San Mateo County Public Health Reporting Guidelines

San Mateo County Health Department
Public Health Division
225 37th Ave, San Mateo, CA 94403
(650) 573-2346
www.smhealth.org/ph

For the latest revisions, go to http://www.smhealth.org/PHreporting

San Mateo County Health Department

Dear Health Care Provider,

The health of the residents of San Mateo County depends on collaboration between individual practitioners like yourself and the staff of the Health Department. By working together, we can identify disease outbreaks early and prevent their spread, whether it be STD's, meningitis, food-borne illness, or other trends adversely affecting our community's health. Healthcare providers are also on the front line to identify child or elder abuse and other situations that are a threat to the well-being of San Mateo County residents.

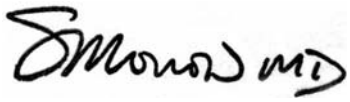
The reporting guidelines and forms in this manual consolidate information on what to report, as well as when, how, and why. Based on your reports of communicable diseases, we identify case contacts and follow up with them to provide post-exposure prophylaxis and medical referrals as necessary. In some cases our staff can help you with patient management, as in providing Directly Observed Therapy to patients with active tuberculosis. We also gather epidemiological data on frequency of various infections and other conditions and report them to the state and the CDC to aid in planning health policies and programs. Most importantly, we use these data to develop health policies locally.

Information on non-communicable conditions such as child and elder abuse, domestic violence, pesticide poisonings, lapses of consciousness, and vaccine reactions is also contained in these guidelines to aid you in reporting and making referrals.

This manual includes some treatment guidelines that are current at the time of publication. In addition, up-to-date information can be found at our website, www.smhealth.org/PHreporting, and also at the state and CDC websites and via your usual consultation networks. If you have any questions or suggestions about these reporting guidelines, please call our Disease Control and Prevention staff at 650-573-2346.

In addition, the Health Department is available to consult with health care providers at 650-573-2346 during the work day, and by calling County Communications at 650-363-4981 to reach the Health Officer on call at all other times.

Sincerely,



Scott Morrow, MD, MPH

Health Officer, San Mateo County

Table of Contents

The health of our community depends on medical providers adhering to reporting regulations. Every report that our Disease Control Unit receives is reviewed, and Communicable Disease Investigators or Public Health Nurses conduct appropriate investigations. Thank you for helping us prevent outbreaks of serious illnesses in our community by reporting promptly and completely.

We will update this manual on a regular basis. Please check **www.smhealth.org/PHreporting** for the latest version of materials included here.

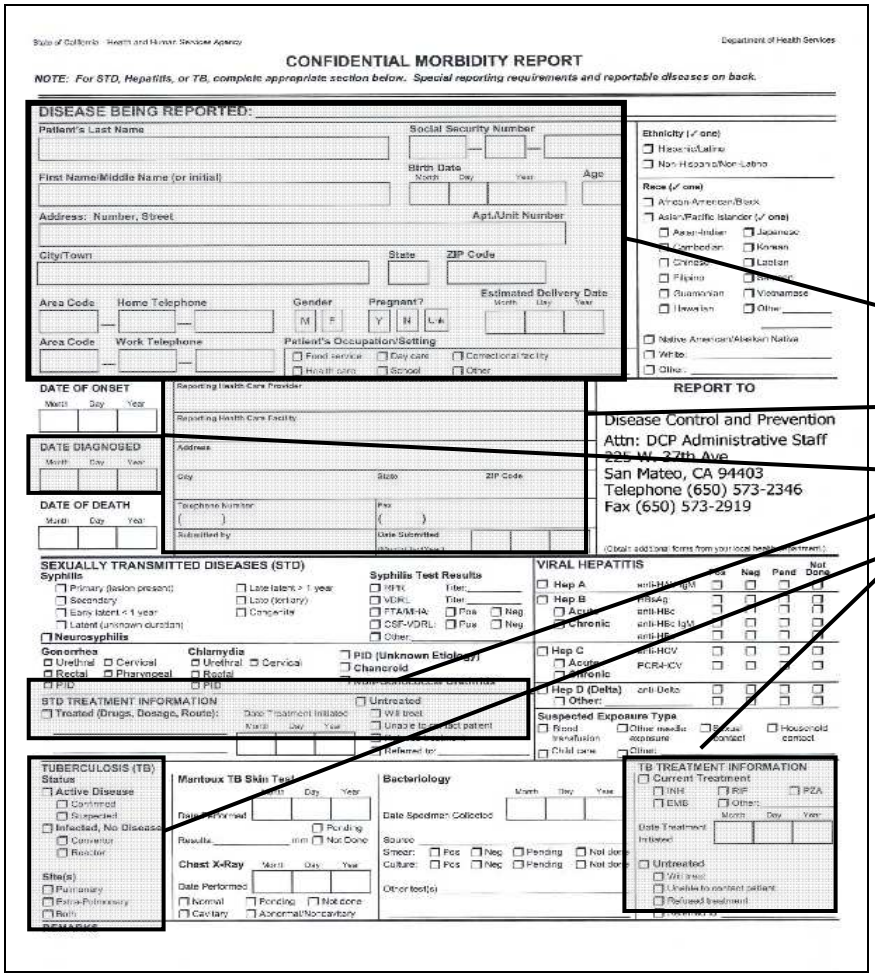
Using the Confidential Morbidity Report (CMR)

All physicians and **health care providers** in San Mateo County are required to report the specified conditions so we can contact the patients as needed to limit spread of the disease, issue appropriate public health alerts and coordinate intervention, and track disease trends. Reporting is not only vital for public health, but it's also mandated by California state law (CCR Title 17, §2500).

Use the standardized CMR (a form developed by California Department of Health Services) to report most diseases and conditions that might affect public health in our county. The thumbnail below is a reduced copy of the first page of the report form (see next page). The diseases that must be reported are listed on the reverse side of the CMR page I.B.1.b., and in a slightly different format on page I.C.

Confidential

As the form's name implies, **data about your patient will be kept confidential**. Data about the disease will be used to guide the public health response and to generate accurate statistics.


CONFIDENTIAL MORBIDITY REPORT

NOTE: For STD, Hepatitis, or TB, complete appropriate section below. Special reporting requirements and reportable diseases on back.

DISEASE BEING REPORTED:

Patient's Last Name | Social Security Number | First Name/Middle Name (or initial) | Birth Date | Age | Address: Number, Street | Apt./Unit Number | City/Town | State | ZIP Code | Area Code Home Telephone | Gender | Pregnant? | Estimated Delivery Date | Area Code Work Telephone | Patient's Occupation/Setting

Ethnicity (✓ one): Hispanic/Latino; Non Hispanic/Non-Latino

Race (✓ one): African-American/Black; Asian/Pacific Islander (✓ one); Native American/Alaskan Native; White; Other

DATE OF ONSET | DATE DIAGNOSED | DATE OF DEATH

Reporting Health Care Provider | Reporting Health Care Facility | Address | City | State | ZIP Code | Telephone Number | Fax | Submitted by | Date Submitted

REPORT TO
Disease Control and Prevention
Attn: DCP Administrative Staff
225 W. 37th Ave
San Mateo, CA 94403
Telephone (650) 573-2346
Fax (650) 573-2919

SEXUALLY TRANSMITTED DISEASES (STD)
Syphilis: Primary (lesion present); Secondary; Early latent < 1 year; Latent (unknown duration); Late latent > 1 year; Late (tertiary); Congenital; Neurosyphilis
Syphilis Test Results: RPR; VDRL; FTA/MHA; CSF-VDRL
Gonorrhea: Urethral; Cervical; Rectal; Pharyngeal; PID
Chlamydia: Urethral; Cervical; Rectal; PID
PID (Unknown Etiology); Chancroid; Other
STD TREATMENT INFORMATION: Treated (Drugs, Dosage, Route); Date Treatment Initiated; Untreated; Will treat; Unable to contact patient; Refused treatment; Referred to:

VIRAL HEPATITIS
Yes | Neg | Pend | Not Done
Hep A: anti-HAV IgM
Hep B: Acute; Chronic: HBsAg, anti-HBc, anti-HBc IgM, anti-HBs
Hep C: Acute; Chronic: anti-HCV, PCR/HCV
Hep D (Delta): anti-Delta; Other:
Suspected Exposure Type: Blood transfusion; Other needle exposure; Sexual contact; Household contact; Child care; Other:

TUBERCULOSIS (TB)
Status: Active Disease: Confirmed, Suspected; Infected, No Disease: Converter, Reactor
Site(s): Pulmonary; Extra-Pulmonary; Both
Mantoux TB Skin Test: Date Performed; Pending; Results: mm; Not Done
Chest X-Ray: Date Performed; Normal; Pending; Not done; Cavitary; Abnormal/Non-cavitary
Bacteriology: Date Specimen Collected; Source; Smear: Pos Neg Pending Not done; Culture: Pos Neg Pending Not done; Other test(s)
TB TREATMENT INFORMATION: Current Treatment: INH; RIF; PZA; EMB; Other; Date Treatment Initiated; Untreated; Will treat; Unable to contact patient; Refused treatment

Be sure to provide complete information

- Sufficient patient ID (name, DOB, & phone) to avoid confusion and to facilitate possible public health contact with patient
- Reporting health care provider (you) and date the CMR is submitted
- Date of Diagnosis = Day specimen collected
- For STDs, treatment information
- For Tuberculosis, status and treatment information

When phoning in an urgent morbidity report to us, you might find it helpful to organize your notes on a scratch CMR before dialing.

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)* | ***Country of Birth***

Occupation or Job Title

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | ***Date of First Specimen Collection*** *(mm/dd/yyyy)* | ***Date of Diagnosis*** *(mm/dd/yyyy)* | ***Date of Death*** *(mm/dd/yyyy)*

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

San Mateo County Health System
Communicable Disease Control
Sexually Transmitted Disease Control
225 37th Avenue
San Mateo, CA 94403
(650) 573-2346 Office
(650) 573-2919 Fax

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners *(check all that apply)*
☐ Male ☐ M to F Transgender
☐ Female ☐ F to M Transgender
☐ Unknown ☐ Other: _____

STD TREATMENT ☐ Treated in office ☐ Given prescription
Drug(s), Dosage, Route | **Treatment Began** *(mm/dd/yyyy)*

☐ ***Untreated***
- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Patient refused treatment
- ☐ Referred to: _____

If reporting Syphilis, Stage:
☐ Primary (lesion present)
☐ Secondary
☐ Early latent < 1 year
☐ Latent (unknown duration)
☐ Late latent > 1 year
☐ Late (tertiary)
☐ Congenital

Neurosyphilis? ☐ Yes ☐ No ☐ Unknown

Syphilis Test Results | **Titer**
- ☐ RPR ☐ Pos ☐ Neg _____
- ☐ VDRL ☐ Pos ☐ Neg _____
- ☐ FTA-ABS ☐ Pos ☐ Neg
- ☐ TP-PA ☐ Pos ☐ Neg
- ☐ EIA/CLIA ☐ Pos ☐ Neg
- ☐ CSF-VDRL ☐ Pos ☐ Neg _____
- ☐ Other: _____

If reporting Chlamydia and/or Gonorrhea:
Specimen Source(s) *(check all that apply)*
☐ Cervical
☐ Pharyngeal
☐ Rectal
☐ Urethral
☐ Urine
☐ Vaginal
☐ Other: _____

Symptoms?
☐ Yes
☐ No
☐ Unknown

If reporting Pelvic Inflammatory Disease: *(check all that apply)*
☐ Gonococcal PID
☐ Chlamydial PID
☐ Other/Unknown Etiology PID

Partner(s) Treated?
☐ Yes, treated in this clinic
☐ Yes, Meds/Prescription given to patient for their partner(s)
☐ Yes, other: _____
☐ No, instructed patient to refer partner(s) for treatment
☐ No, referred partner(s) to: _____
☐ Unknown

VIRAL HEPATITIS

Diagnosis (check all that apply)
☐ Hepatitis A
☐ Hepatitis B (acute)
☐ Hepatitis B (chronic)
☐ Hepatitis B (perinatal)
☐ Hepatitis C (acute)
☐ Hepatitis C (chronic)
☐ Hepatitis D
☐ Hepatitis E

Is patient symptomatic? ☐ Yes ☐ No ☐ Unknown

Suspected Exposure Type(s)
☐ Blood transfusion, dental or medical procedure
☐ IV drug use
☐ Other needle exposure
☐ Sexual contact
☐ Household contact
☐ Perinatal
☐ Child care
☐ Other: _____

ALT (SGPT) Result: _____ Upper Limit: _____
AST (SGOT) Result: _____ Upper Limit: _____
Bilirubin result: _____

		Pos	Neg
Hep A	anti-HAV IgM	☐	☐
Hep B	HBsAg	☐	☐
	anti-HBc total	☐	☐
	anti-HBc IgM	☐	☐
	anti-HBs	☐	☐
	HBeAg	☐	☐
	anti-HBe	☐	☐
	HBV DNA: _____		

		Pos	Neg
Hep C	anti-HCV	☐	☐
	RIBA	☐	☐
	HCV RNA (e.g., PCR)	☐	☐
Hep D	anti-HDV	☐	☐
Hep E	anti-HEV	☐	☐

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care 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 to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax
✆ ! Avian Influenza (human)
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound)
✆ ! Brucellosis
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (only hospitalizations and deaths)
Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
FAX ✆ ✉ Colorado Tick Fever
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cysticercosis or Taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae* invasive disease (report an incident less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
Hepatitis, Viral
FAX ✆ ✉ Hepatitis A
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta)
Hepatitis, other, acute
Influenza deaths (report an incident of less than 18 years of age)
Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
FAX ✆ ✉ Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, Human or Animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, Human or Animal
FAX ✆ ✉ Relapsing Fever
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
✆ ! Tularemia
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
Typhus Fever
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)
FAX ✆ ✉ West Nile Virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! **OCCURRENCE of ANY UNUSUAL DISEASE**
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) § 2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Heatlh and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting Tuberculosis.

DISEASE BEING REPORTED → Tuberculosis

Patient Name - Last Name	***First Name***	***MI***
Home Address: Number, Street		***Apt./Unit No.***
City	***State***	***ZIP Code***
Home Telephone Number	***Cell Telephone Number***	***Work Telephone Number***
Email Address	***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____	
Birth Date *(mm/dd/yyyy)*	***Age*** ☐ Years ☐ Months ☐ Days	***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____
Pregnant? ☐ Yes ☐ No ☐ Unknown	***Est. Delivery Date*** *(mm/dd/yyyy)*	***Country of Birth***
Occupation or Job Title	***Occupational or Exposure Setting (check all that apply):*** ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____	

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Date of Onset *(mm/dd/yyyy)*	***Date of First Specimen Collection*** *(mm/dd/yyyy)*	***Date of Diagnosis*** *(mm/dd/yyyy)*	***Date of Death*** *(mm/dd/yyyy)*

Reporting Health Care Provider	***Reporting Health Care Facility***		
Address: Number, Street		***Suite/Unit No.***	
City	***State***	***ZIP Code***	
Telephone Number	***Fax Number***		
Submitted by	***Date Submitted*** *(mm/dd/yyyy)*		

REPORT TO:

San Mateo County Health System
Tuberculosis Control
225 37th Avenue
San Mateo, CA 94403
(650) 573-2346 Office
(650) 573-2919 Fax

(Obtain additional forms from your local health department.)

Laboratory Name	***City***	***State***	***ZIP Code***

TUBERCULOSIS (TB)

Status
☐ Active Disease
- ☐ Confirmed
- ☐ Suspected

☐ Infected, No Disease
- ☐ Converter*

* For TST, an increase of ≥10 mm in induration size during ≤2 years.

Sites(s)
☐ Pulmonary
☐ Extra-Pulmonary
☐ Both

Mantoux TB Skin Test

_____ Date Placed *(mm/dd/yyyy)*
_____ Date Read *(mm/dd/yyyy)*

Results: _____ mm ☐ Not done ☐ Pending ☐ Not read

Interferon Gamma Release Assay (IGRA)

Date Collected: _____ *(mm/dd/yyyy)*

Specify test name: _____

Results: ☐ Positive ☐ Not done ☐ Indeterminate ☐ Unknown ☐ Negative

Imaging: ☐ *Chest X-Ray* ☐ *Chest CT Scan or Other Chest Imaging Study*

Date Performed: _____ *(mm/dd/yyyy)*

Results: ☐ Normal ☐ Pending ☐ Cavitary ☐ Abnormal/Noncavitary ☐ Not done

Bacteriology/Pathology

Please mark positive on smear or culture if any of initial specimens obtained was positive

Date Specimen Collected: _____ *(mm/dd/yyyy)*

Source: _____

Smear for acid-fast bacilli: ☐ Pos ☐ Neg ☐ Pending ☐ Not done

Culture for *M. tuberculosis* complex: ☐ Pos ☐ Neg ☐ Pending ☐ Not done

Pathology suggests TB ☐

Rapid Drug Resistance Assay
☐ INH resistance ☐ Not done
☐ RIF resistance
☐ No INH or RIF resistance detected

Nucleic Acid Amplification/PCR Test for M. tuberculosis complex

Specify test type: _____

Results: ☐ Pos ☐ Indeterminate ☐ Neg ☐ Not done

Other test(s): _____

TB TREATMENT INFORMATION

☐ **Current Treatment** *(check all that apply)*
- ☐ INH ☐ RIF ☐ PZA
- ☐ EMB
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Date Treatment Initiated: _____ *(mm/dd/yyyy)*

☐ ***Drug resistance suspected***

☐ ***Untreated***
- ☐ Will treat
- ☐ Unable to contact patient
- ☐ Patient refused treatment
- ☐ Other: _____
- ☐ Referred to: _____

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care 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 to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax
✆ ! Avian Influenza (human)
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound)
✆ ! Brucellosis
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (only hospitalizations and deaths)
Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
FAX ✆ ✉ Colorado Tick Fever
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cysticercosis or Taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae* invasive disease (report an incident less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
Hepatitis, Viral
FAX ✆ ✉ Hepatitis A
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta)
Hepatitis, other, acute
Influenza deaths (report an incident of less than 18 years of age)
Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
FAX ✆ ✉ Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, Human or Animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, Human or Animal
FAX ✆ ✉ Relapsing Fever
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
✆ ! Tularemia
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
Typhus Fever
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)
FAX ✆ ✉ West Nile Virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! **OCCURRENCE of ANY UNUSUAL DISEASE**
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) § 2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Heatlh and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting lapses of consciousness or control, Alzheimer's disease or other conditions which may impair the ability to operate a motor vehicle safely (pursuant to H&S 103900).

CONDITION BEING REPORTED

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** | ☐ Years ☐ Months ☐ Days | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown | ***Est. Delivery Date*** *(mm/dd/yyyy)* | ***Country of Birth***

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
- ☐ Asian Indian ☐ Hmong ☐ Thai
- ☐ Cambodian ☐ Japanese ☐ Vietnamese
- ☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
- ☐ Filipino ☐ Laotian

☐ Pacific Islander *(check all that apply)*
- ☐ Native Hawaiian ☐ Samoan
- ☐ Guamanian ☐ Other *(specify)*: _____

☐ White
☐ Other *(specify)*: _____
☐ Unknown

Occupation or Job Title

Occupational or Exposure Setting (check all that apply): ☐ Food Service ☐ Day Care ☐ Health Care ☐ Correctional Facility ☐ School ☐ Other *(specify)*: _____

Date of Onset *(mm/dd/yyyy)* | ***Date of First Specimen Collection*** *(mm/dd/yyyy)* | ***Date of Diagnosis*** *(mm/dd/yyyy)*

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Submitted by | ***Date Submitted*** *(mm/dd/yyyy)*

REPORT TO:

San Mateo County Health System
Reportable Conditions Administration
225 37th Avenue
San Mateo, CA 94403
(650) 573-2346 Office
(650) 573-2919 Fax

(Obtain additional forms from your local health department.)

DEPARTMENT OF MOTOR VEHICLES (DMV)

California Driver License or Identification Card Number (eight characters): ☐☐☐☐☐☐☐☐

1. If this report is based upon episodic lapses of consciousness, when was the most recent episode?: _____ *(mm/dd/yyyy)*
2. If there have been multiple episodes of loss of consciousness or control within the past three years, please indicate the dates if they are known to you.

   (a): _____ *(mm/dd/yyyy)* (b): _____ *(mm/dd/yyyy)* (c): _____ *(mm/dd/yyyy)* (d): _____ *(mm/dd/yyyy)* (e): _____ *(mm/dd/yyyy)* (f): _____ *(mm/dd/yyyy)*
3. Within the past 12 months, has there been an episode of loss of consciousness or control while driving? ☐ Yes ☐ No ☐ Uncertain
4. Are additional lapses of consciousness likely to occur? ☐ Yes ☐ No ☐ Uncertain
5. If the patient has had episodes of nocturnal seizures, is there likelihood of lapses of consciousness occurring while he/she is awake? ☐ Yes ☐ No ☐ Uncertain
6. Has this patient been diagnosed with dementia or Alzheimer's disease? ☐ Yes ☐ No ☐ Uncertain
7. Would you currently advise this patient not to drive because of his/her medical condition? ☐ Yes ☐ No ☐ Uncertain
8. Does this patient's condition represent a permanent driving disability? ☐ Yes ☐ No ☐ Uncertain
9. Would you recommend a driving evaluation by DMV? ☐ Yes ☐ No ☐ Uncertain

Remarks:

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 Reportable Diseases and Conditions*

§ 2500. REPORTING TO THE LOCAL HEALTH AUTHORITY.

