case or outbreak of any disease contact the Communicable Disease Reporting System Hotline

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥ 13 years of age at time of diagnosis)

I. This is for Health Department use. Uniquely identifying information is not transmitted to the Centers for Disease Control and Prevention.

| | | | | |
|----------------------------------|--|------------------|------------------------|----------------|
| Patient's name (last, first, MI) | | Telephone number | Social Security Number | |
| Address (number, street) | | City | County | State ZIP code |

| | | | | | |
|---------------------|---|--|-----------------------------|-----------------------------|----------------------------|
| Date form completed | Report status | II. Health Department Use Only | | | |
| Month Day Year | <input type="checkbox"/> 1 New <input type="checkbox"/> 2 Update | Report source | Reporting health department | State patient number | City/county patient number |
| Soundex code | Date of birth | Gender | CLIA number | Lab report/Accession number | *Confidential C&T number |
| | Month Day Year | <input type="checkbox"/> 1 M <input type="checkbox"/> 3 M>F <input type="checkbox"/> 2 F <input type="checkbox"/> 4 F>M | | | |

| | | | | | |
|---|--|---|---|--|--|
| III. Demographic Information | | | | | |
| Diagnosis status at report (check one) | Age at Diagnosis | Current status | Date of death | State/Territory of death | |
| <input type="checkbox"/> 1 HIV Infection (not AIDS)..... <input type="checkbox"/> 2 AIDS..... | Years | <input type="checkbox"/> 1 Alive <input type="checkbox"/> 2 Dead <input type="checkbox"/> 9 Unknown | Month Day Year | | |
| ETHNICITY | RACE | | Country of birth | | |
| <input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 2 Not Hispanic nor Latino | <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown | | <input type="checkbox"/> 1 U.S. <input type="checkbox"/> 7 U.S. Territories (including Puerto Rico) <input type="checkbox"/> 8 Other (specify): <input type="checkbox"/> 9 Unknown | | |
| Expanded race (specify): | | | | | |
| <input type="checkbox"/> Check if HIV infection is presumed to have been acquired outside United States and Territories. Specify country: | | | | | |
| Residence at first diagnosis of HIV or AIDS: <input type="checkbox"/> Homeless (Must use city/county/ZIP code of local health department (LHD) or facility of diagnosis.) | | | | | |
| City | | County | State/Country | ZIP code | |
| IV. Facility of Diagnosis (LHDs use approved abbreviations from "Facility List.") | | | | | |
| Facility name | | City | State/Country | | |
| Facility setting (check one) | | Facility type (check one) | | 39 Adult HIV Clinic | |
| <input type="checkbox"/> 1 Public <input type="checkbox"/> 3 Federal <input type="checkbox"/> 2 Private <input type="checkbox"/> 9 Unknown | | <input type="checkbox"/> 01 Physician, HMO <input type="checkbox"/> 29 Community Health Center <input type="checkbox"/> 22 Counseling and Testing Site <input type="checkbox"/> 30 Correctional Facility | | <input type="checkbox"/> 31 Hospital, inpatient <input type="checkbox"/> 88 Other (specify): <input type="checkbox"/> 32 Hospital, outpatient <input type="checkbox"/> 99 Unknown | |

| | | | | | | | | |
|---|-----|----|---------|---|-------|------|---------|------|
| V. Patient Risk History (Check all that apply.) | | | | | | | | |
| • Sex with a male..... | Yes | No | Unknown | • Received clotting factor for hemophilia/coagulation disorder | Yes | No | Unknown | |
| • Sex with a female..... | 1 | 0 | 9 | Specify disorder: | 1 | 0 | 9 | |
| • Injected nonprescription drugs..... | 1 | 0 | 9 | <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) | | | | |
| • HETEROSEXUAL relations with any of the following: | Yes | No | Unknown | <input type="checkbox"/> 8 Other (specify): | | | | |
| • Intravenous/injection drug user..... | 1 | 0 | 9 | • Received transfusion of blood/components (other than clotting factor) | Month | Year | Month | Year |
| • Bisexual male..... | 1 | 0 | 9 | First: Last: | 1 | 0 | 9 | |
| • Person with hemophilia/coagulation disorder..... | 1 | 0 | 9 | • Received transplant of tissue/organs or artificial insemination. | 1 | 0 | 9 | |
| • Transfusion recipient with documented HIV infection..... | 1 | 0 | 9 | • Worked in a health care or clinical laboratory setting..... | 1 | 0 | 9 | |
| • Transplant recipient with documented HIV infection..... | 1 | 0 | 9 | (Specify occupation): | Yes | No | Unknown | |
| • Person with AIDS or documented HIV infection, risk not specified..... | Yes | No | Unknown | • Perinatally-acquired HIV infection regardless of year of birth... | 1 | 0 | 9 | |
| | 1 | 0 | 9 | • Other (specify) | 1 | 0 | 9 | |