- **§ 2500(b)** It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the juridiction where the patient resides. Where no health care 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 to the local health officer for the jurisdiction where the patient resides.
- **§ 2500(c)** The administrator of each health facility, clinic, or other setting where more than one health care provider may know of a case, a suspected case or an outbreak of disease within the facility shall establish and be responsible for administrative procedures to assure that reports are made to the local officer.
- **§ 2500(a)(14)** "Health care provider" means a physician and surgeon, a veterinarian, a podiatrist, a nurse practitioner, a physician assistant, a registered nurse, a nurse midwife, a school nurse, an infection control practitioner, a medical examiner, a coroner, or a dentist.

URGENCY REPORTING REQUIREMENTS [17 CCR §2500(h)(i)]

✆ ! = Report immediately by telephone (designated by a♦ in regulations).
† = Report immediately by telephone when two or more cases or suspected cases of foodborne disease from separate households are suspected to have the same source of illness (designated by a ● in regulations.)
FAX ✆ ✉ = Report by electronic transmission (including FAX), telephone, or mail within one working day of identification (designated by a + in regulations).
= All other diseases/conditions should be reported by electronic transmission (including FAX), telephone, or mail within seven calendar days of identification.

REPORTABLE COMMUNICABLE DISEASES §2500(j)(1)

Acquired Immune Deficiency Syndrome (AIDS)
(HIV infection only: see "Human Immunodeficiency Virus")
FAX ✆ ✉ Amebiasis
Anaplasmosis/Ehrlichiosis
✆ ! Anthrax
✆ ! Avian Influenza (human)
FAX ✆ ✉ Babesiosis
✆ ! Botulism (Infant, Foodborne, Wound)
✆ ! Brucellosis
FAX ✆ ✉ Campylobacteriosis
Chancroid
FAX ✆ ✉ Chickenpox (only hospitalizations and deaths)
Chlamydia trachomatis infections, including Lymphogranuloma Venereum (LGV)
✆ ! Cholera
✆ ! Ciguatera Fish Poisoning
Coccidioidomycosis
FAX ✆ ✉ Colorado Tick Fever
Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
FAX ✆ ✉ Cryptosporidiosis
Cysticercosis or Taeniasis
✆ ! Dengue
✆ ! Diphtheria
✆ ! Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
FAX ✆ ✉ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
† FAX ✆ ✉ Foodborne Disease
Giardiasis
Gonococcal Infections
FAX ✆ ✉ *Haemophilus influenzae* invasive disease (report an incident less than 15 years of age)
✆ ! Hantavirus Infections
✆ ! Hemolytic Uremic Syndrome
Hepatitis, Viral
FAX ✆ ✉ Hepatitis A
Hepatitis B (specify acute case or chronic)
Hepatitis C (specify acute case or chronic)
Hepatitis D (Delta)
Hepatitis, other, acute
Influenza deaths (report an incident of less than 18 years of age)
Kawasaki Syndrome (Mucocutaneous Lymph Node Syndrome)
Legionellosis
Leprosy (Hansen Disease)
Leptospirosis
FAX ✆ ✉ Listeriosis
Lyme Disease
FAX ✆ ✉ Malaria
FAX ✆ ✉ Measles (Rubeola)
FAX ✆ ✉ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
✆ ! Meningococcal Infections
Mumps
✆ ! Paralytic Shellfish Poisoning
Pelvic Inflammatory Disease (PID)
FAX ✆ ✉ Pertussis (Whooping Cough)
✆ ! Plague, Human or Animal
FAX ✆ ✉ Poliovirus Infection
FAX ✆ ✉ Psittacosis
FAX ✆ ✉ Q Fever
✆ ! Rabies, Human or Animal
FAX ✆ ✉ Relapsing Fever
Rheumatic Fever, Acute
Rocky Mountain Spotted Fever
Rubella (German Measles)
Rubella Syndrome, Congenital
FAX ✆ ✉ Salmonellosis (Other than Typhoid Fever)
✆ ! Scombroid Fish Poisoning
✆ ! Severe Acute Respiratory Syndrome (SARS)
✆ ! Shiga toxin (detected in feces)
FAX ✆ ✉ Shigellosis
✆ ! Smallpox (Variola)
FAX ✆ ✉ *Staphylococcus aureus* infection (only a case resulting in death or admission to an intensive care unit of a person who has not been hospitalized or had surgery, dialysis, or residency in a long-term care facility in the past year, and did not have an indwelling catheter or percutaneous medical device at the time of culture)
FAX ✆ ✉ Streptococcal Infections (Outbreaks of Any Type and Individual Cases in Food Handlers and Dairy Workers Only)
FAX ✆ ✉ Syphilis
Tetanus
Toxic Shock Syndrome
FAX ✆ ✉ Trichinosis
FAX ✆ ✉ Tuberculosis
✆ ! Tularemia
FAX ✆ ✉ Typhoid Fever, Cases and Carriers
Typhus Fever
FAX ✆ ✉ *Vibrio* Infections
✆ ! Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
FAX ✆ ✉ Water-Associated Disease (e.g., Swimmer's Itch or Hot Tub Rash)
FAX ✆ ✉ West Nile Virus (WNV) Infection
✆ ! Yellow Fever
FAX ✆ ✉ Yersiniosis
✆ ! **OCCURRENCE of ANY UNUSUAL DISEASE**
✆ ! OUTBREAKS of ANY DISEASE (Including diseases not listed in § 2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS § 2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, § 2641.5-2643.20 and http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)
Pesticide-related illness or injury (known or suspected cases)**
Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) § 2593)***

LOCALLY REPORTABLE DISEASES (If Applicable):

* This form is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Heatlh and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).
*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrcal.org

San Mateo County Health Department
Public Health Reporting Guidelines

Reportable Diseases and Conditions

Title 17, California Code of Regulations: Every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases listed below, must report to the local health officer for the jurisdiction where the patient resides. This list includes the same conditions as the CMR in a slightly different format.

URGENCY REPORTING REQUIREMENTS	**REPORT TO:**
☎ = Report immediately by telephone & discuss with health officer. ❶ = Report within one working day of identification, by FAX, telephone, or mail. ⑦ = Report within 7 calendar days by FAX, phone or mail.	Disease Control & Prevention 225 37th Ave, San Mateo, CA 94403 M-F 8am-5pm: (650) 573-2346 After Hours: (650) 363-4981 Fax: (650) 573-2919

COMMUNICABLE DISEASES

- ⑦ AIDS
- ❶ Amebiasis
- ❶ Animal Bites *
- ❶ Anisakiasis
- ☎ Anthrax **
- ❶ Babesiosis
- ☎ Botulism (Infant, Foodborne, Wound) **
- ☎ Brucellosis
- ⑦ Campylobacteriosis
- ⑦ Chancroid
- ⑦ Chlamydial Infections
- ☎ Cholera
- ☎ Cinguatera Fish Poisoning
- ⑦ Coccidioidomycosis
- ❶ Colorado Tick Fever
- ❶ Conjunctivitis of the newborn, specify etiology
- ❶ Cryptosporidiosis
- ❶ Cysticercosis
- ☎ Dengue
- ☎ Diarrhea of the Newborn, Outbreaks
- ☎ Diphtheria
- ☎ Domoic Acid (Amnesic Shellfish) poisoning
- ⑦ Echinococcosis (Hydatid Disease)
- ⑦ Ehrlichiosis
- ❶ Encephalitis, Infectious (specficy etiology)
- ☎ Escherichia coli O157:H7 Infection
- ⑦ Foodborne illness (2 or more cases from different households)
- ⑦ Giardiasis
- ⑦ Gonococcal Infections
- ❶ Haemophilus Influenzae, Invasive Disease
- ☎ Hantavirus infections
- ☎ Hemolytic Uremic Syndrome
- ⑦ Hepatitis, Viral
- ❶ Hepatitis A
- ⑦ Hepatitis B (specify acute case or chronic)
- ⑦ Hepatitis C (specify acute case or chronic)
- ⑦ Hepatitis D (Delta)
- ⑦ Hepatitis, other acute
- ⑦ HIV
- ⑦ Kawasaki Syndrome
- ⑦ Legionellosis
- ⑦ Leprosy (Hansen Disease)
- ⑦ Leptospirosis
- ❶ Listeriosis
- ⑦ Lyme Disease
- ❶ Lymphocytic Choriomeningitis
- ❶ Malaria
- ❶ Measles (Rubeola)
- ❶ Meningitis (specify etiology)
- ☎ Meningococcal Infections
- ⑦ Methicillin-Resistant Staph Aureus-MRSA†
- ⑦ Mumps
- ⑦ Non-Gonococcal Urethritis
- ☎ Paralytic Shellfish Poisoning
- ⑦ Pelvic Inflammatory Disease (PID)
- ⑦ Penicillin-resistant pneumococcus (PRP) †
- ❶ Pertussis (Whooping Cough)
- ☎ Plague (Human or Animal) **
- ❶ Poliomyelitis
- ❶ Psittacosis
- ❶ Q Fever
- ☎ Rabies (Human or Animal)
- ❶ Relapsing Fever
- ⑦ Reye Syndrome
- ⑦ Rheumatic Fever, Acute
- ⑦ Rocky Mountain Spotted Fever
- ⑦ Rubella (German Measles)
- ⑦ Rubella Syndrome, Congenital
- ❶ Salmonellosis (other than Typhoid)
- ☎ Scombroid Fish Poisoning
- ☎ Severe Acute Respiratory Syndrome-SARS
- ❶ Shigellosis
- ☎ Smallpox (Variola) **
- ❶ Streptococcal Infections, outbreaks of any type and individual cases in food handlers and dairy workers only
- ❶ Swimmer's itch (Schistosomal Dermatitis)
- ❶ Syphilis
- ⑦ Tetanus
- ⑦ Toxic Shock Syndrome
- ⑦ Toxoplasmosis
- ❶ Trichinosis
- ❶ Tuberculosis
- ☎ Tularemia **
- ❶ Typhoid Fever (cases and carriers)
- ⑦ Typhus fever
- ⑦ Vancomycin-resistant Enterococcus-VRE †
- ☎ Varicella (deaths only)
- ❶ Vibrio infections
- ☎ Viral Hemorrhagic Fevers (e.g. Crimean- Congo, Ebola, Lassa & Marburg viruses) **
- ❶ Water-associated Diseases
- ❶ West Nile Virus (WNV) Infection
- ☎ Yellow Fever
- ⑦ Yersiniosis

- ☎ Any Unusual Diseases
- ☎ New Diseases or Syndrome not previously recognized
- ☎ Outbreaks of any disease

NON-COMMUNICABLE CONDITIONS

- ⑦ Alzheimer's Disease & related conditions
- ⑦ Cancer (Except basal & squamous skin cancer unless occurring on genitalia; carcinoma in-situ & CIN III of the cervix)
- ⑦ Disorders characterized by lapses of consciousness
- ⑦ Domestic Violence or assaultive behavior (Telephone report must be made to local law enforcement as soon as possible) *
- ⑦ Pesticide-related illness or injury

* Use specific form(s)
** Potential Bioterrorism Agents, Class A
† Locally reportable

Laboratory Reporting Responsibilities

All medical laboratories in San Mateo County must report test results of public health significance to the Health Department so we can issue appropriate public health alerts and coordinate intervention. This is required by California state law (CCR Title 17, §2505). **Providers are responsible for making reports even if they believe a lab has already reported an infection.** The list below describes the role of laboratories.

What to report

The laboratory is required to report the following information:

- Date specimen was obtained and source (blood, sputum, etc.)
- Specimen accession or unique ID #
- Lab findings for tests performed and date of result
- Patient ID number
- Patient info (name, gender, DOB, address, phone)
- Health care provider who ordered test (name, address, phone)

Special reporting for E. coli O157:H7 , Shigella, & Salmonella

The Public Health Lab will need to examine the culture that confirmed the infection.

Special reporting for Malaria

The Public Health Lab will examine the blood film slides to confirm. If you ask upfront, we'll return the slides to you.

Special reporting for Tuberculosis

Please see special requirements for TB specimens on page II.A.7.

Phone or fax within 1 working day

(650) 573-2346

(650) 573-2919 fax

If results indicate:

Chlamydial infections

Cryptosporidiosis

Diphtheria

Encephalitis (arboviral)

Escherichia coli 0157:H7 infection

Gonorrhea

Hepatitis A -
acute infection by HAV IgM antibody test or positive antigen test

Hepatitis B -
acute infection by IgM anti-HBc antibody test or positive antigen test

Listeriosis

Malaria

Measles (Rubeola) -
acute infection by IgM antibody test or positive viral antigen test

Rabies (animal or human)

Salmonella

Shigella

Syphilis

Tuberculosis

Typhoid

Vibrio infections

Phone Disease Control and Prevention immediately!

(650) 573-2346 workdays

(650) 363-4981 for after hours emergencies

If results indicate:

Anthrax

Botulism

Brucellosis

Plague (animal or human)

SARS (Severe Acute Respiratory Syndrome)

Smallpox

Tularemia

Viral Hemorrhagic Fever (Ebola, Crimean-Congo, Lassa, or Marburg viruses)

Medical labs are in the position to sound an early-warning alarm for a number of infectious diseases.

Public Health Reporting & Privacy

Reporting obligations for communicable diseases have not changed under the new Health Insurance Portability & Accountability Act (HIPAA).

Health care providers continue to have a legal obligation to provide information for public health investigations and interventions.

The only material change is that you'll now need to document such disclosures in your patients' files.

Documenting disclosures under HIPAA

Health care providers do have one new patient privacy responsibility described in 45 CFR §164.528. You must now account for the disclosures of protected health information provided to local and state public health departments.

Compliance is relatively easy: Place either an accounting of disclosures form in the patient's chart, or maintain an accounting of disclosures log, documenting the following:

- date of disclosure
- name and address of person or entity to which disclosed
- brief description of health information disclosed
- brief description of purpose of the disclosure.

Public Health disclosures allowed

HIPAA's Privacy Rule explicitly permits disclosures to public health authorities for public health purposes:

"A covered entity may disclose protected health information … for the purpose of preventing or controlling disease, injury or disability, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions ...."
45 CFR §164.512(b)(1)

So when the health department calls for more information on a CMR, please cooperate!

The law allows sharing of clinical, laboratory, and other information to assist public health investigations. It also provides penalties for refusal to report vital public health information.

We promise to maintain your patients' privacy

San Mateo County Health Department will treat patient information that you report to us as confidential. We may use it to make patient contact, enforce quarantines, enroll patients in programs, plot location of diseases, compile statistics, or comply with legal process.

Only health department personnel with a need to know will have access to identifiable patient information. When statistics are compiled, identifiable patient data will be removed. When we no longer need files, we will destroy them.

Questions?

If you have questions about patient privacy in the context of public health, contact San Mateo County Health Department at (650) 573-2346 or California Department of Health Services at (916) 552-9820.

The CDC has developed a guidance paper about privacy and public health: **www.cdc.gov/privacyrule/Guidance/Content.htm**

Tuberculosis

Symptoms

Consider a diagnosis of **tuberculosis** in patients with any of the following symptoms, especially if other causes have been ruled out:

- Cough lasting over 3 weeks
- Hemoptysis
- Night sweats
- Unexplained fatigue or weight loss
- Persistent fever or weakness

TB infection of other parts of the body

Also, consider extrapulmonary TB, especially in HIV infected individuals, if there are symptoms which cannot be ascribed to other causes.

Pneumonia and TB

If cultures from a patient with pneumonia fail to show an organism and the patient does not respond to conventional antibiotics, consider obtaining a specimen for smear and culture for acid-fast bacilli to rule out TB or other *mycobacteria*.

Populations with increased rates of TB infection:

- Contacts of infectious TB cases
- Foreign-born visitors or migrants from Mexico, Central or South America, Africa, Eastern Europe, Asia, the Pacific Islands, or the Middle East
- Homeless and medically underserved persons
- Residents of long-term care facilities (prisons or nursing homes)
- Healthcare workers

Any person diagnosed with tuberculosis should be tested for HIV.

Conditions associated with increased risk of progression to active TB

- Immunosuppression HIV, organ transplant, immunosuppresive medications including infliximab (Remicade) and prolonged corticosteroid therapy (≥ 15 mg/ day for ≥ 1 month)
- Infants and children <5 yrs of age
- Recent contact to an infectious active TB case
- Recent tuberculin skin test conversion (an increase of 10 mm of induration within a 2 year period)
- Head and neck cancer
- Intravenous drug use
- Diabetes
- Malnutrition
- Renal failure
- Silicosis
- Alcholism
- Gastrectomy, jejunoileal bypass

Persons with these conditions should have TB considered in their differential diagnoses, and a thorough history taken. The history should include specific questions about any exposure to active TB, travel to endemic countries, history of homelessness or incarceration, or history of a positive skin test or abnormal x-ray.

County TB services

San Mateo County Health Department provides consultation, case management, and clinical services for patients with active TB disease and some low-income uninsured patients with latent TB infection.

A **public health nurse** is assigned to every active TB case to promote patient compliance and to initiate a contact investigation. In addition, educational materials about TB, and TB screening and diagnosis are available for providers and patients through the County TB Coordinator, who can be reached at 573-2346.

Active TB: Report by phone or fax within 1 working day

(650) 573-2346
(650) 573-2919 fax

Do not wait for lab results to confirm the diagnosis prior to reporting.

For faxed reports, use the *Confidential Morbidity Report* included with this binder. Please fill out the TB section at the bottom as completely as possible.

Do not wait for lab results to confirm diagnosis of active TB prior to reporting.

Latent TB Infections: Report by fax or mail within 1 week

(650) 573-2919 fax
Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

Which LTBI patients need to be reported?
Report only recent converters (patients with tuberculin skin test indurations increasing 10 mm or more in 2 years) and all children up to 5 years of age. Report after chest x-ray results are known on the *Confidential Morbidity Report (CMR)*.

What about patients from one county who see healthcare providers in another county?

The Health Departments in both counties need to receive reports.

TB Screening: A Decision to Test is a Decision to Treat

Tuberculin skin test (TST)

Tuberculosis screening of the general population is no longer recommended. Screening should be targeted to populations with increased rates of TB infection (*see previous page*); persons with an increased risk of progression to active TB if infected; and those likely to be exposed or to expose others, such as health care workers and volunteers.

Mantoux Test

The Mantoux test (0.1 cc PPD injected intradermally in the inner forearm) is the only recommended method of skin testing for TB. Multiple-puncture "tine" tests are unreliable and should not be used.

The test should be read by a trained professional 48-72 hours after injection. The edge of the induration (palpable swelling, not redness) is marked with a ballpoint pen and the diameter is measured in millimeters.

Interpreting TST Reactions

Size of Induration	Clinical Circumstances
Positive if ≥ 5 mm	• HIV infected person • Close contacts to active disease • Abnormal Chest X-ray consistent with prior TB • Immunosuppressed patients
Positive if ≥ 10 mm	Everyone else, with special focus on: • Persons with certain medical conditions • IV drug users • Homeless people • Foreign born people from TB-endemic countries • Infants and children < 5 years of age • Residents & staff of long-term care facilities • Healthcare workers

Skin test limitations

The tuberculosis skin test is neither 100% sensitive nor 100% specific. Vaccination within the last year or multiple vaccinations with BCG (*Bacillus Calmette Guerin)* can cause a false positive, as can infection with non-TB *mycobacteria*. **Generally a history of BCG vaccination is ignored in skin test interpretation if the BCG was given over one year ago.**

Quantiferon test

This screening tool for latent TB was recently approved by the FDA. It is a blood test that also differentiates TB from BCG and Mycobacterium avium. The San Mateo County Public Health Laboratory will have the capability to perform Quantiferon testing. Further information will be provided as it becomes available.

A negative TB skin test or a negative quantiferon test does not rule out active TB. The clinical picture and patient history should always be taken into account.

Up to 25% of persons with active pulmonary TB will be skin test negative. Furthermore, it can take up to 10 weeks for a positive reaction to develop in a newly infected person.

Chest X-ray

If the TST is positive or a patient has symptoms compatible with TB, a chest x-ray is indicated.

A pregnant patient with a positive TST should be questioned about symptoms at least each trimester, and if any are present she should have a chest x-ray with abdominal shielding immediately. If she has no symptoms, the chest x-ray may be postponed until the second trimester.

See next page for further management.

Tuberculosis screening of the general population is no longer recommended. Screening should be targeted to populations with increased rates of TB infection or persons with increased risk of progression to active TB if infected.

Managing Patients with Positive Tuberculin Skin Tests

If the chest x-ray shows No Active Disease:

If the chest x-ray is not suggestive of active TB, the patient may be a candidate for latent TB treatment (this was previously called "prophylaxis").

The current recommendation for LTBI treatment is **Isoniazid** for 9 months in most situations. Specific information is on the next page.

Pregnancy is not a contraindication for LTBI treatment. However, treatment may be delayed until after delivery if adequate follow-up is reasonably expected. The patient should be questioned regularly during pregnancy about symptoms of active disease.

TB medications may be used safely during breastfeeding and LTBI treatment should be started postpartum. Levels secreted into breast milk are not significant and unlikely to lead to toxicity in the infant.

Some low-income uninsured patients are eligible for treatment for LTBI through the San Mateo County Clinics – please call if you have questions about a specific patient.

If the chest x-ray suggests Prior TB:

Three sputum samples should be obtained for smear and culture. Treatment for LTBI should not be initiated until final culture results are available. If the patient has symptoms suggesting TB disease, consult with Disease Control and Prevention (650-573-2346) or your infectious disease specialist to determine if a 4-drug regimen should be started.

In order to avoid development of drug-resistant strains, it is important not to treat with INH alone before active TB has been ruled out.

Which patients with positive TSTs but negative CXRs need to be reported?
Send reports of TST converters or any positive TST in a child up to age 5 by fax or mail within one working day of receiving X-ray report.

Latent TB Infection (LTBI) Treatment

Preventative therapy is especially indicated for LTBI patients who are at increased risk for progression to active disease because of the following conditions:

- Immunosuppression (HIV, organ transplant, immunosuppressive medications)
- Chest X-ray with parenchymal abnormalities consistent with prior TB (not just isolated calcified granulomas or apical thickening)
- Infants and children <5 years of age
- Persons from countries with high TB rates
- Recent contact to an infectious active TB case
- Recent tuberculin skin test conversion (and increase of 10 mm of induration within a 2 year period)
- Head and neck cancer
- Intravenous drug use
- Diabetes
- Malnutrition
- Renal failure
- Silicosis
- Alcholism
- Gastrectomy, jejunoileal bypass


To prevent possible infection of medical staff or other patients, do not send a patient with suspected or known active TB patient directly to the Health Department or any medical facility without prior notification. Phone first so that arrangements can be made for an appropriate reception. The patient should wear a surgical mask when going to any medical or laboratory appointments.

If the chest x-ray shows Active TB:

If the chest x-ray suggests active disease, the patient should be isolated and should provide three sputum specimens. Four-drug therapy should be initiated. Isolation should be continued until three consecutive sputum smears collected on different days are negative for acid fast bacilli. Please contact Disease Control and Prevention if you have questions about appropriate treatment regimens.

All cases of suspected active TB should be reported by fax or phone within 1 working day.

(650) 573-2346

(650) 573-2919 fax

Disease Control and Prevention

San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

Patients with active tuberculosis may not be discharged from a hospital without clearance from the Health Department. Outpatients with suspected active TB should also be discussed immediately with the Health Department. Call 650-573-2346 to discuss the case; on weekends or after hours, contact the health officer on call at 650-363-4981.

Treatment of Latent TB Infection

Medication Regimens and Completion Guidelines

TB Class 2: INH for 9 months (or 270 doses within 12 months)
(INH for 6 months [or 180 doses within 9 months] is acceptable if a patient is over 18, is not HIV infected, and is lost to follow-up or otherwise refuses any further treatment.)

TB Class 4: INH for 9 months (or 270 doses within 12 months) **OR**
INH plus RIF for 4 months (or 120 doses in 6 months)

RIF for 4 months (or 120 doses in 6 months) is acceptable for **adults** if INH is not tolerated/useful AND the patient has high-risk indications for treatment
RIF for 6 months (or 180 doses in 9 months) is acceptable for **children** if INH is not tolerated AND the patient has high-risk indications for treatment

Medication Dosages

Isoniazid: (INH)	10-20 mg/kg/day for children 5 mg/kg/day for adults Maximum daily dose for children or adults: 300 mg
Rifampin:	10-20 mg/kg/day for children 10 mg/kg/day for adults Maximum daily dose for children or adults: 600 mg

INH should be supplemented with Vitamin B6 to prevent neuropathy in pregnancy, breastfeeding, and certain conditions such as HIV/AIDS, diabetes, alcoholism, and history of prior neuropathy.

Baseline laboratory testing is not routinely indicated at the start of LTBI treatment. Check AST and ALT if history of liver disease (hepatitis or cirrhosis), HIV-infected, and in pregnant women and those in the immediate postpartum period. Liver function studies should be obtained if patient reports nausea, vomiting, abdominal pain, anorexia, dark urine or unusual fatigue. Check CBC if easy bruising or bleeding.

Liquid INH frequently causes GI upset in small children. Crushed pills at the above doses, mixed with a semi-solid vehicle (chocolate pudding, jams and jellies, Nutella, ice cream), are preferred.

Please call the San Mateo County TB program if you have any questions:
(650) 573-2346

TUBERCULOSIS CLASSIFICATION

Class	Type	Description
TB-0	- No TB exposure - Not infected	No history of exposure. Negative reaction to tuberculin skin test.
TB-1	- TB exposure - No evidence of infection	History of exposure. Negative reaction to tuberculin test skin test.
TB-2	- TB infection - No disease	Positive reaction to tuberculin skin test. Negative bacteriologic studies (if done). No clinical or radiographic evidence of TB.
TB-3	- Current TB disease	*M. tuberculosis* cultured (if done) or *both a* positive reaction to tuberculin skin test *and* clinical and/or radiographic evidence of current disease.
TB-4	- Previous TB disease	History of episode(s) of TB, abnormal stable radiographic findings in a person with a positive reaction to the tuberculin skin test, negative bacteriologic studies (if done) and no clinical or radiographic evidence of current disease.
TB-5	- TB suspect	Diagnosis pending (a patient should not be in this class for more than 3 months).

Comparison of Latent and Active Tuberculosis Classes 2, 3, and 4

	Class 2 Latent TB Infection	**Class 4 Latent TB Infection, Previous TB disease**	**Class 3 Active TB Disease**
TB Bacteria in Body	Yes (Dormant)	Yes (Dormant)	Yes (Active)
TB Skin Test Result	Positive	Positive	Positive
Chest X-Ray	Normal	Abnormal	Abnormal
Sputum Exam	Not done	Negative	Positive if pulmonary or laryngeal
Symptoms	No	No	Yes
Contagious	No	No	Yes – if pulmonary or laryngeal

Resources on Tuberculosis

Additional information on management of tuberculosis can be found in the following websites:

California Tuberculosis Controllers Association

Main website: http://www.ctca.org

Targeted Testing and Treatment of Latent TB Infection in Adults and Children:
http://www.ctca.org/guidelines/IIA2targetedskintesting.doc

Guidelines for the Treatment of Active Tuberculosis Disease:
http://www.ctca.org/guidelines/IIA1treatmentactivetb.pdf

National Tuberculosis Center:

Tuberculosis Exposure Control Plan: Template for the Clinic Setting:
http://www.nationaltbcenter.edu/products/product_details.cfm?productID=WPT-08

Drug Resistant TB: A Survival Guide for Clinicians:
http://www.nationaltbcenter.edu/drtb

Centers for Disease Control and Prevention

Division of Tuberculosis Elimination:
http://www.cdc.gov/nchstp/tb/default.htm

Laboratory Responsibilities for TB

Positive AFB Stain

Whenever a clinical laboratory finds a positive AFB stain in a patient with known or suspected tuberculosis and the patient has not had a culture which identifies that acid fast organism within the past 30 days, the clinical laboratory shall culture and identify the acid fast bacteria or refer a subculture to another laboratory for those purposes.

Positive TB Culture

Any laboratory that isolates *Mycobacterium tuberculosis* from a patient specimen must submit a culture to the public health laboratory as soon as available from the primary isolate on which a diagnosis is established.

The public health laboratory will do further tests for strain typing of the isolate.

Drug susceptibility

When tuberculosis is detected, clinical laboratories must test the specimen for drug susceptibility.

The exception is if such testing has already been performed on a sample obtained from the same patient within the previous three months.

Multi-drug resistant TB

If drug susceptibility testing determines the culture to be resistant to at least **isoniazid** and **rifampin**, prepare another culture or subculture from each patient for the public health lab.

Because multi-drug resistant (MDR) TB patients pose a high risk to public health, all instances of MDR TB must be reported promptly to the public health department.

Phone or fax positive culture reports within 1 working day

(650) 573-2346
(650) 573-2919 fax

Include this information in your report:

- Date specimen was obtained and source (sputum, wound drainage, etc.)
- Specimen accession or unique ID
- Lab findings for tests performed and date of result
- Patient ID
- Patient info (name, gender, DOB, address, phone)
- Health care provider who ordered test (name, address, phone)

Note that both the laboratory and the physician make reports to the health department.

San Mateo County Tuberculosis Control
Discharge Planning Summary

San Mateo County Health Department
225 W. 37th Avenue, San Mateo, CA 94403
(650) 573-2346 (650) 573-2919 (Fax)

Patient Information

Patient name- Last First MI AKA:			Date of Birth (mm/dd/yy) _____/_____/_____	Age	Gender ☐ Male ☐ Female
Address			Telephone number ( )		Other number (specify) ( )
City	County		State	ZIP code	Social Security number _____/____/_____
Race/ Ethnicity	Primary Language	Guardian/ Parent (If Minor)	Health Insurance		Occupation
Country of Birth			Date Arrived in U.S. Month/Year:_____/_____		

Hospital Information

Name of Institution & Reporting Unit	Medical Record #	Admission Diagnosis		Date of Admission
Address		Telephone number ( )		Fax number ( )
City	County	State	ZIP code	
Medical Provider		Provider Phone #:		

Patient TB Information

TB Status Suspect ☐ Confirmed ☐	Date of Diagnosis _____/____/_____	Symptom Onset Date ____/____/_____	Site of TB Pulmonary ☐ Laryngeal ☐ Extra-pulmonary ☐ _____

Immunocompromised Yes ☐ No ☐	Homeless Yes ☐ No ☐	Hx of Substance abuse Yes ☐ No ☐ Specify: _____	Psychiatric Disability Yes ☐ No ☐	HIV Test Offered? Yes ☐ No ☐ Result: Pos ☐ Neg ☐

Bacteriology: (Include specimens collected during the current admission)

Date	Source	AFB Smear	AFB Culture	Organism Identified	Lab name

Chest X-Ray: Date: _____/_____/_____ Cavitary ☐ Non-Cavitary ☐ Normal ☐	Follow-up Chest X-Ray: Date: _____/_____/_____ Improved ☐ Stable ☐ Worse ☐ Not done ☐	Tuberculin Skin Test (TST): Yes ☐ ____mm No ☐ Date: ___/_____/_____	Quantiferon: Yes ☐ No ☐ Date: _____/_____/_____ Result: Pos ☐ Neg ☐ Indeterminate ☐

Patient Name: _____ **DOB:** _____

TB Medication Regimen

Date medication started:	Patient's Weight:	Allergies:
_____/_____/_____	_____lbs_____kg	

Isoniazid (INH)	Rifampin (RIF)	Ethambutol(EMB)	Pyrazinamide (PZA)	Vitamin B6
_____mg po qd	_____mg po qd	_____mg po qd	_____mg po qd	_____mg po qd
Streptomycin	Other:			
_____ mg IM qd	_____mg___	_____mg_____	_____mg____	_____mg_____

Note: TB Medications should be given *once daily.*

Is there a change of TB medication regimen upon Discharge? Yes ☐ No ☐ If yes, please provide medication name and dosage:

Other Non-TB Medications taken regularly:

Discharge Information

Estimated date of Discharge (Pending Health Department Approval):_____/_____/_____	Discharge to: Home ☐ Shelter ☐ SNF ☐ Other ☐ _____

Medical Provider after Discharge:	Provider Phone #:	Follow-up Appt Date: _____/_____/_____

Household Composition: ☐ Child < 5 years old ☐ Immunocompromised person
Number of Children: _____
Number of Adults: _____

Anticipated adherence to TB medications after discharge : ☐ Good ☐ Fair ☐ Poor	Case reported to San Mateo County Health Department Yes ☐ No ☐ Date Reported: ____/____/____ If not, please do so by calling (650) 573-2346 fax: (650) 573-2919

Provider Signature

Provider Signature Title	Date	Phone number

For Discharge Approval Fax Completed Form To TB Control
Fax: 650-573-2919 Main Line: 650-573-2346
After Hours (After 5:00 pm) or Weekend Call: 650-363-4981

Health Officer/ TB Controller Review

Discharge Approved Yes ☐ No ☐	*If Discharge not approved see attached for action required.*

Signature of TB Controller/Health Officer: **Date:**

Sexually Transmitted Infections (STI)

Health care providers play an essential role in preventing the spread of sexually transmitted infections by screening and educating their patients, treating those with infections, and sending in CMR forms. The Health Department can often assist in the next steps: identifying, testing, and treating the contacts, and providing more extensive education on Sexually Transmitted Infections.

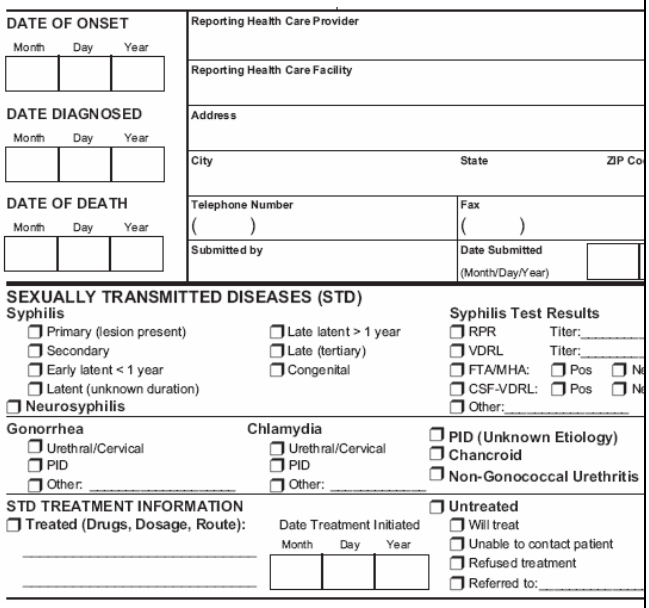
Reporting Tips

- Timely reporting is essential to limiting the spread of infection! Report syphilis within 1 working day of receiving the lab report; report gonorrhea and chlamydia within 1 week.

- You are required to make a report even if you believe a laboratory has already done so; you have information on the patient's condition and treatment that the lab does not have!

- Use the date the specimen was obtained for "Date Diagnosed" and the date of first symptoms (if present) for "Date of Onset".

- On the CMR form, be sure to include information on whether you have treated your patient yet, specific medication, dose, and duration. If you have not treated the patient, indicate if you plan to treat, haven't been able to reach the patient, etc.



DATE OF ONSET
Month Day Year

DATE DIAGNOSED
Month Day Year

DATE OF DEATH
Month Day Year

Reporting Health Care Provider

Reporting Health Care Facility

Address

City State ZIP Co

Telephone Number ( )

Fax ( )

Submitted by

Date Submitted (Month/Day/Year)

SEXUALLY TRANSMITTED DISEASES (STD)

Syphilis
- ❒ Primary (lesion present)
- ❒ Secondary
- ❒ Early latent < 1 year
- ❒ Latent (unknown duration)
- ❒ Late latent > 1 year
- ❒ Late (tertiary)
- ❒ Congenital
- ❒ Neurosyphilis

Syphilis Test Results
- ❒ RPR Titer:
- ❒ VDRL Titer:
- ❒ FTA/MHA: ❒ Pos ❒ Ne
- ❒ CSF-VDRL: ❒ Pos ❒ Ne
- ❒ Other:

Gonorrhea
- ❒ Urethral/Cervical
- ❒ PID
- ❒ Other:

Chlamydia
- ❒ Urethral/Cervical
- ❒ PID
- ❒ Other:

- ❒ PID (Unknown Etiology)
- ❒ Chancroid
- ❒ Non-Gonococcal Urethritis

STD TREATMENT INFORMATION
- ❒ Treated (Drugs, Dosage, Route):

Date Treatment Initiated
Month Day Year

- ❒ Untreated
- ❒ Will treat
- ❒ Unable to contact patient
- ❒ Refused treatment
- ❒ Referred to:

Syphilis - report by phone or fax within 1 working day

(650) 573-2346
(650) 573-2919 fax

Other STI - report by fax or mail within 1 week

(650) 573-2919 fax

Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

Follow-up

- Provide appropriate treatment.

- Advise your patients to refrain from sexual intercourse until 7 days after they and their partners have initiated treatment to prevent reinfection.

- Inform your patient that a health department staff member may call them; that all information will be confidential, and that the name of the patient will not be given to contacts. Our staff are assigned to contact patients who are most infectious or at highest risk of complications.

See next page for specific information on health department follow-up for syphilis, gonorrhea, and chlamydia.

Did you know?

In San Mateo County, 80% of women with chlamydia are between 15 and 30 years of age. Screen them!

Sexually Transmitted Infections, cont'd

Health Department Follow-up

Syphilis

Health department staff will contact all patients with syphilis of less than one year's duration (primary, secondary, and early latent syphilis) because this is the time when transmission is likely. Highest risk patients include those who

-- are pregnant

-- are under 20 years of age

-- have a fourfold increase in titer from a previous test

-- have lesions or symptoms consistent with syphilis

-- have titers 1:16 or higher

-- are HIV infected

-- have other risk factors such as being in a correctional facility or living in geographic areas with higher morbidity patterns.

Chlamydia and Gonorrhea

Health department staff will contact all pregnant women with chlamydia or gonorrhea and patients under 20 years of age. If you are having trouble contacting any patient, please call us at 573-2346 and our staff will assist in making the contact and arranging follow-up, either in your office or at a county clinic.

We can help …

Health Department staff will contact untreated patients upon request of their physician. In addition, they will give them Field Delivered Therapy (FDT) if necessary on difficult or unresponsive patients.

California SB 648 enables medical providers to initiate partner-delivered therapy for chlamydia. This is a useful tool for treating people who are often hard to reach.

Treatment for Sexually Transmitted Infections

Treatment guidelines are on the following pages and updates can be found online at: http://www.stdhivtraining.org/. Click on Resources, and enter "Guidelines" in the search screen.

If you have questions about the appropriate treatment regimen, please call us.

Thank you for helping us to limit the spread of sexually transmitted infections by reporting them promptly and completely!

Sexually Transmitted Diseases (STD) Treatment Guidelines

The Centers for Disease Control and Prevention's (CDC) latest STD Treatment Guidelines are available at www.cdc.gov/std/treatment

The California Department of Health Services, STD Control Branch provides supplemental treatment guidelines that include specific recommendations for California. These are available at www.dhs.ca.gov/ps/dcdc/std/stdindex.htm. The 2007 Guidelines are on the next pages.

CALIFORNIA STD TREATMENT GUIDELINES FOR ADULTS & ADOLESCENTS 2007

These guidelines for the treatment of patients with STDs reflect the 2006 CDC STD Treatment Guidelines and the Region IX Infertility Clinical Guidelines. The focus is primarily on STDs encountered in office practice. These guidelines are intended as a source of clinical guidance; they are not a comprehensive list of all effective regimens and are not intended to substitute for use of the full 2006 STD treatment guidelines document. Call the local health department to report STD infections; to request assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection; or to obtain additional information on the medical management of STD patients. The California STD/HIV Prevention Training Center is an additional resource for training and consultation in the area of STD clinical management and prevention (510-625-6000) or **www.stdhivtraining.org**.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
CHLAMYDIA			
Uncomplicated Genital/Rectal/Pharyngeal Infections [1]	• Azithromycin **or** • Doxycycline[2]	1 g po 100 mg po bid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Ofloxacin[2] 300 mg po bid x 7 d **or** • Levofloxacin[2] 500 mg po qd x 7 d
Pregnant Women[3]	• Azithromycin **or** • Amoxicillin	1 g po 500 mg po tid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin base 250 mg po qid x 14 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA Ceftriaxone is the preferred treatment for adult and adolescent patients with uncomplicated gonorrhea infections. Fluoroquinolones are no longer recommended for treatment of gonococcal infections in California because of high levels of resistance to this class of drugs. Routine use of azithromycin to treat gonorrhea is not recommended because of mounting concern about emerging resistance. Complete guidelines for the treatment of gonorrhea in California are available at www.std.ca.gov			
Uncomplicated Genital/Rectal Infections[1]	• Ceftriaxone[4] **or** • Cefixime[4,5] **plus** • A chlamydia recommended regimen listed above if not ruled out by NAAT	125 mg IM 400 mg po	• Cefpodoxime[4] 400 mg po • Spectinomycin[6] 2 g IM • Azithromycin[7] 2 g po in a single dose
Pharyngeal Infections	• Ceftriaxone[4] **plus** • A chlamydia recommended regimen listed above if not ruled out by NAAT	125 mg IM	• Azithromycin[7] 2 g po in a single dose
Pregnant Women[3]	• Ceftriaxone[4] **or** • Cefixime[4,5] **plus** • A chlamydia recommended regimen listed above if not ruled out by NAAT	125 mg IM 400 mg po	• Spectinomycin[6] 2 g IM • Azithromycin[7] 2 g po in a single dose
PELVIC INFLAMMATORY DISEASE[8,9]	**Parenteral**[10] • **Either** Cefotetan **or** Cefoxitin **plus** Doxycycline[2] **or** • Clindamycin **plus** Gentamicin **IM/Oral** • **Either** Ceftriaxone **or** Cefoxitin with Probenecid **plus** Doxycycline[2] **plus** Metronidazole if BV is present	 2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IV q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 250 mg IM 2 g IM, 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d	**Parenteral**[10] • Ampicillin/Sulbactam 3 g IV q 6 hrs **plus** Doxycycline[2] 100 mg po or IV q 12 hrs **Oral**[11] • **Either** Ofloxacin[2] 400 mg po bid x 14 d **or** Levofloxacin[2] 500 mg po qd x 14 d **plus** Metronidazole 500 mg po bid x 14 d
CERVICITIS [8,9,12]	• Azithromycin **or** • Doxycycline[2] **plus** Metronidazole if BV is present	1 g po 100 mg po bid x 7 d 500 mg po bid x 7 d	
NONGONOCOCCAL URETHRITIS [8]	• Azithromycin **or** • Doxycycline	1 g po 100 mg po bid x 7 d	• Erythromycin base 500 mg po qid x 7 d **or** • Erythromycin ethylsuccinate 800 mg po qid x 7 d **or** • Ofloxacin 300 mg po bid x 7 d **or** • Levofloxacin 500 mg po qd x 7 days
EPIDIDYMITIS [8]	Likely due to Gonorrhea or Chlamydia • Ceftriaxone **plus** Doxycycline Likely due to enteric organisms • Ofloxacin [13] **or** • Levofloxacin [13]	 250 mg IM 100 mg po bid x 10 d 300 mg po bid x 10 d 500 mg po qd x 10 d	
TRICHOMONIASIS[14]			
Non-pregnant women	• Metronidazole **or** • Tinidazole [15]	2 g po 2 g po	• Metronidazole 500 mg po bid x 7 d
Pregnant Women	• Metronidazole	2 g po	• Metronidazole 500 mg po bid x 7 d
BACTERIAL VAGINOSIS			
Adults/Adolescents	• Metronidazole **or** • Metronidazole gel **or** • Clindamycin cream[16]	500 mg po bid x 7 d 0.75%, one full applicator (5g) intravaginally qd x 5 d 2%, one full applicator (5g) intravaginally qhs x 7 d	• Clindamycin 300 mg po bid x 7 d **or** • Clindamycin ovules[16] 100 g intravaginally qhs x 3 d
Pregnant Women	• Metronidazole **or** • Metronidazole **or** • Clindamycin	500 mg po bid x 7 d 250 mg po tid x 7 d 300 mg po bid x 7 d	

1. Annual screening for women age 25 years or younger. Nucleic acid amplification tests (NAATS) are recommended. All patients should be retested 3 months after treatment for chlamydia or gonorrhea infections.
2. Contraindicated for pregnant and nursing women.
3. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy.
4. For patients with cephalosporin allergy, anaphylaxis-type (IgE-mediated) penicillin allergy or other contraindication: CDC recommends considering desensitization. However, in the vast majority of cases, this may not be feasible. Judicious use of azithromycin is a practical option if spectinomycin is not available or not indicated.
5. Cefixime tablets have not been available in the U.S. since November 2002. An oral suspension formulation is available.
6. Spectinomycin has not been manufactured since January 2006, and future availability is uncertain.
7. Use only if medical contraindications to a cephalosporin, and when spectinomycin is not available or not indicated. Test-of-cure is prudent because efficacy data are limited and because of mounting concern about emergent resistance.
8. Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management, and because these infections are reportable by California state law.
9. Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole.
10. Discontinue 24 hours after patient improves clinically and continue with oral therapy for a total of 14 days.
11. Fluoroquinolones may be used for PID in California if the risk of gonorrhea is low, a NAAT test for gonorrhea is performed, and follow-up of the patient is considered likely. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.
12. If local prevalence of gonorrhea is greater than 5%, co-treat for gonorrhea infection.
13. If gonorrhea is documented, change to a medication regimen that does not include a fluoroquinolone, or obtain test-of-cure to ensure patient does not have resistant gonorrhea infection.
14. For suspected drug-resistant trichomoniasis, rule out reinfection; see 2006 CDC Guidelines, Trichomonas Follow-up p. 53, for other treatment options, and evaluate for metronidazole-resistant *T. vaginalis*. For laboratory and clinical consultations, contact CDC at 770-488-4115, http://www.cdc.gov/std.
15. Safety in pregnancy has not been established; pregnancy category C.
16. Might weaken latex condoms and diaphragms because oil-based.