| | | | | | | | |
|--|-------|-----|---|--|-----------------------|-----|------|
| VI. Laboratory Data (Indicate first documented test(s).) | | | | | | | |
| A. HIV Antibody Test at Initial HIV/AIDS Diagnosis | | | C. HIV Viral Load Test (Record earliest test.) | | | | |
| • HIV-1 EIA..... | Month | Day | Year | Test type*: Version*: | Month | Day | Year |
| • HIV-1/HIV-2 combination EIA..... | | | | Other (specify type and version): | | | |
| • Rapid HIV-1 EIA..... | | | | Test result (Record in copies/mL and log ₁₀ values.) | | | |
| • HIV-1 Western Blot/IFA..... | | | | <input type="checkbox"/> Detectable | Copies/mL: , , | | |
| • Other HIV antibody test..... | | | | <input type="checkbox"/> Undetectable | Log ₁₀ : , | | |
| (Specify): | | | | Greater than: , , copies/mL | | | |
| | | | | Less than: copies/mL | | | |
| B. Positive HIV Detection Test (Record earliest test.) | Month | Day | Year | * Test type and version: 11 = Nuclisens® HIV-1 QT (Organon-NASBA) 12 = Amplicor HIV-1 Monitor® (Roche-RT-PCR), version: 1.0 or 1.5 13 = Bayer/Chiron (bDNA), version: 2.0 or 3.0 18 = Other (kit name/manufacturer/version) | | | |
| <input type="checkbox"/> Culture <input type="checkbox"/> Antigen <input type="checkbox"/> DNA PCR <input type="checkbox"/> RNA PCR | | | | D. Immunologic Lab Tests - At or closest to current diagnostic status | | | |
| <input type="checkbox"/> Other (specify): | | | | • CD4 count..... | | | |
| Date of last documented negative HIV test..... | Month | Day | Year | • CD4 percent..... | | | |
| Specify type: | | | | First <200 µl or <14% | | | |
| Specify facility type (use codes in Section IV): | | | | • CD4 count..... | | | |
| <input type="checkbox"/> 01 <input type="checkbox"/> 22 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 99 <input type="checkbox"/> 88 (Specify): | | | | • CD4 percent..... | | | |
| If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician?..... | Yes | No | Unknown | | | | |
| | 1 | 0 | 9 | | | | |
| If yes, provide date of documentation by physician..... | Month | Day | Year | | | | |

VII. Provider Information

| | | | | | | | |
|------------------------------------|--|------|-------|-------------------------------------|------------------------|--|-------------------------|
| Physician's name (last, first, MI) | | | | Physician's telephone number () | | Patient's/inmate's medical record number | |
| Address (number, street) | | City | State | ZIP code | Person completing form | | Telephone number () |

VIII. Clinical Status

Clinical record reviewed Yes No Enter date patient was diagnosed as:

 • Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy)..... Month Day Year

• Symptomatic (not AIDS).....