Developed by the California STD/HIV Prevention Training Center
Revised March 2007

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
CHANCROID	• Azithromycin **or** • Ceftriaxone **or** • Ciprofloxacin[2] • Erythromycin base	1 g po 250 mg IM 500 mg po bid x 3 d 500 mg po tid x 7 d	
LYMPHOGRANULOMA VENEREUM	• Doxycycline[2]	100 mg po bid x 21 d	• Erythromycin base 500 mg po qid x 21 d **or** • Azithromycin 1 g po q week x 3 weeks
ANOGENITAL WARTS			
External Genital/ Perianal Warts	**Patient Applied** • Imiquimod [17] 5% cream **or** • Podofilox[17] 0.5% solution or gel **Provider Administered** • Cryotherapy **or** • Podophyllin[17] resin 10%-25% in tincture of benzoin **or** • Trichloroacetic acid (TCA) 80%- 90% **or** • Bichloroacetic acid (BCA) 80%- 90% **or** • Surgical removal	 Topically qhs 3 x wk up to 16 wks Topically bid x 3 d followed by 4 d no tx for up to 4 cycles Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks	**Alternative Regimen** • Intralesional interferon **or** • Laser surgery
Mucosal Genital Warts[18]	• Cryotherapy **or** • TCA or BCA 80%-90% **or** • Podophyllin[17] resin 10%-25% in tincture of benzoin **or** • Surgical removal	Vaginal, urethral meatus, and anal Vaginal and anal Urethral meatus only Anal warts only	
ANOGENITAL HERPES [19]			
First Clinical Episode of Herpes	• Acyclovir **or** • Acyclovir **or** • Famciclovir **or** • Valacyclovir	400 mg po tid x 7-10 d 200 mg po 5/day x 7-10 d 250 mg po tid x 7-10 d 1 g po bid x 7-10 d	
Established Infection Suppressive Therapy[20]	• Acyclovir **or** • Famciclovir **or** • Valacyclovir **or** • Valacyclovir	400 mg po bid 250 mg po bid 500 mg po qd 1 g po qd	
Episodic Therapy for Recurrent Episodes	• Acyclovir **or** • Acyclovir **or** • Acyclovir **or** • Famciclovir **or** • Famciclovir **or** • Valacyclovir **or** • Valacyclovir	400 mg po tid x 5 d 800 mg po bid x 5 d 800 mg po tid x 2 d 125 mg po bid x 5 d 1000 mg po bid x 1 d 500 mg po bid x 3 d 1 g po qd x 5 d	
HIV Co-Infected[21]			
Suppressive Therapy[20]	• Acyclovir **or** • Famciclovir **or** • Valacyclovir	400-800 mg po bid or tid 500 mg po bid 500 mg po bid	
Episodic Therapy for Recurrent Episodes	• Acyclovir **or** • Famciclovir **or** • Valacyclovir	400 mg po tid x 5-10 d 500 mg po bid x 5-10 d 1 g po bid x 5-10 d	
SYPHILIS[22]			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• Doxycycline[23] 100 mg po bid x 14 d **or** • Tetracycline[23] 500 mg po qid x 14 d **or** • Ceftriaxone[23] 1 g IM or IV qd x 8-10 d
Late Latent and Latent of Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• Doxycycline[23] 100 mg po bid x 28 d **or** • Tetracycline[23] 500 mg po qid x 28 d
Neurosyphilis[24]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d **or** • Ceftriaxone[23] 2 g IM or IV qd x 10-14 d
Pregnant Women[25]			
Primary, Secondary, and Early Latent	• Benzathine penicillin G	2.4 million units IM	• None
Late Latent and Latent of Unknown duration	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• None
Neurosyphilis[24]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d
HIV Co-Infected			
Primary, Secondary and Early Latent	• Benzathine penicillin G	2.4 million units IM	• Doxycycline[23] 100 mg po bid x 14 d **or** • Tetracycline[23] 500 mg po qid x 14 d
Late Latent, and Latent of Unknown duration **with normal CSF Exam**	• Benzathine penicillin G	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	• Doxycycline[23] 100 mg po bid x 28 d
Neurosyphilis[24]	• Aqueous crystalline penicillin G	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	• Procaine penicillin G, 2.4 million units IM qd x 10-14 d **plus** Probenecid 500 mg po qid x 10-14 d **or** • Ceftriaxone[23] 2 g IM or IV qd x 10-14 d

17. Contraindicated in pregnancy.
18. Cervical warts should be managed by a specialist.
19. Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.
20. The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission.
21. If HSV lesions persist or recur while receiving antiviral treatment, antiviral resistence should be suspected. A viral isolate should be obtained for sensitivity testing, and consultation with an infectious disease expert is recommended.
22. Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name) which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.
23. Alternates should only be used for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.
24. Some specialists recommend 2.4 million units of benazthine penicillin G q week for up to 3 weeks after completion of neurosyphilis treatment.
25. Patients allergic to penicillin should be treated with penicillin after desensitization.

Developed by the California STD/HIV Prevention Training Center
Revised March 2007

HIV Infection and AIDS

State of California regulations require that all health care providers and medical laboratories report cases of HIV/AIDS to the local health department.

Diagnosing HIV and AIDS

A diagnosis of AIDS is determined by the presence of HIV infection in conjunction with one or more specific opportunistic infections or clinical conditions, or with a CD4 count < 200 cells/mm^3. A person may not meet the definition of AIDS for years after initial HIV infection.

Lab tests that indicate HIV infection include, but are not limited to:

- HIV antibody (ELISA with confirmatory Western Blot)
- Quantitative HIV viral load

Changes in HIV/AIDS Reporting

In California, AIDS cases have been reportable by name since 1983. HIV cases have been reportable since 2002. Initially the state used a coded non-name HIV reporting method. Beginning in 2006, the HIV reports changed to a name-based system in order to allow more exact tracking of trends. In order to provide an extra measure of confidentiality, reports should be sent by mail, not by fax.

Reports are made on the HIV/AIDS Confidential Case Report Forms (DHS 8641). There are separate forms for children ≤ 12 and adults ≥ 13 years old.

Why is reporting of HIV and AIDS mandatory?

Our public health department is charged with helping local HIV/AIDS patients and designing effective prevention programs. Your reports are the foundation for accurate statistics on the disease. Data on HIV prevalence are used to identify areas that need more resources for education, prevention, and treatment.

What about anonymous HIV testing sites?

Sites that offer anonymous testing (i.e., the patient is not identified by name anywhere in the site's records) will not be required to report positive HIV results. When the patient returns for results the staff will advise him or her to obtain care for the infection as soon as possible, and the report should be made by the health care provider that treats the patient.

Are there legal ramifications for health care providers who fail to report confirmed HIV cases?

Yes, every person charged with a duty under the HIV Reporting Regulations who willfully neglects or refuses to report in accordance with the regulations is guilty of a misdemeanor under Health and Safety Code Section 100182 and may be subject to prosecution.

Report all new cases within 1 week by phone or mail, not by fax

(650) 573-2346
Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

Phone us with any questions.

Please do not use the regular Confidential Morbidity Report (CMR) to report HIV.

Instead, use the specific HIV/AIDS Confidential Case Report forms on the following pages.

State of California - Health and Human Services Agency

Department of Health Services
Office of AIDS
HIV/AIDS Surveillance Program

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: Month Day Year | Report status: 1 New, 2 Update

II. *Health Department Use Only*

Report source | Reporting health department | State patient number | City/county patient number

Soundex code | Date of birth: Month Day Year | Gender: 1 M, 2 F, 3 M▶F, 4 F▶M | CLIA number | Lab report/Accession number | *Confidential C&T number

*Publicly funded confidential counseling and testing sites only

III. Demographic Information

Diagnosis status at report (check one): 1 HIV Infection (not AIDS), 2 AIDS | Age at Diagnosis Years | Current status: 1 Alive, 2 Dead, 9 Unknown | Date of death: Month Day Year | State/Territory of death

Country of birth: 1 U.S., 7 U.S. Territories (including Puerto Rico), 8 Other (specify):_____, 9 Unknown

ETHNICITY: 1 Hispanic, 2 Not Hispanic nor Latino

RACE: ☐ American Indian/Alaskan Native ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown

Expanded race (specify):_____

☐ 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: ☐ 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

Facility name | City | State/Country

Facility setting (check one): 1 Public, 2 Private, 3 Federal, 9 Unknown

Facility type (check one): 01 Physician, HMO; 22 Counseling and Testing Site; 29 Community Health Center; 30 Correctional Facility; 31 Hospital, inpatient; 32 Hospital, outpatient; 88 Other (specify):_____; 99 Unknown

V. Patient Risk History (Check all that apply.)

	Yes	No	Unknown
• Sex with a male	1	0	9
• Sex with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A), 2 Factor IX (Hemophilia B), 8 Other (specify):_____

	Yes	No	Unknown
• Received transfusion of blood/components (other than clotting factor) First: Month Year Last: Month Year	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health care or clinical laboratory setting	1	0	9
(Specify occupation):_____			
• Perinatally-acquired HIV infection regardless of year of birth	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 | Month Day Year

- HIV-1 EIA
- HIV-1/HIV-2 combination EIA
- Rapid HIV-1 EIA
- HIV-1 Western Blot/IFA
- Other HIV antibody test

(Specify):_____

B. *Positive* HIV Detection Test *(Record earliest test.)* | Month Day Year

☐ Culture ☐ Antigen ☐ DNA PCR ☐ RNA PCR

☐ Other (specify):_____

Date of last documented ***negative*** HIV test | Month Day Year

Specify type:_____

Specify facility type (use codes in Section IV):

01 22 29 30 31 32 99 88 (Specify):_____

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1 | No 0 | Unknown 9

If yes, provide date of documentation by physician | Month Day Year

C. HIV Viral Load Test *(Record earliest test.)* | Month Day Year

Test type*: Version*:

Other (specify type and version):_____

Test result *(Record in copies/mL **and** log_{10} values.)*

☐ Detectable — Copies/mL: , , ; Log_{10}: . ; Greater than: , , copies/mL

☐ Undetectable — Less than: copies/mL

*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)_____

D. Immunologic Lab Tests - At or closest to current diagnostic status

- CD4 count: , cells/µl
- CD4 percent: %

Month Day Year

First <200 µl or <14%

- CD4 count: , cells/µl
- CD4 percent: %

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 [1] No [0]

Enter date patient was diagnosed as:

	Month	Day	Year
• Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy)			
• Symptomatic (not AIDS)			

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Month	Initial Date Year
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Carcinoma, invasive cervical	1	NA		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 month duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 month duration): or bronchitis, pneumonitis, or esophagitis	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 month duration)	1	NA		
Kaposi's sarcoma	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, pulmonary*	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis jirovecí pneumonia (PCP)	1	2		
Pneumonia, recurrent, in 12-month period	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Salmonella septicemia, recurrent	1	NA		
Toxoplasmosis of brain	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 [1] No [0] Unknown [9]

IX. Treatment/Services Referrals

	Yes	No	Unknown
Has the patient been informed of his/her HIV infection?	1	0	9

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

[1] Health Department [2] Physician/Provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:	Yes	No	NA	Unknown
• HIV-related medical services	1	0	-	9
• Substance abuse treatment services	1	0	8	9

This patient received or is receiving:	Yes	No	Unknown
• Antiretroviral therapy	1	0	9
• PCP prophylaxis	1	0	9

This patient has been enrolled at:

Clinical Trial	*Clinic*
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other public funding
[7] Clinical trial/government program [9] Unknown

For women:

	Yes	No	Unknown
• This patient is receiving or has been referred for gynecological or obstetrical services	1	0	9
• This patient is currently pregnant	1	0	9
• This patient has delivered live born infant(s)	1	0	9

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

Child's date of birth Month Day Year	Hospital of birth / City / State	Child's Soundex	*Health Department Use Only* Child's state patient number

X. Comments

MAIL COMPLETED FORM MARKED "CONFIDENTIAL" TO THE HIV/AIDS SURVEILLANCE PROGRAM AT YOUR LOCAL HEALTH DEPARTMENT.
LHD contact information is available on the website: www.dhs.ca.gov/AIDS

Pediatric HIV/AIDS Reporting Form

To report a confirmed case of HIV or AIDS in a child ≤ 12 years of age at time of diagnosis, please call your local Health Department and request the Pediatric HIV/AIDS confidential case report form.

If the case lives in San Mateo County, please contact the HIV/AIDS Surveillance Coordinator for assistance at 650-573-2346.

Animal Bites & Rabies

Why Report?

Rabies is endemic in wildlife in San Mateo County, and can affect domestic animals as well. Any bite that breaks the skin, and any exposure of mucus membranes or broken skin to saliva of potentially rabid animals, can cause human rabies. Prophylaxis with Rabies Immune Globulin and Rabies Vaccine is effective at preventing this deadly disease.

Bats and Rabies

Bats are important reservoirs for rabies, and their bites are often imperceptible. Therefore, if there is any contact with a bat or if a bat is found in a room with children or where people are sleeping, rabies prophylaxis should be considered. Call the DCP or the health officer on call to discuss specific cases.

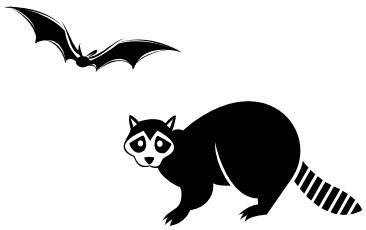
Dog Bite Facts

Number of licensed dogs in San Mateo County in 2004: 55,452

Number of dog bites reported in San Mateo County in 2004: 619

Fewer than half of these dogs had been vaccinated against rabies!

Many more people are bitten by other animals, wild or domestic. Because bites may spread rabies, health care providers must report all animal bites.



Testing Animals for Rabies

The Public Health Laboratory performs rabies testing on domestic or wild animals at risk for rabies, such as bats, skunks, foxes, raccoons, and opossums. Animals like mice, rats, gophers, rabbits and squirrels are unlikely to transmit rabies. As testing involves examination of the brain tissue, it's necessary to euthanize the animal to perform rabies testing. Please call Disease Control and Prevention at 573-2346 to discuss whether testing is indicated.

Rabies testing is done at least weekly. Additional testing will be done on recommendation of a public health physician. Dead animals may be brought in between 8 am and 4 pm, Monday through Friday.

Non-owned Animals

The Peninsula Humane Society will attempt to catch stray animals that have bitten humans and bring them to the lab for testing.

General Information on Human Rabies

Incubation period is usually 3-8 weeks, rarely as short as 9 days or as long as 7 years; depends on the severity of the wound, site of the wound in relation to the richness of the nerve supply and its distance from the brain, amount and strain of virus introduced, protection provided by clothing and other factors. Prolonged incubation periods have occurred in prepubertal individuals.

Report all animal bites immediately to:

Peninsula Humane Society & SPCA
12 Airport Boulevard
San Mateo, CA 94401
(650) 348-7891
(650) 340-7022

For questions on management of animal bites, or if you suspect rabies disease, call:

Disease Control and Prevention

(650) 573-2346
(650) 363-4981 for after-hours emergencies)

Other useful numbers:

To obtain Rabies Vaccine, call

1-800-CHIRON or

1-800-VACCINE

For Rabies Immune Globulin (RIG), call

1-800-VACCINE or
1-800-243-4153

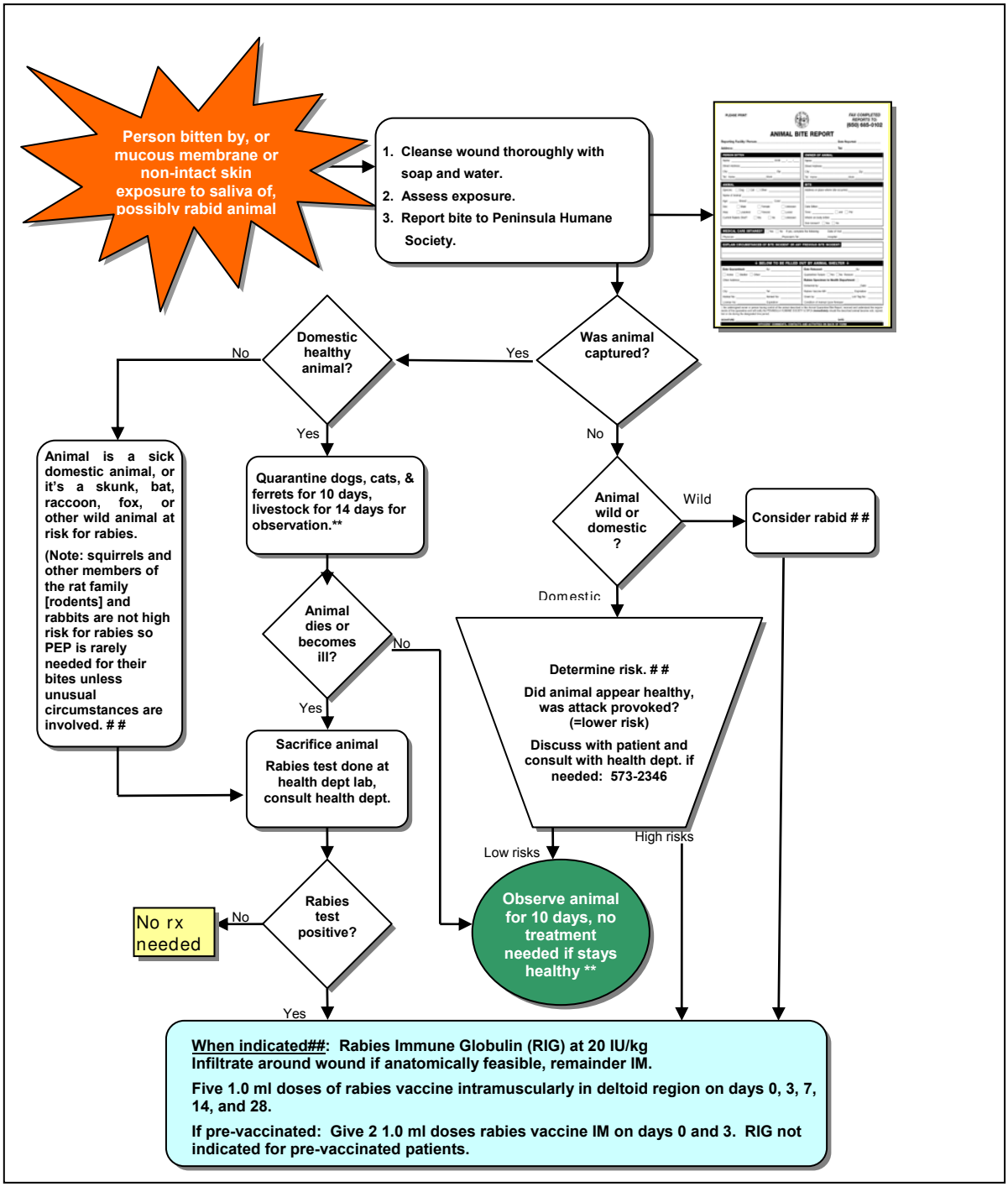
Public Health Lab

225 37th Avenue, Room 113
San Mateo, CA 94403
(650) 573-2500

... for questions about where and when to bring an animal for testing.

See next page for guidelines for determining whether rabies vaccine and RIG (Rabies Immune Globulin) are needed for a patient.

Rabies Post-exposure Prophylaxis (PEP) Guide



****Detain and clinically observe for 10 days** any healthy-appearing dog, cat, or ferret known to have bitten a person (unwanted dogs and cats may be euthanized immediately and examined for rabies by fluorescent microscopy). **Dogs and cats showing signs suspicious for rabies should be sacrificed and tested for rabies.** If the biting animal was infective at the time of the bite, rabies will usually develop within 4-7 days, followed by death. **All wild mammals that have bitten a person should be sacrificed immediately so the brain can be examined for evidence of rabies.**

Bites from squirrels, rats, mice, chipmunk, gophers, other rodents, hamsters, guinea pigs, gerbils, rabbits and hares <u>almost never call for rabies prophylaxis</u>. However, each case should be reviewed to ensure that abnormal behavior or unusual circumstances are not involved with the animal, as any mammal can develop rabies. **Bats should be considered rabid unless captured, tested, and results are negative.**

PLEASE PRINT

FAX COMPLETED REPORTS TO:
(650) 685-0102

ANIMAL BITE REPORT

Reporting Facility / Person: _____ **Date Reported:** _____

Address: _____ **Tel:** _____

PERSON BITTEN

Name: _____ DOB: ___ / ___ /____

Street Address: _____

City: _____ Zip: _____

Tel: Home _____ Work _____

OWNER OF ANIMAL

Name: _____

Street Address: _____

City: _____ Zip: _____

Tel: Home _____ Work _____

ANIMAL

Species: ☐ Dog ☐ Cat ☐ Other: _____

Name of Animal: _____

Age: _____ Breed: _____ Color: _____

Sex: ☐ Male ☐ Female ☐ Unknown

Was: ☐ Leashed ☐ Fenced ☐ Loose

Current Rabies Shot? ☐ Yes ☐ No ☐ Unknown

BITE

Address or place where bite occurred: _____

_____

_____

Date Bitten: _____

Time: _____ ☐ AM ☐ PM

Where on body bitten: _____

Skin broken? ☐ Yes ☐ No

MEDICAL CARE OBTAINED?

☐ Yes ☐ No If yes, complete the following: Date of Visit _____

Physician: _____ Physician's Tel: _____ Hospital: _____

EXPLAIN CIRCUMSTANCES OF BITE INCIDENT OR ANY PREVIOUS BITE INCIDENT:

_____

_____

↓ BELOW TO BE FILLED OUT BY ANIMAL SHELTER ↓

Date Quarantined: _____ By: _____

☐ Home ☐ Shelter ☐ Other: _____

Other Address: _____

_____

City: _____ Tel: _____

Animal No.: _____ Kennel No.: _____

License No.: _____ Expiration: _____

Date Released: _____ By: _____

Quarantine Failure: ☐ Yes ☐ No Reason: _____

Rabies Specimen to Health Department ☐

Delivered by: _____ Date: _____

Rabies Vaccine Mfr: _____ Expiration: _____

Given by: _____ Lot / Tag No.: _____

Condition of Animal Upon Release: _____

I, the undersigned owner or person having control of the animal described in this Animal Quarantine / Bite Report, received and understand the requirements of this quarantine and will notify the PENINSULA HUMANE SOCIETY & SPCA ***immediately*** should the described animal become sick, injured, lost or die during the designated time period.

SIGNATURE: _____ **DATE:** _____

OFFICERS' COMMENTS, CONTACTS AND ACTIVITIES ON BACK OF FORM

Return Form to:
Peninsula Humane Society & SPCA
12 Airport Boulevard
San Mateo, CA 94401
Tel (650) 340-8200
Fax (650) 685-0102

DATE OF BITE
DUE DATE OUT
DATE RELEASED
RELEASED BY

OFFICIAL USE ONLY

BITE REPORT NO. _____

FRA Result_____ FRA Test Date _____ PH Staff Initials_____

Printed under the direction of the San Mateo County Environmental Health Department 455 County Center, 4th Floor, Redwood City, CA 94063-1646

Revised 6/2005 BLUE—PHS Officer Copy YELLOW—PHS Permanent File Copy PINK—S.M.H.D. Copy

West Nile Virus (WNV)

West Nile Virus first appeared in the United States in 1999 in New York and since then has spread across the country. It is caused by a flavivirus that infects several species of birds and is transmitted to humans, horses, and a few other mammals by mosquitoes. Rarely transmission occurs by transfusion, transplant, transplacentally, or via breast milk. The blood supply is now screened for WNV. The incubation period after mosquito bite ranges from 3 to 14 days. WNV is not transmitted from person to person.

Symptoms

Infection with WNV is usually asymptomatic. Approximately 20% of infections result in West Nile Fever, a mild to moderate nonspecific febrile illness. Less than 1% of infections lead to severe neurological illness.

■ **West Nile Fever** is a syndrome characterized by headache and fever (T ≥ 100.4F). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. Symptoms generally last 3 to 6 days but may continue for weeks. There is no specific treatment. Individuals recover fully.

■**West Nile Encephalitis/West Nile Meningitis** is a severe illness with headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, and paralysis. Symptoms of severe disease (encephalitis or meningitis) may last several weeks, and neurological effects may be permanent. The most significant risk factor for developing severe neurological disease is age ≥ 50 years. I.

■**Acute Flaccid Paralysis;** atypical Guillain-Barré syndrome or transverse myelitis.

West Nile Virus Can Cause Long-term Sequelae

Survivors of WNV encephalitis/ meningitis may face a long road to recovery. In New York City, only 33% were ambulatory and only 50% were at their previous level of mental function at hospital discharge. One year later, 67% still experienced fatigue, 50% had persistent problems with memory, 49% had difficulty walking, 44% had muscle weakness and 38% had depression.

Testing

Virus-specific IgM can be detected in nearly all cerebrospinal fluid (CSF) and serum specimens received from WNV-infected patients at the time of their clinical presentation. Serum IgM antibody may persist for more than a year, but IgM antibody in CSF strongly suggests acute infection. Consider testing individuals with:

- Encephalitis
- Aseptic meningitis (if < 18 yrs, also work up for enteroviruses)
- Acute Flaccid Paralysis, Atypical Guillain Barré Syndrome, or Transverse myelitis
- West Nile Fever lasting ≥ 7 days

Prevention

Since almost all cases of West Nile Virus are the result of a bite from an infected mosquito, preventing mosquito bites is the best protection. Advise all your patients:

- **Drain** all standing water so mosquitoes won't have breeding sites
- **Dawn** and dusk are the main times for mosquito activity, so stay inside or use effective mosquito repellents
- **DEET** or Picaridin repellents should be used
- **Dress** appropriately – with long sleeves and pants
- **Doors** and windows should have screens to keep mosquitoes out

Wild birds are often the first victims when West Nile Virus reaches an area. To report a dead bird during West Nile Virus season, call

1-877-WNV-BIRD

(1-877-968-2473)

Reporting WNV

All cases of WNV infection must be reported by phone, fax or mail within 1 day

(650) 573-2346
(650) 573-2919 fax
Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

To coordinate processing of specimens by the Public Health Lab, contact the Disease Control Unit. **A West Nile Virus Specimen Submittal Form is required for testing – see next page.** If a case is confirmed by laboratory testing, a West Nile Case History Form will be needed.

For questions about mosquito control, contact:

San Mateo County Mosquito Abatement District (MAD)

(650) 344-8592 or visit www.smcmad.org

California Department of Public Health – Viral and Rickettsial Disease Laboratory

WEST NILE VIRUS SPECIMEN SUBMITTAL FORM

PLEASE USE ONE FORM PER PATIENT

West Nile virus testing is recommended on individuals with the following:

A. Encephalitis

B. Aseptic meningitis (Note: Consider enterovirus for individuals ≤ 18 years of age)

C. Acute flaccid paralysis; atypical Guillain-Barré Syndrome; transverse myelitis; or

D. Febrile illness compatible with West Nile fever* and lasting ≥ 7 days (must be seen by health care provider):

** The West Nile fever syndrome can be variable and often includes headache and fever (T≥38C). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. After initial symptoms, the patient may experience several days of fatigue and lethargy.*

---

1. **Required specimens**:
   - ❑ **Acute Serum:** ≥ 2cc serum
   - ❑ **Cerebrospinal Fluid (CSF):** 1-2cc CSF if lumbar puncture is performed
2. If West Nile virus is highly suspected and acute serum is negative or inconclusive:
   - ❑ **2nd Serum:** ≥ 2 cc serum collected 3-5 days after acute serum

---

- ❑ Refrigerated specimens should be sent on **cold pack** using an overnight courier
- ❑ If CSF is frozen, send on dry ice (all specimens may be sent on dry ice)
- ❑ Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name**
- ❑ Please do not send specimens on Fridays (Specimen Receiving Hours: M-F 8-5)
- ❑ Send specimens to CDPH VRDL: **Specimen Receiving – West Nile**
  850 Marina Bay Parkway
  Richmond, CA 94804
- ❑ Local Public Health Laboratory West Nile **IFA/EIA IgM results** (or attach copy of results):

Specimen	Date Collected	IgM Assay Method	Results			
			Negative	Reactive	Indeterminate	Not Tested
		o IFA o EIA				
		o IFA o EIA				

**** IMPORTANT: THE INFORMATION BELOW MUST BE COMPLETED AND SUBMITTED WITH SPECIMENS ****

Patient's last name, first name:			**Patient Information** **Address** _____ **City**_____ **Zip**_____ **County**_____ **Phone Number (_____)**_____
Age or DOB:	Sex (circle): M F	Onset Date:	
Clinical findings: o Encephalitis o Meningitis o Acute flaccid paralysis o Febrile illness o Other: _____ Other tests requested:			Other information (immunocompromised, travel hx, hx of flavivirus infection, etc.):

	Specimen type and/or specimen source	Date Collected	**This section for Laboratory use only. Date received by VRDL and State Accession Number**
1st			1st
2nd			2nd
3rd			3rd

Questions? Call Cynthia Jean at (510) 307-8606

Submitting Physician_____ Phone Number (_____) _____

Submitting Facility_____ Phone Number (_____) _____

West Nile Virus (WNV) Infection Case Report 2008

Date Form Completed:___/___/___

Patient Information:

Last Name: _____ **First Name:**_____ **DOB:**___/___/___ **Age:**__ **Med Rec #:**_____

Address: _____ **City:** _____ **Zip Code:** _____

Phone: Home (_____)_____ Work (_____)_____ **Occupation:** _____

Sex: ☐ Male ☐ Female ☐ Unknown **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Race:** ☐ White ☐ Black ☐ Unknown ☐ Asian/ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other: _____

Physician Information (Mandatory):

Name: _____ **Facility:** _____

Pager/Phone: (_____)_____ **Fax:** (_____)_____ **Email:** _____

Date of first symptom(s):____/____/____ ☐ Hospitalized **or** ☐ ER / Outpatient

If hospitalized, admit date: ____/____/____ **Discharge date:** ____/____/____ **If patient died, date of death:** ____/____/____

Clinical syndrome (check all that apply):

Encephalitis ……	☐ Yes	☐ No	☐ Unk
Aseptic meningitis …….	☐ Yes	☐ No	☐ Unk
Acute flaccid paralysis ….	☐ Yes	☐ No	☐ Unk
Febrile illness ……..…..	☐ Yes	☐ No	☐ Unk
Asymptomatic ……	☐ Yes	☐ No	☐ Unk

Other _____

Do the following apply anytime during current illness:

In ICU ……..	☐ Yes	☐ No	☐ Unk
Seizures …..……..….	☐ Yes	☐ No	☐ Unk
Altered consciousness ….	☐ Yes	☐ No	☐ Unk
Fever ≥38˚C …..……	☐ Yes	☐ No	☐ Unk
Headache……	☐ Yes	☐ No	☐ Unk
Rash ……..…….	☐ Yes	☐ No	☐ Unk
Stiff neck…..……	☐ Yes	☐ No	☐ Unk
Muscle pain ……..….	☐ Yes	☐ No	☐ Unk
Muscle weakness …….	☐ Yes	☐ No	☐ Unk

Other: _____

Past medical history:

Immunocompromised:	☐ Yes	☐ No	☐ Unk
Hypertension ……	☐ Yes	☐ No	☐ Unk
Diabetes Type _____	☐ Yes	☐ No	☐ Unk

Specify: _____

Other: _____

CSF Results	CBC Results
Date: ____/____/____	Date: ____/____/____
RBC: ____	WBC: ____
WBC: ____	%Diff: _____
%Diff: _____	HCT: ____
Protein: ____	Plt: ____
Glucose: ____	

Travel/Exposures within 4 wks of onset (specify details):

Mosquito bites/exposure ……..…	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Travel outside of California ……..…	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Travel outside the U.S. ……..……..	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Donated blood …….	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Donated organ …….	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Received blood transfusion ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Received organ transplant: ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Currently pregnant ……..	☐ Yes	☐ No	☐ Unk
Week of gestation: ____			
Ever traveled outside the U.S. ….	☐ Yes	☐ No	☐ Unk
Dates/Locations: _____			
Ever rec'd yellow fever vaccine.....	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			

Knowledge of WNV prior to illness:

Did patient do anything to avoid mosquito bites?			
If yes,	☐ Yes	☐ No	☐ Unk
- used insect repellent?	☐ Yes	☐ No	☐ Unk
- drained standing water near home?	☐ Yes	☐ No	☐ Unk

Other significant history/exposures: _____

_____

Other lab results (MRI/CT, etc.): _____

_____

West Nile Virus Test Results:

Testing Laboratory	Specimen Type	Coll Date	Test Type	Result
_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____

For questions regarding testing or specimens, call San Mateo Co. Disease Control & Prevention (650) 573-2346
Fax this form to (650) 573-2919 or mail to: San Mateo Co. Public Health Lab, 225 37th Avenue, San Mateo, Ca 94403

West Nile Virus (WNV) Infection Case Report
SUPPLEMENTAL INVESTIGATION FORM 2008

Date Form Completed:___/___/____

Beginning in 2008, the Centers for Disease Control and Prevention (CDC) will collect surveillance data on selected underlying medical conditions and therapies that have previously been identified as risk factors for severe illness, hospitalization, and/or death among persons with WNV disease. Initial reports of WNV infections should be sent to the California Department of Public Health immediately after they have been confirmed. However, this supplemental investigation form is not time-sensitive and can be submitted at any time after a case has been reported.

Questions to Assess Underlying Medical Conditions and Medication Use

Patient Name (Last, First): _____ **DOB:**___/___/___

Clinical syndrome: ☐ Neuroinvasive disease ☐ West Nile fever ☐ Other clinical ☐ Asymptomatic infection

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

Diabetes ……....	☐ Yes	☐ No	☐ Unknown
High blood pressure (hypertension) ……..…	☐ Yes	☐ No	☐ Unknown
Heart attack (myocardial infarction) …….	☐ Yes	☐ No	☐ Unknown
Angina or coronary artery disease ……	☐ Yes	☐ No	☐ Unknown
Congestive heart failure (CHF) …….	☐ Yes	☐ No	☐ Unknown
Stroke ……	☐ Yes	☐ No	☐ Unknown
Chronic obstructive pulmonary disease (COPD) ..	☐ Yes	☐ No	☐ Unknown
Chronic liver disease …….....	☐ Yes	☐ No	☐ Unknown
Kidney failure or chronic kidney disease ……	☐ Yes	☐ No	☐ Unknown
Alcoholism ……	☐ Yes	☐ No	☐ Unknown
Bone marrow transplant ……	☐ Yes	☐ No	☐ Unknown
Solid organ transplant ……	☐ Yes	☐ No	☐ Unknown
If yes: What organ was transplanted?: _____			
What year was the transplant?: _____			
Cancer ……..	☐ Yes	☐ No	☐ Unknown
If yes: What type(s)?: _____			
What year were you diagnosed?: _____			
Are you currently being treated for cancer?:	☐ Yes	☐ No	☐ Unknown

2. Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection? ☐ Yes ☐ No ☐ Unknown

If yes: What condition(s)?: _____

3. At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?

Chemotherapy …….....	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer ……...……	☐ Yes	☐ No	☐ Unknown
Hemodialysis ……..…….	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease ……	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical) ...	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes ……	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure ……..	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease ….....	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure …….	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system ….	☐ Yes	☐ No	☐ Unknown

4. Which of the following sources provided the information above? (check all that apply)

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No

For questions regarding testing or specimens, call San Mateo Co. Disease Control & Prevention (650) 573-2346
Fax this form to (650) 573-2919 or mail to: San Mateo Co. Public Health Lab, 225 37th Avenue, San Mateo, Ca 94403

Lyme Disease

We know that many people in San Mateo County work and play in areas where the risk of tick exposure is high.

Lyme disease is caused by the bacterium *Borrelia burgdorferi*. In California, the infection is transmitted to humans by the bite of infected Western black legged ticks (*Ixodes pacificus*). 3-5% of nymphs and adult black-legged ticks in San Mateo County test positive for *Borrelia burgdorferi*.

Symptoms of Lyme Disease

Untreated, Lyme Disease symptoms become more severe over time. One to two weeks after infection, many to most people will exhibit **erythema migrans** (**EM**), a red, expanding rash radiating from the attachment site.

Other signs of early Lyme Disease may be mild and non-specific, or present as flu-like symptoms of fever, malaise, fatigue, headache, muscle and joint aches.

Late manifestations of Lyme Disease can occur days, weeks, or months after the appearance of the first EM lesion. Late disease affects the:

- **musculoskeletal system**, manifesting as migratory joint and muscle pain with or without obvious swelling
- **nervous system**, manifesting as meningitis, cranial neuropathy, and encephalopathy
- **cardiovascular system**, seen as myocarditis or acute onset of atrioventricular blocks of varying degrees.

Western black legged tick, responsible for carrying Lyme Disease in the Western US.

Lab testing for Lyme Disease:

Blood tests are indicated only if history, signs and symptoms are equivocal. If there has been exposure to Western black legged ticks and typical symptoms are present, antibiotics are generally started empirically. If testing is needed, antibody testing using a two-step procedure should be performed:

1. Initial test with ELISA or IFA. If positive do confirmatory test.

2. Confirm with Western Blot test: IgG and IgM if less than 4 weeks from onset; IgG alone if more than 4 weeks. Consult with an infectious disease specialist for any questions.

Laboratories have been required to report positive tests for Lyme disease to the Health Department since 2005. Be sure to send in a CMR as well, so that we have specific information on your patient.

Phone, fax, or mail within 1 week

(650) 573-2919 fax
Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

Prevention

Advise your patients to take tick precautions when walking outdoors from December to June: wear long-sleeved shirts tucked in to pants, pants tucked into boots or socks. Apply permethrin products to clothes and DEET to skin to repel ticks. Check clothes and skin frequently for several days after walking outdoors. Remove ticks with tweezers, grabbing the tick close to the skin and pulling straight out. **If ticks are removed within 24 hours of attachment, the chance of contracting Lyme disease is extremely low.**

Tick Testing Services

If your patient has removed a tick, it can be submitted to our Public Health Lab for identification. If the tick is determined to be of a species capable of transmitting Lyme Disease, it will be tested for *Borrelia burgdorferi*. Call (650) 573-2500 for instructions.

Suspected Avian Influenza

Early identification of any individual with H5N1 avian influenza will be vital to preventing its spread.

When evaluating patients with fever and respiratory symptoms, it is essential to consider the possibility of avian flu. If they meet either of the criteria listed below, they should be placed in respiratory isolation and tested for H5N1 influenza.

1) An illness that requires hospitalization or is fatal and,

2) has a documented fever >38°C (100.4°F) and,

3) has radiographically- confirmed pneumonia, acute respiratory distress syndrome (ARDS) or other respiratory illness with no alternate diagnosis established and,

4) has at least one of the following exposures within 10 days of symptom onset:

A. Travel to an area with documented avian (H5N1) influenza in poultry, wild birds and/or humans with at least one of the following: • Direct contact with (e.g. touching sick or dead domestic poultry); OR

- Direct contact with surfaces contaminated with poultry feces; OR
- Consumption of raw or incompletely cooked poultry or poultry products; OR
- Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1; OR
- Close contact (within 1 meter or 3 feet) of a person who was hospitalized or died due to unexplained respiratory illness.
- List country(ies) and dates of travel
- List details of suspect H5N1 poultry, wild bird or human exposure history:

B. Close contact (within 1 meter) of an ill patient who was confirmed or suspected to have H5N1; OR

C. Worked with live influenza H5N1 virus in a laboratory.

Testing for H5N1 virus

If H5N1 influenza is suspected, specimens should be obtained and sent to the Public Health Laboratory for sub-typing.

This should be done regardless of rapid flu test results, because the sensitivity of the rapid flu test is not high enough to rule out influenza.

Collect a naso-pharyngeal swab and a throat swab and send them on viral transport medium to the Health Laboratory.
Mark all respiratory specimens "Suspect Avian Flu" so that cultures will not be done.

A surgical mask and tissues should be given to any patient in your waiting area with a cough to protect other patients and staff.

Report to Disease Control and Prevention immediately!

(650) 573-2346 workdays, 8 am - 5 pm

(650) 363-4981 for after hours emergencies ask for the on-call Health Officer.

See the Avian Influenza Algorithm and Specimen Submittal Form on the next two pages for more specific information.

San Mateo County Health System

EMERGENCY DEPARTMENT/OUTPATIENT GUIDELINES FOR AVIAN INFLUENZA SPECIMEN COLLECTION AND TESTING

Patient enters ED/Clinic with cough:
Provide surgical mask to patient to wear over mouth and nose; provide facial tissue and hand sanitizer. Place in separate room if possible.