| AIDS INDICATOR DISEASES | Initial Diagnosis | | Initial Date | | AIDS INDICATOR DISEASES | Initial Diagnosis | | Initial Date | |
|--|-------------------|-------|--------------|------|---|-------------------|-------|--------------|------|
| | Def. | Pres. | Month | Year | | Def. | Pres. | Month | Year |
| Candidiasis, bronchi, trachea, or lungs | 1 | NA | | | Lymphoma, Burkitt's (or equivalent term) | 1 | NA | | |
| Candidiasis, esophageal | 1 | 2 | | | Lymphoma, immunoblastic (or equivalent term) | 1 | NA | | |
| Carcinoma, invasive cervical | 1 | NA | | | Lymphoma, primary in brain | 1 | NA | | |
| Coccidioidomycosis, disseminated or extrapulmonary | 1 | NA | | | <i>Mycobacterium avium</i> complex or <i>M.kansasii</i> , disseminated or extrapulmonary | 1 | 2 | | |
| Cryptococcosis, extrapulmonary | 1 | NA | | | <i>M. tuberculosis</i> , pulmonary* | 1 | 2 | | |
| Cryptosporidiosis, chronic intestinal (>1 month duration) | 1 | NA | | | <i>M. tuberculosis</i> , disseminated or extrapulmonary* | 1 | 2 | | |
| Cytomegalovirus disease (other than in liver, spleen, or nodes) | 1 | NA | | | <i>Mycobacterium</i> of other species or unidentified species, disseminated or extrapulmonary | 1 | 2 | | |
| Cytomegalovirus retinitis (with loss of vision) | 1 | 2 | | | <i>Pneumocystis jiroveci</i> pneumonia (PCP) | 1 | 2 | | |
| HIV encephalopathy | 1 | NA | | | Pneumonia, recurrent, in 12-month period | 1 | 2 | | |
| Herpes simplex: chronic ulcer(s) (>1 month duration); or bronchitis, pneumonitis, or esophagitis | 1 | NA | | | Progressive multifocal leukoencephalopathy | 1 | NA | | |
| Histoplasmosis, disseminated or extrapulmonary | 1 | NA | | | Salmonella septicemia, recurrent | 1 | NA | | |
| Isosporiasis, chronic intestinal (>1 month duration) | 1 | NA | | | Toxoplasmosis of brain | 1 | 2 | | |
| Kaposi's sarcoma | 1 | 2 | | | Wasting syndrome due to HIV | 1 | NA | | |

Def. = definitive diagnosis

Pres. = presumptive diagnosis

* RVCT case number: If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?

| | | |
|--------------------------|--------------------------|--------------------------|
| Yes | No | Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

IX. Treatment/Services ReferralsHas the patient been informed of his/her HIV infection?.....

This patient's partner(s) has been or will be notified about their HIV exposure and counseled by:

 Health Department Physician/Provider Patient Unknown

This patient is receiving or has been referred for:

• HIV-related medical services..... • Substance abuse treatment services.....

This patient received or is receiving:

• Antiretroviral therapy..... • PCP prophylaxis.....

This patient has been enrolled at:

| | |
|---|---|
| Clinical Trial | Clinic |
| <input checked="" type="checkbox"/> NIH-sponsored | <input type="checkbox"/> HRSA-sponsored |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other |
| <input type="checkbox"/> None | <input type="checkbox"/> None |
| <input type="checkbox"/> Unknown | <input type="checkbox"/> Unknown |

This patient's medical treatment is primarily reimbursed by:

| | |
|--|--|
| <input checked="" type="checkbox"/> Medicaid | <input type="checkbox"/> Private insurance/HMO |
| <input type="checkbox"/> No coverage | <input type="checkbox"/> Other public funding |
| <input type="checkbox"/> Clinical trial/government program | <input type="checkbox"/> Unknown |

For women: • This patient is receiving or has been referred for gynecological or obstetrical services.....

• This patient is currently pregnant.....

• This patient has delivered live born infant(s).....

(If yes, provide birth information below for the most recent birth.)

| | | |
|--------------------------|--------------------------|--------------------------|
| Yes | No | Unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | |
|---|-------------------|----------------------|---|
| Child's date of birth Month Day Year | Hospital of birth | Child's Soundex | Health Department Use Only Child's state patient number |
| <input type="text"/> | City | <input type="text"/> | <input type="text"/> |
| | State | | |

X. Comments

Patient's home address at time of diagnosis: _____

Assigned to: _____

Reviewed by: _____

First lab test result on or after 4/17/2006:

Any Viral Load: Date: _____ Result: _____ Copies/mL Log; Test Type: _____

Entered by: _____

Positive WB/IFA: Date: _____

MAIL COMPLETED FORM TO: LOS ANGELES COUNTY DEPT OF PUBLIC HEALTH
600 S. COMMONWEALTH AVE, SUITE 1260, LOS ANGELES, CA 90005

Los Angeles County
Phone: (213)744-6160
Fax: (213)749-0926

Confidential Morbidity Report of Tuberculosis Suspects & Cases

Department of
Public Health
Rev: 7/06

Under California law, all TB suspects and cases must be reported within **one** working day

| | | | | | | |
|---------------------|------------------|-----------------------------|-----------------------|--------|----------------|---------------|
| Patient's Last Name | First | Middle | Date of Birth / / | Age | Sex | Patient's SS# |
| Patient's Address | City | State | Zip | County | Phone () - | |
| Occupation | Country of Birth | Date Arrived in U.S. / / | Medical Record Number | | | |