Test for avian influenza H5N1 virus infection for any patient who:

1. Has an illness that requires hospitalization or is fatal; **AND**
2. Has/had documented fever≥38˚; **AND**
3. Has radiographically confirmed pneumonia, ARDS or a severs respiratory illness for which an alternate diagnosis is not established; **AND**

Has at least one of the following potential exposures within 10 days of symptom onset:

1. Travel history to a county with documents avian (H5N1) influenza in poultry, wild birds, and/or humans (updated listing at http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm) **AND** at least one of the following potential exposures during travel:
   - Direct contact with sick or dead domestic poultry
   - Direct contact with surfaces contaminates with poultry feces
   - Consumption of raw or incompletely cooked poultry or poultry produces
   - Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1
   - Close contact (approximately 3 feet) of a person who was hospitalized or died due to a severe unexplained respiratory illness
2. Close contact of an ill patient with confirmed or suspected H5N1
3. Worked with live influenza H5N1 virus in a laboratory

Complete the California Department of Public Health screening form for suspect Avian (H5N1) Influenza (www.cdph.ca.gov/programs/vrdl/Documents/CA_AVFLU_Case_screeningform.pdf) and consult with the San Mateo County Disease Control and Prevention Unit. Call (650) 573-2346 Monday through Friday 8 am to 5 pm. After hours call (650) 363-4981; ask for the Health Officer.

Infection Control Measures

1. Place patient in strict respiratory isolation, preferably a negative pressure room. Health care workers should wear fit-tested N-95 respirators, gloves, gown, and eye protection, especially during bronchoalveolar lavage, which is considered to be a high-risk aerosol-generating procedure.
2. **DO NOT DISCHARGE** suspect avian flu cases without Health Department clearance. Outpatients or discharged patients must be isolated at home under a Health Officer Isolation Order that will be served to the patient by calling the Disease Control and Prevention Unit at (650) 573-2346 or the on-call Health Officer at (650) 363-4981 24/7.

PUBLIC HEALTH SPECIMEN COLLECTION GUIDELINES

- To improve diagnostic sensitivity, testing should be performed on multiple samples types. Oropharyngeal swab specimens and lower respiratory tract specimens (e.g. bronchalveolar lavage or tracheal aspirates) are preferred because they appear to contain the highest quantity of influenza A (H5N1) virus based on current data. Given that most human cases have presented with lower respiratory tract infections, the collection of only an upper respiratory specimen, particularly a single nasopharyngeal or nasal swab, is NOT recommended. Respiratory specimens are optimally collected within the first 3 days of illness onset. If possible, serial specimens should be obtained over several days from the same patient.

- **At a minimum the following should be collected:**
  1. Oropharyngeal swab specimens collected in 3 cc viral transport media (VTM**); AND**
  2. A nasopharyngeal swab OR nasopharyngeal wash OR nasopharyngeal aspirate collected in 3 cc viral transport media (VTM)**; AND**
  3. Any specimen(s) from the lower respiratory tract (e.g., sputum, bronchoalveolar lavage, tracheal aspirate or pleural fluid tap).
     - Oropharyngeal swabs may have better yield than nasopharyngeal specimens. While both types of specimens should be collected, an oropharyngeal swab should be performed preferentially if only one sample can be taken.
     - In outpatient settings, it may be difficult to obtain samples from the lower respiratory tract in children. In these instances, two specimens from the upper respiratory tract (e.g. a nasopharyngeal wash and a throat swab) are acceptable.

- **Collecting specimens from the upper respiratory tract**
  1. **Nasopharyngeal wash/aspirate**
     - Have the patient sit with head tilted slightly backward.
     - Instill 1 ml–1.5 ml of nonbacteriostatic saline (pH 7.0) into one nostril. Flush a plastic catheter or tubing with 2 ml–3 ml of saline. Insert the tubing into the nostril parallel to the palate. Aspirate nasopharyngeal secretions. Repeat this procedure for the other nostril.
     - Collect the specimens in sterile vials.
     - For shipping, use cold packs to keep the sample at 4°C.

  2. **Nasopharyngeal or oropharyngeal swabs**
     - Use only sterile dacron swabs with aluminum or plastic shafts. Do **not** use calcium alginate or cotton swabs or swabs with wooden sticks, as they may contain substances that inactivate some viruses and inhibit PCR testing.
     - To obtain a **nasopharyngeal swab**, insert a swab into the nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nostrils.
     - To obtain an **oropharyngeal swab**, swab the posterior pharynx and tonsillar areas, avoiding the tongue.
     - Place each swab immediately into two separate sterile vials containing 2 ml of viral transport media (VTM, either commercially available, herpes buffere tryptose gelatin meium or Hanks' balanced salt solution with gelatin). Break the applicator sticks off near the tip to permit tightening of the cap. Place at

4°C immediately after collection.
- For shipping, use cold packs to keep the sample at 4°C.

- **Collecting specimens from the lower respiratory tract**
  1. **Broncheoalveolar lavage, tracheal aspirate, or pleural fluid tap**
     - During bronchoalveolar lavage or tracheal aspirate, use a double-tube system to maximum shielding from oropharyngeal secretions.
     - Place the unspun fluid in sterile vials with external caps and internal O-ring seals. If there is no internal O-ring seal, then seal tightly with the available cap and secure with Parafilm®.
     - For shipping, use cold packs to keep the sample at 4°C.

  2. **Sputum**
     - Educate the patient about the difference between sputum and oral secretions.
     - Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile screw-cap sputum collection cup or sterile dry container.
     - For shipping, use cold packs to keep the sample at 4°C.

- **BLOOD COMPONENTS (optional)**
  Collection of sera for serologic testing for influenza as well as other respiratory viruses can be considered, but should not replace collection of respiratory specimens, which are highly recommended for influenza A (H5N1) testing. Serologic testing for influenza H5N1-specific antibody can be considered if other influenza H5N1 diagnostic testing methods are unsuccessful (for example, due to delays in respiratory specimen collection). For serologic testing, paired blood samples are ideal. Collect an acute phase blood specimen (5-10 ml whole clotted blood) on each patient within the first week of illness, complete a San Mateo County Public Health Lab Specimen Submittal Form for Suspect Avian Influenza A (H5N1), and schedule patient to return in 14-21 days for a convalescent blood specimen. A demonstrated rise in the H5N1-specific antibody level is required for a diagnosis of H5N1 infection. Serum specimens will be forwarded to the Centers for Disease Control and Prevention where the micro-neutralization assay, which requires live virus, can be performed to test for H5N1-specific antibody.

  1. **To collect serum for antibody testing:**
     - Collect 5 ml–10 ml of whole blood in a serum separator tube. Allow the blood to clot, centrifuge briefly, and collect all resulting sera in vials with external caps and internal O-ring seals. If there is no internal O-ring seal, then seal tightly with the available cap and secure with Parafilm®.
     - The minimum amount of serum preferred for each test is 200 microliters, which can easily be obtained from 5 ml of whole blood. A minimum of 1 cc of whole blood is needed for testing of pediatric patients. If possible, collect 1 cc in an EDTA tube and in a clotting tube. If only 1cc can be obtained, use a clotting tube.
     - If unfrozen, ship with cold packs to keep the sample at 4°C. If frozen, ship on dry ice.

Revised 8/13/07

SAN MATEO COUNTY PUBLIC HEALTH LABORATORY

Specimen Submittal Form for Suspect Avian Influenza A (H5N1)

To improve diagnostic sensitivity, testing should be performed on multiple samples types collected over several days. Given that most human cases have presented with lower respiratory tract infections, the collection of only a upper respiratory specimen, particularly single nasopharyngeal or nasal swabs, is **NOT** recommended.

- **MINIMUM SPECIMEN REQUIREMENTS INCLUDE THE FOLLOWING:**
  1. Oropharyngeal swab specimens collected in 3 cc viral transport media (VTM); AND
  2. A nasopharyngeal swab OR nasopharyngeal wash OR nasopharyngeal aspirate collected in 3 cc viral transport media (VTM)*; AND
  3. Any specimen(s) from the lower respiratory tract** (e.g., sputum, bronchoalveolar lavage, tracheal aspirate or pleural fluid tap).

  * An oropharyngeal swab may be more likely than a nasopharyngeal swab to yield a positive result. While both an oropharyngeal swab and nasopharyngeal specimen should be collected, an oropharyngeal swab should be performed preferentially if only one sample can be taken.
  ** In outpatient settings, it may be difficult to obtain samples from the lower respiratory tract in children. In these instances, two specimens from the upper respiratory tract (e.g. a nasopharyngeal wash and a throat swab) are acceptable.

- Each specimen should be labeled with ***date of collection***, ***specimen type***, and ***patient name***. Because culture is not recommended in these cases, please note clearly on the form that this is a suspect case of avian influenza A (H5N1).
- Specimens should be sent **cold** using an overnight courier.
- Send to: San Mateo County Health System
  Public Health Laboratory
  225 37th Ave.
  San Mateo, CA 94403
- Please do not send specimens on a Friday. Refrigerate over the weekend & send on Monday.

IMPORTANT: please complete the form below and submit with specimens

Patient's last name, first name			Patient's mailing address (including Zip code)	Route to:
Age or DOB:	Sex (circle): M F	Onset Date:	**This section for Virus Laboratory use only. Date received by VRDL and State Accession Number**	[ ] SERO [ ] ISOL [ ] FA [ ] _____ [ ] _____ [ ] _____ [ ] _____
1st	Specimen type and/or specimen source	Date Collected	1st	
2nd	Specimen type and/or specimen source	Date Collected	2nd	
3rd	Specimen type and/or specimen source	Date Collected	3rd	
4th	Specimen type and/or specimen source	Date Collected	4th	
Please provide clinical findings and/or pertinent laboratory data				

Questions? Call Bruce Fujikawa, Dr.P.H. at (650) 573-2500

Submitter: _____ Phone: _____ Fax: _____

CALIFORNIA CASE REPORT FORM FOR LABORATORY-CONFIRMED AVIAN (H5N1) INFLUENZA

- For use in the World Health Organization Pandemic Phase 3 (no or very limited human-to-human transmission)
- Refer to http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm and click on "GRAPH" at the top for a list of affected countries.
- Please report any suspect or laboratory-confirmed cases to the San Mateo County Disease Control and Prevention at (650) 573-2346 or San Mateo County On-call Health Officer 24/7 at (650) 363-4981.

FAX completed form to (650) 573-2919

Date of Initial report to LHD: _____/_____/_____ **State ID#_____**

Section 1. Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____

Current Street Address: _____

Current Residence City: _____State: _____ County: _____

Home telephone: _____ Work telephone: _____

Age at onset: _____ ☐ Years ☐ Months Date of Birth ___/___/___ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ African-American/Black ☐ White ☐ Other ☐ Unk

Nationality/Citizenship: _____ Residency: ☐ U.S. Resident ☐ Non-U.S. Resident

Specify patient occupation: _____

Is individual a health care worker with close contact to patients, patient care areas or patient care items (e.g., linens or clinical specimens)?

☐ Yes ☐ No ☐ Unk *If yes*, specify:

Health care worker type: ☐ Physician ☐ Nurse/ PA ☐ Laboratory ☐ Other _____

Place of employment: ☐ Hospital ☐ Long Term Care Facility ☐ Laboratory ☐ Ambulatory Care ☐ Other_____

Does patient have DIRECT patient care responsibilities? ☐ Yes ☐ No ☐ Unk

Section 2. Risk Factors for Influenza Complications

☐ Cardiac disease _____

☐ Chronic lung disease (e.g, asthma) _____

☐ Chronic metabolic/renal disease (e.g., diabetes) _____

☐ Chronic neurologic disease (e.g. seizure disorder) _____

☐ Immunosuppression (e.g., HIV, transplant, malignancy, steroids) _____

☐ Child < 18 yrs old on chronic aspirin therapy _____ ☐ Hemoglobinopathy (e.g., SCD) _____

☐ Pregnancy (note 1st, 2nd or 3rd trimester) _____ ☐ Nursing home resident / institutionalized _____

☐ Other underlying illness (specify): _____

Section 3. Signs and Symptoms

Date of initial symptom onset: _____/_____/_____

Fever (subjective or objective): ☐ Yes ☐ No ☐ Unk

If yes, date of fever onset: _____/_____/_____ ***If yes,* temperature >38º C (>100.4º F):** ☐ Yes ☐ No ☐ Unk

Influenza-associated symptoms: ☐ Chills ☐ Rigors ☐ Myalgias ☐ Headache ☐ Sore throat ☐ Runny nose/congestion

☐ Conjunctivitis ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Bloody respiratory secretions ☐ Otitis ☐ Diarrhea

☐ Nausea/vomiting ☐ Abdominal pain ☐ Apnea ☐ Lethargy ☐ Altered mental status ☐ Other: _____

Complications: ☐ Viral pneumonia ☐ Encephalitis ☐ Myocarditis ☐ Seizures ☐ Sepsis ☐ Reyes Syndrome

☐ Multi-organ failure ☐ 2º bacterial pneumonia ☐ Other_____

Antiviral medications: ☐ Yes ☐ No ☐ Unk

If yes, specify: ☐ Amantadine ☐ Rimantadine ☐ Oseltamivir ☐ Zanamavir Dose: _____

Date started: ____ /_____/_____ Date completed: ____ /_____/_____

Received flu vaccine for current/most recent season: ☐ Yes ☐ No ☐ Unk *If yes*, specify date: ____/_____/_____

Comments: _____

CDHS ID#: _____

Section 4. Clinical Status

Date of first clinical evaluation for this illness: ____ /____/____

Laboratory results (note most abnormal value): Hct: _____ Platelet: _____ WBC: _____ Differential: _____

AST: _____ ALT: _____ Alk phos: _____ Tbili: _____ LDH: _____ CPK: _____ BUN: _____ Creatinine: _____

Was a chest X-ray or chest CAT scan performed? ☐ Yes ☐ No ☐ Unk
If yes, date: _____ /_____/_____
If yes, was there evidence **of pneumonia or respiratory distress syndrome**? ☐ Yes ☐ No ☐ Unk
Comments/interpretation: _____

Was the patient **hospitalized for > 24 hours?** ☐ Yes ☐ No ☐ Unk
If yes: Name of hospital: _____ Medical Record Number:_____
City: _____ County/State: _____
Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____

Was the patient seen or transferred from another clinic or facility after first symptom onset? ☐ Yes ☐ No ☐ Unk
If yes, clinic or facility name: _____ Dates seen/hospitalized: _____/_____/_____ - _____/_____/_____
(If more, please list on back of page).

Was the patient ever in the ICU? ☐ Yes ☐ No ☐ Unk
Was the patient ever on mechanical ventilation? ☐ Yes ☐ No ☐ Unk

Did the patient **die** as a result of this illness? ☐ Yes ☐ No ☐ Unk
If yes, date of death: _____/_____/_____
If yes, was an autopsy performed? ☐ Yes ☐ No ☐ Unk
If yes, please forward autopsy report.

Pathologist name: _____ Phone number: _____

Section 5. Avian (H5N1) Influenza Epidemiological Risk Factors

In the 10 days prior to symptom onset:

1. Did the patient travel to an area with documented avian (H5N1) influenza in poultry, wild birds and/or humans?
   ☐ Yes ☐ No ☐ Unk *If yes,* complete section 6.
2. Did the patient have history of any of the following exposures in an H5N1-affected country?
   a. Direct contact with (e.g. touching) sick or dead domestic poultry* ☐ Yes ☐ No ☐ Unk
   b. Consumption of raw or incompletely cooked poultry* or poultry* products ☐ Yes ☐ No ☐ Unk
   c. Direct contact with surfaces contaminated with poultry* feces ☐ Yes ☐ No ☐ Unk
   d. Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1 ☐ Yes ☐ No ☐ Unk
   e. Close contact (within 1 meter) of a person who was hospitalized or died due to unexplained respiratory illness ☐ Yes ☐ No ☐ Unk
3. Did the patient come in close contact (within 1 meter) of an ill patient who was confirmed or suspected to have H5N1
   ☐ Yes ☐ No ☐ Unk *If yes*, please fill out source case information in ANNEX 1.
4. Did the patient work with live influenza H5N1 virus in laboratory? ☐ Yes ☐ No ☐ Unk *If yes*, please give further detail below.

Comment on exposures listed above: _____

_____

_____

*The definition of poultry is domestic fowls, such as chickens, turkeys, ducks, or geese, raised for meat or eggs.

Section 6. Travel History

Complete if travel to area with documented or suspected transmission of H5N1 in birds or humans. Use additional pages if necessary.

Leg 1

Departure Date: ____/____/____ Departure City/Country: _____

Arrival Date: ____/____/____ Arrival City/Country: _____

Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____

Transport company: _____ Transport number: _____

Residence at arrival city (e.g., hotel, relative's home):_____ Purpose/activities:_____

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: _____

Section 6 continued:

Leg 2

Departure Date: ____/____/____ Departure City/Country: _____

Arrival Date: ____/____/____ Arrival City/Country: _____

Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____

Transport company: _____ Transport number: _____

Residence at arrival city (e.g., hotel, relative's home):_____ Purpose/activities:_____

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: _____

Leg 3

Departure Date: ____/____/____ Departure City/Country: _____

Arrival Date: ____/____/____ Arrival City/Country: _____

Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____

Transport company: _____ Transport number: _____

Residence at arrival city (e.g., hotel, relative's home):_____ Purpose/activities:_____

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: _____

Section 7. Local Clinic/Hospital Laboratory Results

*****NOTE: VIRAL CULTURE SHOULD NOT BE PERFORMED IN SUSPECT AVIAN INFLUENZA CASES*****

☐ Rapid influenza test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

If positive, result: ☐ Influenza A ☐ Influenza B ☐ Influenza A/B, not distinguished

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify _____

Test performed: ☐ Directigen Flu ☐ FLU OIA ☐ QuickVue Influenza Test ☐ ZstatFlu ☐ NOW Flu Test

☐ Rapid RSV test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ Respiratory culture: ☐ Neg ☐ Pos ☐ Unk Organism isolated: _____ Collection Date: _____/_____/_____

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ Blood culture: ☐ Neg ☐ Pos ☐ Unk Organism isolated: _____ Collection Date: _____/_____/_____

☐ Other test results:

Test: _____ Result: _____ Collection date: _____/_____/_____

Test: _____ Result: _____ Collection date: _____/_____/_____

Were other respiratory co- pathogens/bacterial infections detected in the patient? ☐ Yes ☐ No ☐ Unk

If yes, indicate which pathogen(s): _____

Comments: _____

CDHS ID#: _____

Section 8. Local Public Health Laboratory Results

Influenza A Results (check all tests that were performed):

☐ Rapid influenza test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

Test performed: ☐ Directigen Flu ☐ FLU OIA ☐ QuickVue Influenza Test ☐ ZstatFlu ☐ NOW Flu Test

☐ DFA: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ PCR for influenza ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

If subtyping available: ☐ H1 positive ☐ H3 positive ☐ H5 positive ☐ untypeable ☐ other, specify _____

Were respiratory co-pathogens other than influenza A detected by PCR or other testing? ☐ Yes ☐ No ☐ Unk

If yes, check pathogen: ☐ influenza B ☐ RSV ☐ adenovirus ☐ human metapneumovirus ☐ other _____

Method of detection: ☐ EIA ☐ DFA ☐ PCR ☐ other, specify _____

Comments: _____

Section 9. Trace Forward Contact Information

Trace –forward contact information refers to those individuals the patient has had contact with **since** becoming ill. In WHO Pandemic Phase 3, CDPH recommends that information be collected on all "trace-forward" contacts for the purposes of symptom monitoring, laboratory testing and possible administration of antiviral medication. A sample template for recording trace-forward contact information is provided in Annex 2.

Section 10. Submitted by:

Last Name: _____ First Name: _____ Phone: (____)_____

Affiliation: _____ County: _____Fax:_____ E-mail: _____

If you would like to consult with a member of the avian influenza team at CDHS, please contact the CDHS Duty Officer of the Day, or the CDPH Viral and Rickettsial Disease Laboratory (Janice Louie or Carol Glaser).

Section 11. Additional Comments

CDHS ID#: _____

Annex 1. Source Case Information

Please complete Annex 1 to provide source case information for a patient with *any* history of contact with a known or suspected human case of influenza A (H5N1) within 10 days of symptom onset.

Was the source case a laboratory-confirmed case of influenza A (H5N1)? ☐ Yes ☐ No ☐ Unk

List country/area(s) where contact with the source case occurred: _____

_____

Name: _____ Age:_____ ☐ Years ☐ Months Gender: ☐ Male ☐ Female

Address: _____

City/Province: _____ Telephone: (____)_____

Nature of contact: ☐ Household ☐ Co-worker ☐ Health care ☐ Other, specify _____

Please describe the nature of the contact: _____

Date of patient's last exposure to source case: _____/_____/_____

Comments: _____

_____

_____

ANNEX 2: AVIAN INFLUENZA A (H5N1) CONTACT FOLLOW-UP SHEET

For use in WHO Pandemic Phase 3

For each contact to a laboratory-confirmed influenza A (H5N1) case, record the information itemized below. Besides household contacts, consider best friends and the information they can provide about contacts that the case may have had. Medical personnel who had contact with the case's oral secretions should also be reported.

Full Name of Contact/Associate Last First	DOB or Age	Type of Contact[1]	Contact Information Phone Number Address	Symptoms[2]	Influenza Test Result		Antivirals		Vaccinated	Quarantined	Isolation
							Prophylaxis	Treatment			
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________	Yes Date: ________ Drug: _____________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND	No Reason: _______ __________________	No Reason:_______ __________________			
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________	Yes Date: ________ Drug: _____________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND	No Reason:_______ __________________	No Reason:________ __________________			
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________	Yes Date: ________ Drug: _____________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND	No Reason:________ __________________	No Reason:________ __________________			
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________	Yes Date: ________ Drug: _____________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND	No Reason:________ __________________	No Reason:________ __________________			

1. Type of contact:
(1) Health care worker (HCW) providing direct patient care to suspect cases;
(2) Close contacts: persons in close proximity (1 meter) and with prolonged exposure to the case such as those who have shared a defined setting (household, extended family, hospital or other residential institution);
(3) Close contacts: persons who otherwise had direct contact with respiratory, oral or nasal secretions (e.g. face to face during coughing or sneezing, sharing water bottles or kissing) during the infectious period (1 day prior to symptom onset to 14 days after symptom onset).

2. Symptoms: Monitor for fever and/or respiratory symptoms for 10 days after the last date of exposure to the confirmed case.
- Close contacts/HCWs with fever should be placed on isolation precautions for suspect H5N1 patients. After specimen collection, treat with antivirals on the assumption of H5N1 infection; complete clinical evaluation.
- Close contacts/HCWs with respiratory symptoms but no fever should remain at home in isolation until H5N1 is ruled out by laboratory testing. Decisions on whether to treat a close contact/HCW with other symptoms but no fever should be made on a case-by-case basis but a specimen should be collected prior to treatment. Consider arranging for H5N1 testing if respiratory symptoms are present.
- Consider post-exposure prophylaxis for asymptomatic close contacts/HCWs who have had an unprotected exposure to infectious aerosols or other secretions. Collect appropriate specimens prior to starting treatment.
- If testing of contact is positive for H5N1, fill out a new case report form. Continue precautions for 14 days post-onset and if not already done, start treatment with antivirals for case and treat complications, as indicated

Annex 3. **(To be filled out by DHS personnel)**

VRDL Results:

☐ DFA: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum
☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ PCR for influenza ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum
☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid
☐ biopsy/autopsy tissue, specify source_____
☐ other specimen type, specify_____

Subtyping result: ☐ H1 positive ☐ H3 positive ☐ H5 positive ☐ untypeable ☐ other _____

☐ PCR for other pathogens ☐ Neg ☐ Pos ☐ Not done ☐ Unk

If yes, check pathogen: ☐ influenza B ☐ RSV ☐ adenovirus ☐ human metapneumovirus ☐ parainfluenza 1-3
☐ enterovirus ☐ coronavirus ☐ Legionella ☐ Chlaymdia ☐ Mycoplasma
☐ other _____

☐ Other test results:

Test: _____ Result: _____ Collection date: _____/_____/_____

Test: _____ Result: _____ Collection date: _____/_____/_____

Notes: _____

_____

_____

_____

CDC Results (if available):

Date of specimen: ____/_____/____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ endotracheal asp
☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid ☐ blood/serum
☐ biopsy/autopsy tissue, specify source _____
☐ other specimen type, specify_____

Results:_____

_____

_____

CDC Contact:

Last Name: _____ First Name: _____ Phone: (____)_____

E-mail: _____ Date reported to CDC: _____/____/_____ CDC ID#: _____

Suspected Bioterrorism (BT)

Bioterrorism agents are likely to cause acute outbreaks of unusual syndromes or they can present common illnesses in an unusual setting like the "wrong" season or geographic area. Health care providers are likely to be the first to identify a case related to bioterrorism. If you can check one or more boxes in both categories below (syndrome and setting), consider BT. If you have any suspicion that a situation is related to bioterrorism, call us immediately.

Syndrome

- ☐ Acute severe pneumonia or respiratory distress
- ☐ Encephalopathy
- ☐ Acute onset of neuromuscular symptoms
- ☐ Unexplained rash with fever
- ☐ Fever with mucous membrane bleeding
- ☐ Unexplained acute icteric syndrome
- ☐ Massive diarrhea, dehydration, and collapse

Setting

***Atypical host characteristics*:**

- ☐ Patient <50 years old
- ☐ Immunologically intact
- ☐ No underlying illness
- ☐ No recent travel or unusual exposure

***Serious, unexplained, acute illness*:**

- ☐ Abrupt onset
- ☐ Prostration
- ☐ Cardiovascular collapse
- ☐ Respiratory distress
- ☐ Obtundation
- ☐ Change in mental status
- ☐ Disseminated intravascular coagulation

***Multiple cases with same symptoms, especially if*:**

- ☐ Geographically associated
- ☐ Closely clustered in time

***Out of season syndromes, such as*:**

- ☐ Influenza-like illness during summer

Phone Disease Control and Protection immediately!

(650) 573-2346 workdays
(650) 363-4981 after hours, weekend, & holidays

Public Health Lab

(650) 573-2500 for specimen submission.

Preventing panic

If you suspect bioterror, recognize the possible **psychological impact** of premature public disclosure of your findings.

Limit discussion with your staff on a **need-to-know basis** so they can prepare your organization and your day's patients. When you call us with your report, do so in private. After all, we all hope it turns out to be a false alarm.

Please do not talk to the **media** - refer them to Public Health officials.

If you maintain a **calm demeanor**, so will your associates and patients. Battling a bioterror agent is work enough without the complications of rumors and hysteria.

For up-to-date, detailed information on bioterrorism, go to http://www.bt.cdc.gov

BT Categories and Resources

Bioterrorism agents are classified into three main categories, ranked in order of potential threat:

Category A

These are the Big 6 in bioterror: anthrax, botulism, plague, smallpox, tularemia, and viral hemorrhagic fevers (Ebola, Crimean-Congo, Lassa, or Marburg viruses).

Category A agents are considered highest risk because they:

- can be easily disseminated or transmitted from person to person
- result in high mortality rates and have the potential for major public health impacts
- cause panic and social disruption
- require special public health preparedness (for example, your reading this document right now).

Category B

Diseases and agents in this category have these properties:

- moderately easy to disseminate
- moderate morbidity rates and low mortality rates
- require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance.

Examples in this category include: brucellosis, glanders, Q fever, typhus fever, psittacosis, and viral encephalitis. Also included are food safety threats like E. coli O157:H7, salmonella, and shigella; water safety threats like cryptosporidium and cholera; and the toxins ricin and Epsilon toxin of Clostridium perfringens.

Category C

These are emerging pathogens that could be bio-engineered for mass dissemination. These agents:

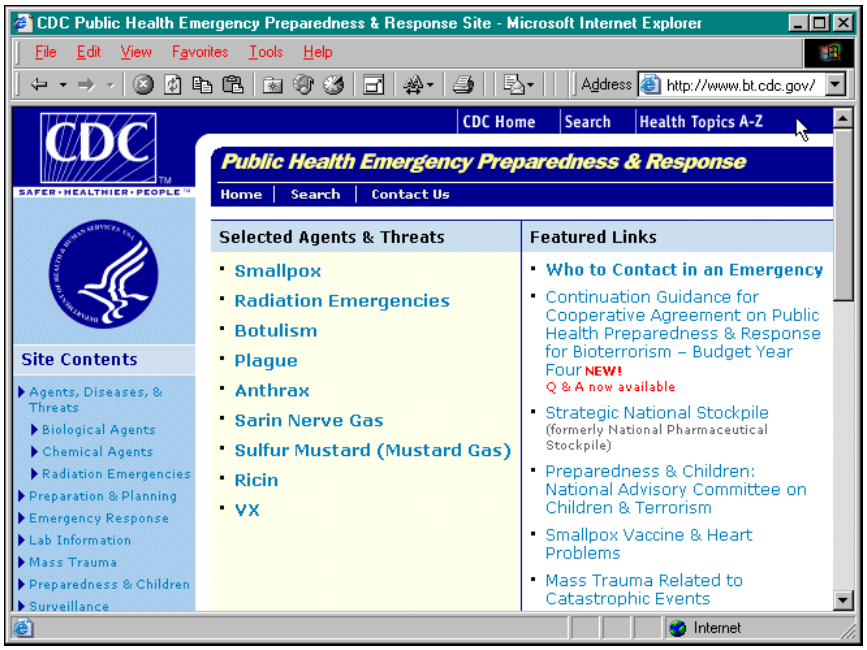
- are readily available
- are relatively easy to produce and disseminate
- have the potential for high morbidity and mortality rates and major health impacts.

Examples include emerging diseases such as Nipah virus and hantavirus.

Staying current

Information about BT agents is constantly evolving. Stay up to date by visiting the following authoritative websites:

www.bt.cdc.gov



Website of the federal **Centers for Disease Control & Prevention (CDC)**, which leads the nation's public health emergency preparedness and response.

www.usamriid.army.mil/education/instruct.html
BT reference library maintained by the US Army Medical Research Institute of Infectious Diseases.

www.dhs.ca.gov/ps/dcdc/bt/pdf/CA_BT_Surv_Epi_Plan-2002b.pdf
The detailed **Bioterrorism Surveillance and Epidemiologic Response Plan** prepared by California Department of Health Services.

Note: *Web addresses above may change, so if you don't find a specific web page, try going to the organization's home page and drilling down from there.*

CDC Bioterrorism Hotline
(770) 488-7100

SELECTED COMMUNICABLE DISEASES: GUIDELINES FOR REPORTING AND MANAGEMENT OF CASES AND CONTACTS

Persons with a communicable disease or their contacts may spread disease through the community as a result of their work duties or participation in group activities. Special restrictions, therefore, may apply. If necessary, persons in sensitive occupations or situations (SOS) shall be removed from these activities as long as they are still contagious. The Disease Control & Prevention Unit of the San Mateo County Public Health Department is responsible for supervising the restriction of infected persons and contacts in sensitive occupations or situations.

Persons employed in ***sensitive occupations*** may include health care providers, commercial food and milk handlers, teachers, child care workers, those treating, cooking for or caring for others, and other persons whose duties appreciably increase the risk of disease transmission.

Persons in ***sensitive situations*** may include: child care or nursery school children, patients in facilities for the developmentally disabled, frail elderly, immunosuppressed and institutionalized individuals, or others with selected contagious diseases.

Non-urgent communicable diseases should be reported by fax, phone or mail to:

San Mateo County DCPS
Attn: Morbidity Clerk
225 37th Avenue
Tel. 650.573.2346
Fax 650.573.2919

Please note that these guidelines address the Public Health aspects of infections. For current information on care of individual patients, consult with standard texts or specialists. Before prescribing or administering any vaccine or medication, check for contraindications and precautions.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Botulism *(infant, foodborne, wound)*			
Report immediately by phone – **Notify Health Officer on Call**	Usually 12-36 hrs after eating contanminated food; sometimes several days afterward. Wound botulism occurs within days of entry of bacteria.	**Foodborne** & **wound**: equine serum trivalent botulinum antitoxin[1] **Infant**: Human-derived botulinum immune globulin (called BIG – iv or Baby Big) if given early in course[2]	There is no evidence of person-to-person transmission. Close medical observation for anyone who ate incriminated foods.
Campylobacteriosis			
Report within 1 working day	2-5 days avg. (1-10 days range) (dose-dependent)	Case investigation will not be routinely performed, and will depend on specific circumstances (outbreaks). In cases involving food handlers, case management may involve excluding from work until asymptomatic and one negative stool.	Contact management depends on individual circumstances. In some cases, symptomatic contacts may be removed from work until asymptomatic with 1 negative stool.
Chickenpox *(varicella)*			
Only report *varicella hospitalizations and deaths* – **report** within 1 working day	14-16 days avg. (2-3 wks. range)	Isolate for at least 5 days after rash onset or until all vesicles become crusted over.	No restrictions. Susceptible unless immunized or history of disease. Refer immunocompromised people and pregnant women to physician immediately for passive immunization with varizag.
Chlamydia (CT)			
Report within 7 calendar days **For more information on Chlamydia treatment, call the STD Control Program at 650.573.2346.**	Probably 7-14+ days	All cases and sexual contacts should refrain from unprotected sexual activity until treatment 1 week post. Evaluate for other STI's. If symptomatic, treat presumptively for gonorrhea as well as Chlamydia.	Examine, test & treat anyone who had sex with the patient during the 60 days preceding the patient's diagnosis or onset of symptoms. Monitor infants born to mothers with chlamydia and treat them if infection develops.

1 Available from CDPH (510.620.3434) or the CDC (404.639.3670).
2 To obtain human-derived Botulinum Immune Globulin, call the Infant Botulism Prevention Program (510.540.2646).
SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Diptheria			
Report immediately by phone	2-5 days, sometimes longer	Immediate hospitalization. Treat with antibiotics and antitoxin[1]. Strict isolation until cleared by DCP.	**Test & prophylax all contacts regardless of immunization status.** Exclude contacts in SOS until negative nose and throat culture results obtained. Observe contacts carefully for 7 days after last exposure.
E. coli: shiga toxin producing (STEC) including E coli: 0157:H7			
Report immediately by phone	3-4 days avg. (2-8 days range)	If symptomatic and in SOS exclude from SOS until 2 consecutive negative specimens obtained (not less than 24 hrs apart and at least 48 hours after completion of antibiotic therapy, if given). Requires clearance from DCP to return to work.	
Giardiasis			
Report within 7 calendar days	7-10 days avg. (3-25+ days range)	Case investigation will not be routinely performed, and will depend on specific circumstances (outbreaks). In cases involving food handlers, case management may involve excluding from work until 5 days of treatment is completed and diarrhea resolved.	Case investigation will not be routinely performed, and will depend on specific circumstances (outbreaks). In some cases, symptomatic contacts may be tested to rule out infection.

[1] Antitoxin available from CDPH at 510.620.3434 or CDC 404.639.8200.

SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Gonorrhea (GC)			
Report within 7 calendar days **For more information on gonorrhea treatment, call the STD Control Program at 650.573.2346.**	2-7 days	All cases and sexual contacts should refrain from unprotected sexual activity until 1 week post treatment. Treat for Chlamydia as well as GC.	See www.cdc.gov/std Examine, test & treat anyone who had sex with the patient during the 60 days preceding the patient's diagnosis or onset of symptoms. Treat all infants born to mothers with gonococcal infections. Prophylax all infants after birth with ophthalmic ointment (erythromycin). **Note: Fluoroquinolones are no longer recommended for treatment of GC in fections in California due to resistance to this class of drugs.**
Haemophilus influenzae, *invasive disease (e.g., HIB meningitis)*			
Report within 1 working day if patient is less than 15 years of age.	Probably 2-4 days	Isolate until 24 hrs of antibiotic therapy is completed. Give rifampin or equivalent antibiotic prior to hospital discharge to eliminate nasal carriage.	If household has one or more infants (< 12 mo. of age) other than index case or inadequately-immunized 1-3 y/o child, prophylax all household contacts (adults & children). Rifampin prophylaxis of staff & children in daycare classrooms is discretionary when 1 case has occurred, but is recommended when 2 or more cases of invasive disease have occurred within 60 days. Observe all contacts under 6 years of age for signs of illness.
Hepatitis A			
Report within 1 working day	Average 28-30 days (15-50 days range)	Exclude from SOS during illness and for 1 week after onset of jaundice.	No restrictions. Contacts are susceptible unless they are immunized or have a history of disease. Susceptible household and/or other close contacts should receive Hepatitis A vaccine and/or immune globulin depending on their age and immune status within 2 weeks of last exposure.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Hepatitis B			
Report within 7 calendar days (specify acute vs. chronic when reporting)	Average 2-3 months (variable)	No restrictions. Use universal blood/body fluid precautions.	No restrictions. Contacts are susceptible unless they are immunized or have a history of disease. Vaccinate with HBV vaccine & HBIG: 1) infants born to HBsAg+ mothers within 12 hrs of birth 2) sexual contacts to acute cases (if > 2 wks. since last exposure or exposure to chronic carrier, give HBV vaccine only) 3) other percutaneous transmucosal exposure to known infectious blood within 24 hrs.
Hepatitis C			
Report within 7calendar days (specify acute vs. chronic when reporting)	Average 40 days (2 wks. - 6 mo. range)	No restrictions. Use universal blood/body fluid precautions.	No restrictions.
Measles *(rubeola, 10-day measles, hard measles)*			
Report within 1 working day	About 10 days But may be 7 to 18 days from exposure to onset of fever, usually 14 days until rash appear; rarely as long as 19-21 days.	Isolate until 5 days after rash onset.	Susceptible unless adequately immunized or history of disease. Vaccinate susceptibles within 72 hours with live virus vaccine. If immuniized or pregnant, may give IG within 6 days of exposure, preferably within 72 hours for maximum protection.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Meningococcal infections			
Report immediately by phone	Average 3-4 days (2-10 days range)	Respiratory isolation for 24 hours after start of chemo treatment. Give rifampin or offer appropriate equivalent antibiotic prior to hospital discharge to eliminate nasal carriage.	Prophylax household, child care center and other intimate contacts with rifampin, or ciprofloxacin (ceftriaxone if pregnant) preferably within 24 hours of diagnosis of primary case. Observe contacts carefully for development of febrile illness.
Mumps			
Report within 7 calendar days	Average 15-18 days (14-25 days range)	Respiratory isolation for 9 days after onset of karotitis.	Susceptible unless immunized, history of disease or born before 1957. Exclude susceptibles from school or workplace from 12th-25th day after exposure.
Pertussis *(whooping cough)*			
Report within 1 working day	Average 9-10 days (range 6-20 days).	Isolate for 3 weeks after paroxysmal cough onset or 5 days of appropriate antibiotic treatment.	**Prophylax household & close contacts regardless of age and immunization status within 21 days of exposure.** Immunize if under 7 and received less than 4 doses of a pertussis-containing vaccine (e.g., DTaP) or 4th dose ≥ 3 years ago. Carefully observe for respiratory symptoms for 21 days after last contact.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Plague *(Yersinia pestis)*			
Report immediately by phone **Notify or call Health Officer immediately.**	1-7 days. 1-4 days in pneumonic plague.	Pneumonic plague: strict isolation with precautions against airborne spread until 48 hours of effective antibiotic therapy completed and clinical improvement. Bubonic plague: drainage and secretion precautions are indicated for 48 hours after start of effective treatment. Rid all patients, their clothing and baggage of fleas.	Prophylax household or face-to-face contacts of all of pneumonic plague. Observe carefully for 7 days after last exposure. If contact refuses prophylaxis, strict isolation for 7 days.
Rabies, *human or animal*			
Report immediately by phone **Notify or call Health Officer.**	3-8 weeks average. (9 days - 7 years range)	See **Rabies Post-exposure Prophylaxis Guide** on page II.D.2.	
Rubella *(German measles)*			
Report within 7 calendar days	14-17 days average. (14-21 days range)	Isolate for 7 days after rash onset.	Susceptible unless immunized or history of disease. Refer to MD if contacts are pregnant or immunocompromised.
Salmonellosis *(other than typhoid fever)*			
Report within 1 working day	*12-36 hours average.* *(6-72 hrs range)*	*Exclude case from SOS until 2 consecutive negative specimens obtained (not less than 24 hours apart and at least 48 hours after completion of antibiotic therapy, if given). Requires clearance from DCP to return to work in SOS.*	Test all symptomatic contacts. Exclude symptomatic contacts from SOS until 2 consecutive negative specimens obtained (not less than 24 hrs apart and at least 48 hours after completion of antibiotic therapy, if given).

SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Shigellosis			
Report within 1 working day	1-3 days average. (12-96 hours range)	Exclude from SOS until 2 consecutive negative specimens obtained (not less than 24 hourrs apart and at least 48 hours after completion of antibiotic therapy, if given). Requires clearance from DCP to return to work in SOS	Test all symptomatic contacts. Exclude symptomatic contacts from SOS until 2 consecutive negative specimens obtained (not less than 24 hours apart and at least 48 hours after completion of antibiotic therapy, if given).
Syphilis			
Report within 1 working day **For more information on Syphilis treatment, call the STD Control Program at 650.573.2346.**	1° Syphilis: Average 3 weeks. for 1º infection (10 days - 3 months range) 2° Syphilis: Average 4 weeks. (2-6 week range)	Advise to refrain from unprotected sexual activity until treatment of case & contacts is complete. Use universal precautions for blood and body secretions for hospitalized patients and for infants with congenital syphilis	Identify all sex partners of 1º, 2º and early latent (< 1 yr. duration) syphilis cases. For late and late latent syphilis identify sexual partners and children of infected mother. If exposure is within 90 days of the primary case's dx, treat regardless of contacts' serology results. All other contacts outside the 90-day exposure window should be evaluated with syphilis serology & treated if infected. Treat all infants born to untreated or inadequately treated seroreactive mothers.
Tetanus			
Report within 7 calendar days **Note: Prevention of tetanus infections by early wound care and administration of TIG and/ or DTap, Td, or Tdap is most important.**	Average 10 days (1-21 days range). Depends on character, extent and location of wound.	IM Tetanus immune globulin (TIG) is the treatment of choice. If TIG is not available give equine tetanus antitoxin in a single large dose following appropriate testing for hypersensitivity. Observe for anaphylaxis. Active immunication should be initiated concurrently with treatment. Separate syringes and separate sites must be used..	Not transmissible person-to-person. Maintain active protection by administering Td booster doses every 10 years. (Tdap once).

SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Tuberculosis			
Report confirmed or suspected cases of active disease within 1 working day. Report TB infection in converters and in children < 2 y/o within 7 days.	2-10 weeks from infection to development of positive TST reaction. Months to years between infection and active disease. **For more information on TB management, contact the TB Control Program at 650.573.2346.**	Respiratory isolation for cases of active pulmonary disease.	Identify and administer TST to household and other close contacts. If negative, a repeat stain first should be performed 2-3 months after exposure has ended. CXRs should be obtained for positive reactors and for some initially negative reactors at a high risk of developing active disease, specially young children, at least until the repeat stain test is shown to remain negative.

Pesticide-Related Illness & Injury

A health care provider must notify the County Health Department when he or she "knows, or has reasonable cause to believe" that an illness or injury was caused by pesticides, including sanitizers and disinfectants.