(mark one) **Race:** White Black Asian spec. _____ Pacific Islander spec. _____ Alaska Native American Indian
(mark one) **Ethnicity:** Hispanic Non-Hispanic

| | | |
|--|--|---|
| Previous TB Skin Test: Date: ___/___/___ mm of induration | Chest X-ray date: ___/___/___ <input type="checkbox"/> Normal <input type="checkbox"/> Cavitory <input type="checkbox"/> Non-Cavitory | <input type="checkbox"/> Check here if Reporting a Skin Test Reactor age 3 and under only |
| Current TB Skin Test: Date: ___/___/___ mm of induration | Impression: _____ _____ | |

Complete for TB Suspect/Case Only

Active Disease

Site of Disease

- TB Suspect Pulmonary TB
 TB Case Extra-pulmonary TB Specify Site: _____

| | | | |
|--|----------------------|--------------------------|----------------------|
| Cough and/or Sputum production <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of Onset / / | Date of Diagnosis / / | Date of Death / / |
|--|----------------------|--------------------------|----------------------|

Bacteriology

Not Done

| Date Collected | Specimen Type | Smear AFB | Culture MTB |
|----------------|---------------|-----------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Treatment

Not Started

| Drug | Dose | Start Date |
|-----------|------|------------|
| INH | | |
| Rifampin | | |
| EMB | | |
| PZA | | |
| Rifamate® | | |
| Rifater® | | |
| Other | | |

Lab Name: _____

Phone: () -

Remarks:

For the TB Control Use

- New or Open
DP#: _____
 Close date _____
 Conf. date _____
 TB or PMD
 Faxed date _____
 Faxed date _____
cc: _____

| | | |
|--|-------------------------|-------------------|
| Reporting Health Care Provider | Telephone Number () | Fax Number () |
| Reporting Health Care Facility Address | Submitted By | Date Submitted |

County of Los Angeles ☆ Department of Public Health

Tuberculosis Control Program

2615 S. Grand Ave., Room 507 Los Angeles, CA 90007

WHY DO YOU REPORT?

Because it is required! Reporting of all patients with ***confirmed*** or ***suspect*** Tuberculosis is mandated by State Health and Safety Codes (HSC) Section 121362 and Title 17, Chapter 4, Section 2500 and must be done within ***one working day of diagnosis***. HSC Section 121361 also mandates that prior to discharge, all tuberculosis suspects and cases in hospitals and prisons have an individualized, written discharge plan approved by the Local Health Officer (i.e. TB Controller).

WHO MUST REPORT?

1. All health care providers (including administrators of health care facilities and clinics) in attendance of a patient suspected to have or confirmed with active tuberculosis must report within ***one working day*** from the time of identification.
2. The director of any clinical lab or designee must report laboratory evidence suggestive of tuberculosis to the Health Department on the same day that the physician who submitted the specimen is notified (California Code of Regulations Section 2505).

WHEN DO YOU REPORT?

1. When the following conditions are present:
 - ☆ signs and symptoms of tuberculosis are present, and /or
 - ☆ the patient has an abnormal chest x-ray consistent with tuberculosis, or
 - ☆ the patient is placed on two or more anti-TB drugs
2. When bacteriology smears or cultures are positive for acid fast bacilli (AFB).
3. When the patient has a positive culture for ***M.tuberculosis complex (i.e., M.tuberculosis, M.bovis, M.canettii, M.africanum, M.microti)***
4. When a pathology report is consistent with tuberculosis.
5. When a patient ***age 3 years*** or younger has a positive Tuberculin skin test and normal CXR.

DELAY OR FAILURE TO REPORT:

Delay or failure to report communicable diseases has contributed to serious consequences in the past. Under the ***California Code of Regulations***, Title 16 (section 1364.10), failure to report a communicable disease is a violation of State regulations subject to a citation(s) and monetary fine(s).

The Medical Board of California determined failure to report in a timely manner a citable offense under ***California Business and Professions Code*** (Section 2234), "Unprofessional Conduct."

HOW DO YOU REPORT?

The Confidential Morbidity Report (CMR) form on the other side is to be completed in its entirety and submitted to Tuberculosis Control:

1. ***BY FAX:*** (213) 749-0926
- or
2. ***BY PHONE:*** (213) 744-6160

After hours, leave your name, phone or pager #, patient name, DOB and medical record number on voicemail.



VETERINARY PUBLIC HEALTH-RABIES CONTROL PROGRAM
TEL: (562) 401-7088 FAX: (562) 401-7112
<http://lapublichealth.org/vet>

**MEDICAL AND OTHER ORGANIZATIONS
ANIMAL BITE REPORTING FORM**

PERSON BITTEN

| | | | | |
|---|-------------|--|--|-----------------------|
| Victim name (last and first) | | Date of Birth | Address (number, street, city and zip) | |
| Victim phone number | | Reported by: | | Reporter phone number |
| Date bitten | Time bitten | Address where bitten (if no address make sure to put city) | | Body location bitten |
| How bite occurred (if other, explain) | | | | |
| <input type="checkbox"/> Provoked <input type="checkbox"/> Vicious <input type="checkbox"/> Playful <input type="checkbox"/> Sick <input type="checkbox"/> break up fight <input type="checkbox"/> Unknown <input type="checkbox"/> Other | | | | |
| Date Treated | Treated by | | | Phone number |
| Type of treatment | | | | |

ANIMAL

| | | | | |
|--|--|---|-----------------------|----------|
| Owner Name (last and first) | | Address (number, street city and zip) | | |
| Phone Number | Type of animal <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Other _____ | | Description of animal | |
| Animal Impounded <input type="checkbox"/> YES <input type="checkbox"/> NO | Animal Shelter | | Impound # | |
| Remarks | | | | |
| | | | | |
| | | | | |
| | | | | |
| Report taken by: | | | | |
| Date | Time | Faxed: <input type="checkbox"/> yes <input type="checkbox"/> No | | Initials |

FOODBORNE ILLNESS REPORTING

Food and drink may be the vehicle of many human diseases, so reporting possible foodborne illnesses to the Public Health is an important surveillance tool. Don't wait for tests results to return before you report; if you see 2 or more cases of the same syndrome in persons from separate households but with the same suspected food source, Public Health should be notified immediately by telephone. This is especially important if illness is suspected of coming from a commercial food item or retail establishment. Public Health can investigate quickly and take control measures to prevent exposure of others to contaminated or spoiled food.

Report possible foodborne illness to the disease reporting hotline: 888-397-3993.

DISEASE REPORTING FORMS INDEX

All Los Angeles County Department of Public Health case reporting forms are available by calling the respective programs and through their web sites. The following forms are included in this issue:

Los Angeles County Department of Public Health, Reportable Diseases and Conditions
Morbidity Unit 888-397-393
Acute Communicable Disease Control 213-240-7941
www.lapublichealth.org/acd/reports/acdcmr.pdf

Confidential Morbidity Form
Morbidity Unit 213-240-7821
Acute Communicable Disease Control 213-240-7941
www.lapublichealth.org/acd/reports/acdcmr.pdf

Adult HIV/AIDS Case Report Form (revised 6/06)
For patients over 13 years of age at time of diagnosis.
Pediatric cases see below.
HIV Epidemiology Program 213-351-8516
www.lapublichealth.org/HIV/hivreporting.htm

Sexually Transmitted Disease Confidential Morbidity Report
STD Program 213-744-3070
<http://www.lapublichealth.org/std/index.htm>

Confidential Morbidity Report of Tuberculosis (TB) Suspects
and Cases (revised 7/06)
Tuberculosis Control 213-744-6160
www.lapublichealth.org/tb/forms/cmr.pdf

Animal Bite Report Form
Veterinary Public Health 877-747-2243
www.lapublichealth.org/vet/biteintro.htm

Not included in this issue:

Pediatric HIV/AIDS Case Report Form
(patients less than 13 years of age at time of diagnosis)
Pediatric AIDS Surveillance Program 213-351-7319
** Must first call program before reporting. **
<http://www.lapublichealth.org/hiv/hivreporting/Pediatric%20HIV-AIDS%20Case%20Report%20Form.pdf>

Animal Diseases and Syndrome Report Form (online):
Veterinary Public Health 323-730-3723
www.lapublichealth.org/vet/disintro.htm

Lead Reporting Form
Lead Program 213-869-7195
Call program to obtain reporting information.

Report -A- Problem Link:
www.lapublichealth.org/repprob.htm

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THE PUBLIC'S HEALTH

Newsletter for Medical Professionals in Los Angeles County

313 North Figueroa Street, Room 212
Los Angeles, California 90012