Reporting these incidents may prevent others from suffering similar injury. Failure to report pesticide related illnesses is punishable by a fine of $250 for each unreported case.

If exposure occurred at work, also report it as an occupational incident

Complete a *Doctor's First Report of Occupational Injury or Illness* form when the incident is occupational and send a copy to:

Division of Labor Statistics and Research
P.O. Box 420603
San Francisco, CA 94142-0603.

This is in addition to contacting the Health Department by phone and faxing the Pesticide Illness Report.

What do I do if exposure occurred in a neighboring county?

Contact the Health Department in that county:

Monterey County
(831) 759-7325

Santa Clara County
(408) 885-4214

Santa Cruz County
(831) 454-4114

San Francisco County
(415) 554-2830

In all cases, phone within 24 hours

(650) 573-2346

(650) 573-2919 fax
Disease Control & Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

See next pages for the Pesticide Illness Report form and instructions, and for the Doctor's First Report of Occupational Injury or Illness.

CONFIDENTIAL REPORT OF KNOWN OR SUSPECTED PESTICIDE-RELATED ILLNESS

Please provide as much information as possible. Fields marked with an asterisk* are critical for follow-up investigations.

Patient's Last Name* | Social Security Number | Birth Date* (Month / Day / Year)

First Name* | Middle Name (or Initial) | Age | Units

Address: Number, Street* | Apt/Unit Number

City/Town* | State* | ZIP Code* | County*

Home Telephone* ( ) | Cellular Telephone* ( ) | Gender* ☐ Male ☐ Female ☐ Unknown

Work Telephone ( ) | Occupation

Ethnicity* (check one)
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Race* (check one or more)
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Asian Indian
- ☐ Black or African American
- ☐ Filipino
- ☐ Guamanian
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ Samoan
- ☐ White
- ☐ Other Race:_____
- ☐ Unknown

Reporting Provider - Last Name* | First Name* | Telephone Number* ( )

Reporting Health Care Facility* | FAX Number ( )

Address: Number, Street | Suite Number | Submitted by*

City | State | ZIP Code | Date Submitted* (Month / Day / Year)

Illness Onset Date (Month / Day / Year) | Initial Examination Date* (Month / Day / Year) | List Any Pre-existing Conditions, If Known (e.g., allergies, asthma, pregnancy, etc)

Signs and Symptoms* (check all that apply)

Dermatologic
- ☐ Blistering
- ☐ Burns
- ☐ Edema
- ☐ Erythema (redness)
- ☐ Irritation/Pain
- ☐ Pruritis (itching)
- ☐ Rash
- ☐ Other_____

Gastrointestinal
- ☐ Abdominal pain/cramping
- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Other_____

Neurologic/Sensory
- ☐ Anxiety/Irritability
- ☐ Ataxia (incoordination)
- ☐ Confusion
- ☐ Depressed consciousness/Coma
- ☐ Diaphoresis (profuse sweating)
- ☐ Dizziness
- ☐ Fasciculation (muscle twitching)
- ☐ Headache
- ☐ Muscle pain/cramping
- ☐ Muscle weakness
- ☐ Numbness/Tingling
- ☐ Salivation
- ☐ Seizure
- ☐ Tremors
- ☐ Other_____

Ocular
- ☐ Blurred vision
- ☐ Corneal abrasion
- ☐ Irritation/Pain
- ☐ Lacrimation (tearing)
- ☐ Miosis (pinpoint pupils)
- ☐ Photophobia
- ☐ Other_____

Respiratory
- ☐ Cough
- ☐ Dyspnea (shortness of breath)
- ☐ Rhinitis (runny nose)
- ☐ Upper respiratory irritation/Pain
- ☐ Wheezing
- ☐ Other_____

Other Systemic
- ☐ Chest pain
- ☐ Excessive urination
- ☐ Fatigue
- ☐ Fever/Hyperexia
- ☐ Malaise
- ☐ Tachycardia
- ☐ Other_____

- ☐ Asymptomatic
- ☐ Pesticide-related death

Date of Death (Month / Day / Year)

Were Diagnostic or Laboratory Tests Conducted?
☐ No ☐ Yes, Completed ☐ Yes, Pending

If Completed or Pending, Please Describe:

Test:

Results (include reporting units):

Normal range or baseline used:

Treatment Rendered*

Medical Diagnosis

Remarks (Include physician observations, or other detail relevant to the case, not provided above. Additional pages may be attached.)

IV.A.2.a. Pesticide-Related Illness Reporting Form

Pesticide Exposure Date Month | Day | Year

Name of Pesticide(s) or Active Ingredient(s)* ☐ Unknown

Location Where Pesticide Exposure Occurred (please provide street address, cross streets, or other appropriate detail)*

County of Exposure*

Describe How Patient Was Exposed to Pesticide (e.g., drift, direct spray, environmental residue, spill, ingestion)

Did Exposure Occur at Work?* ☐ Yes ☐ No ☐ Unknown

If Yes, Name of Patient's Employer

Name of Patient's Supervisor

Patient's Activity When Pesticide Exposure Occurred (Check one)

- ☐ Mixing/loading/applying pesticide
- ☐ Field work
- ☐ Flagging
- ☐ Maintaining/repairing pesticide application equipment
- ☐ Manufacturing/formulating pesticide
- ☐ Packing/processing agricultural commodities
- ☐ Transporting/storing/disposing of pesticide
- ☐ Routine indoor activity not involved with pesticide application
- ☐ Routine outdoor activity not involved with pesticide application
- ☐ Emergency response
- ☐ Other_____
- ☐ Unknown

Were Others Exposed? ☐ Yes ☐ No ☐ Unknown

Additional Detail on Pesticide Exposure Incident

Reporting Agency Name*

Street Address

Suite Number

City

State

ZIP Code

County

Telephone Number ( )

FAX Number ( )

Date Reported* Month | Day | Year

Person Filing Report with State

Definition of a Pesticide Illness

A pesticide illness case is a patient who is or may be suffering from pesticide poisoning or any disease or condition caused by a pesticide. The term ***pesticide*** includes any product intended to repel, kill, prevent, destroy, control, or mitigate any pest. Pesticides include insecticides, herbicides, plant growth regulators, rodenticides or other vertebrate control agents, repellents, dessicants, fungicides, miticides, disinfectants, sterilants, and sanitizers. Spray adjuvants are pesticides under California law.

Reporting Requirement

Physicians are required to report known or suspected pesticide-related illness to the **local health officer** within 24 hours (Health and Safety Code §105200). Failure to report is a citable offense and subject to civil penalty ($250).

The **local health officer** is required to immediately notify the **county agricultural commissioner** and to file the pesticide-illness report with the following **state agencies** within 7 calendar days:

Office of Environmental Health Hazard Assessment
Pesticide and Environmental Toxicology Branch
P.O. Box 4010
Sacramento, CA 95812-4010
(916) 327-7324 (Voice)
(916) 327-7320 (Fax)

Department of Pesticide Regulation
Worker Health and Safety Branch
P.O. Box 4015
Sacramento, CA 95812-4015
(916) 445-4222 (Voice)
(916) 322-8577 (Fax)

Department of Industrial Relations
Division of Labor Statistics and Research
P.O. Box 420603
San Francisco, CA 94142-0603
(415) 703-3020 (Voice)
(415) 703-3029 (Fax)

Medical Cost Reimbursements from Pesticide Drift Episodes

Food and Agricultural Code §12997.5 requires that persons responsible for pesticide drift, which causes acute pesticide illness or injury in a non-occupational setting that requires emergency medical transport or treatment, be liable to the individual harmed or to the medical provider for the immediate costs of uncompensated medical care. The acute pesticide illness or injury must result from a pesticide use violation where the pesticide was used for agricultural commodities. For more information, visit the Department of Pesticide Regulation website at http://www.cdpr.ca.gov/docs/county/sb391.pdf.

Confidential Patient Medical Information Requirements

This document contains confidential medical information, subject to federal and state law. Submission as prescribed will not violate the Health Insurance Portability and Accountability Act of 1996, or HIPAA (Pub. L. 104-191; 45 CFR Part 160 and Part 164, Subparts A and E). Information is confidential pursuant to Cal. Const. Art. 1, §1; Gov. Code §6254(c); and Civil Code §1798 et seq.

Reporting of known or suspected pesticide illness is mandatory. Use of this exact form is not required, but it is provided for data standardization.

For additional forms, please visit: http://www.oehha.ca.gov/pesticides.

Thank-you for reporting a known or suspected pesticide-related illness!

Child Abuse and Neglect

Physicians and other licensed healthcare staff are mandated reporters for suspected child abuse. A report is required when in your professional capacity or within the scope of your employment you obtain knowledge of or observe a child whom you reasonably suspect has been the victim of child abuse.

There are four general types of abuse:

PHYSICAL ABUSE includes fractures, lacerations, bruises, burns and other injuries that cannot be explained, or for which the explanations offered are improbable given the extent of the injury

SEXUAL ABUSE may cause bruising or tears around the genital area or rectum, abdominal pain or pain with urination or defecation, or evidence of sexually transmitted infection. Sexual abuse includes sex acts with children even if force isn't used as well as sexual exploitation including child pornography and child prostitution.

EMOTIONAL ABUSE and WILLFUL CRUELTY involve situations in which any person willfully causes or permits any child to suffer, or inflicts thereon, unjustifiable physical pain or mental suffering or willfully causes the child's person or health to be endangered.

NEGLECT is the failure of a parent or caretaker to provide adequate food, clothing, shelter, medical care, or supervision, where no physical injury has occurred.

How do I report abuse of a child by someone besides the family or guardian?

If abuse occurs in another setting, it is treated under regular criminal statutes and should be reported to the police. If you are concerned that the parent or guardian did not act appropriately to protect the child, call the Child Abuse Hotline to determine if it should be reported there as well.

What about possible child abuse encountered outside of my medical role?

In this case, you are encouraged but not mandated to make a report by calling the Child Abuse Hotline. If you are in a situation outside of your medical care role, you are not required to give your name.

What happens after a report is made?

Child Protective Services staff will evaluate the situation and determine if the child should be removed from the home pending further evaluation, if referrals or services should be provided, or if no action is needed. In some cases they may refer a case for prosecution. You can request follow-up on disposition of the case.

Report Immediately by Phone:

Child Abuse Hotline (650) 595-7922

Call 911 if the child is in immediate danger.

File a written report within 36 hours: Send the Suspected Child Abuse Form, SS 8572 (see next page), to Child Protective Services or the police jurisdiction where the abuse is alleged to have occurred. A list of police jurisdictions with addresses, phone, and fax numbers is on page included after the reporting form.

If you have any questions about whether a situation should be reported, call the San Mateo County Child Abuse Hotline at (650) 595-7922.

➢ **The Suspected Child Abuse Form and Instructions are on the next two pages.**

Can I be sued for reporting?

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA (Child Abuse and Neglect Reporting Act).

SUSPECTED CHILD ABUSE REPORT

To Be Completed by **Mandated Child Abuse Reporters**
Pursuant to Penal Code Section 11166

PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE		MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS	Street	City Zip	DID MANDATED REPORTER WITNESS THE INCIDENT? ❒ YES ❒ NO
REPORTER'S TELEPHONE (DAYTIME) ( )	SIGNATURE		TODAY'S DATE

B. REPORT NOTIFICATION

❒ LAW ENFORCEMENT ❒ COUNTY PROBATION ❒ COUNTY WELFARE / CPS (Child Protective Services)	AGENCY		
ADDRESS Street	City	Zip	DATE/TIME OF PHONE CALL
OFFICIAL CONTACTED - TITLE			TELEPHONE ( )

C. VICTIM
One report per victim

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street	City	Zip	TELEPHONE ( )	
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE	
PHYSICALLY DISABLED? ❒ YES ❒ NO	DEVELOPMENTALLY DISABLED? ❒ YES ❒ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME	
IN FOSTER CARE? ❒ YES ❒ NO	IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE: ❒ DAY CARE ❒ CHILD CARE CENTER ❒ FOSTER FAMILY HOME ❒ FAMILY FRIEND ❒ GROUP HOME OR INSTITUTION ❒ RELATIVE'S HOME		TYPE OF ABUSE *(CHECK ONE OR MORE)* ❒ PHYSICAL ❒ MENTAL ❒ SEXUAL ❒ NEGLECT ❒ OTHER (SPECIFY)	
RELATIONSHIP TO SUSPECT	PHOTOS TAKEN? ❒ YES ❒ NO		DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ❒ YES ❒ NO ❒ UNK	

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY
1.			
2.			
3.			
4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street	City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	
NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street	City Zip	HOME PHONE ( )	BUSINESS PHONE ( )	

SUSPECT

SUSPECT'S NAME (LAST, FIRST, MIDDLE)		BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street	City	Zip	TELEPHONE ( )	
OTHER RELEVANT INFORMATION				

E. INCIDENT INFORMATION

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ❒ *IF MULTIPLE VICTIMS, INDICATE NUMBER:* _____

DATE / TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incidents involving the victim(s) or suspect)

SS 8572 (Rev. 12/02)

DEFINITIONS AND INSTRUCTIONS ON REVERSE

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code Section 11169 to submit to DOJ a Child Abuse Investigation Report Form SS 8583 if (1) an active investigation was conducted and (2) the incident was determined not to be unfounded.

WHITE COPY-Police or Sheriff's Department; BLUE COPY-County Welfare or Probation Department; GREEN COPY- District Attorney's Office; YELLOW COPY-Reporting Party

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM SS 8572

All Penal Code (PC) references are located in Article 2.5 of the PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://www.leginfo.ca.gov/calaw.html (specify "Penal Code" and search for Sections 11164-11174.3). A mandated reporter must complete and submit the form SS 8572 even if some of the requested information is not known. (PC Section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

- Mandated child abuse reporters include all those individuals and entities listed in PC Section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

- Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC Section 11165.9.)

III. REPORTING RESPONSIBILITIES

- Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC Section 11166(a).)
- No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC Section 11172(a).)

IV. INSTRUCTIONS

- **SECTION A - REPORTING PARTY:** Enter the mandated reporter's name, title, category (from PC Section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes-no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (Continued)

- **SECTION B - REPORT NOTIFICATION:** Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.
- **SECTION C - VICTIM (One Report per Victim):** Enter the victim's name, address, telephone number, birth date or approximate age, sex, ethnicity, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes-no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes-no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes-no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.
- **SECTION D - INVOLVED PARTIES:** Enter the requested information for: Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).
- **SECTION E - INCIDENT INFORMATION:** If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

- **Reporting Party:** After completing Form SS 8572, retain the yellow copy for your records and submit the top three copies to the designated agency.
- **Designated Agency:** ***Within 36 hours*** of receipt of Form SS 8572, send **white copy** to police or sheriff's department, **blue copy** to county welfare or probation department, and **green copy** to district attorney's office.

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

Elder and Dependent Adult Abuse

Health care practitioners, e.g. doctors, dentists, nurses, therapists, and their office staff, are in a position to observe or hear from their patients about abuse of elders and dependent adults, and have the responsibility to protect these patients. All are mandated reporters.

If you suspect abuse:

Mandated reporters must report any incident of alleged or suspected physical, emotional, or financial harm or abuse, *or a reasonable suspicion of abuse*, that comes to their attention.

If you have questions about a situation or are making a report, call the TIES Line at Aging and Adult Services toll-free at (800) 675-8437 (any time of the day or night, any day of the week). If you are not sure whether a report is appropriate, call and discuss it with the social worker or public health nurse on duty.

What happens when a report is made?

A social worker or public health nurse will respond to and investigate the report. If appropriate, an intervention and support plan will be developed using the least restrictive method of intervention. The client has the right to refuse any service or support. If a request for Adult Protective Services is not considered appropriate, the TIES line is available for consultation or to provide information and referral services.

For more information, go to www.smhealth.org and follow links to Aging and Adult Services, Protection, and Adult Protective Services.

Legal Requirements

The Welfare and Institutions Code, Section 15630, states:

"Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, or neglect, or reasonably suspects abuse shall report the known or suspected instance of abuse by telephone immediately or as soon as possible, and by written report sent within two working days."

What about possible abuse encountered outside of your medical role?

If you are concerned or suspect that someone you know outside of your professional activities is at risk of physical, emotional, or financial harm or abuse, you are encouraged but not mandated to make a report by calling the number listed above. If you are in a situation outside of your medical care role, you are not required to give your name.

For information, advice and 24-hour emergency response on elder care issues, call the TIES Line at Aging and Adult Services:

(800) 675-8437

(650) 573-3900

(Outside CA)
(800) 994-6166 (TDD)

Reports should be made immediately, or as soon as practically possible, by telephone to 1-800-675-8437. In addition, the "Report of Suspected Dependent Adult/Elder Abuse" (see next page) should be sent within 2 working days to:

Adult Protective Services

225 37th Avenue

San Mateo, CA 94403

🖷 (650) 573-2310 fax

See next page for a copy of the reporting form.

STATE OF CALIFORNIA – HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES

CONFIDENTIAL REPORT - NOT SUBJECT TO PUBLIC DISCLOSURE

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE

DATE COMPLETED:

TO BE COMPLETED BY REPORTING PARTY. PLEASE PRINT OR TYPE. SEE GENERAL INSTRUCTIONS.

A. VICTIM ☐ Check box if victim consents to disclosure of information [Ombudsman use only - WIC 15636(a)]

*NAME (LAST NAME FIRST) | *AGE | DATE OF BIRTH | SSN | GENDER ☐ M ☐ F | ETHNICITY | LANGUAGE (✓ CHECK ONE) ☐ NON-VERBAL ☐ ENGLISH ☐ OTHER (SPECIFY)

*ADDRESS (IF FACILITY, INCLUDE NAME AND NOTIFY OMBUDSMAN) | *CITY | *ZIP CODE | *TELEPHONE ( )

*PRESENT LOCATION (IF DIFFERENT FROM ABOVE) | *CITY | *ZIP CODE | *TELEPHONE ( )

☐ ELDERLY (65+) ☐ DEVELOPMENTALLY DISABLED ☐ MENTALLY ILL/DISABLED ☐ PHYSICALLY DISABLED ☐ UNKNOWN/OTHER ☐ LIVES ALONE ☐ LIVES WITH OTHERS

B. SUSPECTED ABUSER ✓ Check if ☐ Self-Neglect

NAME OF SUSPECTED ABUSER ☐ CARE CUSTODIAN (type)_____ ☐ PARENT ☐ SON/DAUGHTER ☐ OTHER_____

☐ HEALTH PRACTITIONER (type)_____ ☐ SPOUSE ☐ OTHER RELATION_____

ADDRESS | *ZIP CODE | TELEPHONE ( ) | GENDER ☐ M ☐ F | ETHNICITY | AGE | D.O.B. | HEIGHT | WEIGHT | EYES | HAIR

C. REPORTING PARTY: *Check appropriate box if reporting party waives confidentiality to:* ☐ ✓ All ☐ ✓ All but victim ☐ ✓ All but perpetrator

*NAME (PRINT) | SIGNATURE | OCCUPATION | AGENCY/NAME OF BUSINESS

RELATION TO VICTIM/HOW KNOWS OF ABUSE | (STREET) | (CITY) | (ZIP CODE) | (E-MAIL ADDRESS) | TELEPHONE ( )

D. INCIDENT INFORMATION - Address where incident occurred:

*DATE/TIME OF INCIDENT(S)

PLACE OF INCIDENT (✓ CHECK ONE)

☐ OWN HOME ☐ COMMUNITY CARE FACILITY ☐ HOSPITAL/ACUTE CARE HOSPITAL

☐ HOME OF ANOTHER ☐ NURSING FACILITY/SWING BED ☐ OTHER (Specify)

E. REPORTED TYPES OF ABUSE (✓ CHECK ALL THAT APPLY).

1. PERPETRATED BY OTHERS (WIC 15610.07 & 15610.63)

a. PHYSICAL
- ☐ ASSAULT/BATTERY
- ☐ CONSTRAINT OR DEPRIVATION
- ☐ SEXUAL ASSAULT
- ☐ CHEMICAL RESTRAINT
- ☐ OVER OR UNDER MEDICATION

b. ☐ NEGLECT
c. ☐ FINANCIAL
d. ☐ ABANDONMENT
e. ☐ ISOLATION
f. ☐ ABDUCTION
g. ☐ OTHER (Non-Mandated: e.g., deprivation of goods and services: psychological/mental)

2. SELF-NEGLECT (WIC 15610.57(b)(5))

a. ☐ PHYSICAL CARE (e.g., personal hygiene, food, clothing, shelter)
b. ☐ MEDICAL CARE (e.g., physical and mental health needs)
c. ☐ HEALTH and SAFETY HAZARDS
d. ☐ MALNUTRITION/DEHYDRATION
e. ☐ OTHER (Non-Mandated e.g., financial)

ABUSE RESULTED IN (✓ CHECK ALL THAT APPLY) ☐ NO PHYSICAL INJURY ☐ MINOR MEDICAL CARE ☐ HOSPITALIZATION ☐ CARE PROVIDER REQUIRED ☐ DEATH ☐ MENTAL SUFFERING ☐ OTHER (SPECIFY) ☐ UNKNOWN

F. REPORTER'S OBSERVATIONS, BELIEFS, AND STATEMENTS BY VICTIM IF AVAILABLE. DOES ALLEGED PERPETRATOR STILL HAVE ACCESS TO THE VICTIM? PROVIDE ANY KNOWN TIME FRAME (2 days, 1 week, ongoing, etc.). *LIST ANY POTENTIAL DANGER FOR INVESTIGATOR (animals, weapons, communicable diseases, etc.).*

☐ ✓CHECK IF MEDICAL, FINANCIAL, PHOTOGRAPHS OR OTHER SUPPLEMENTAL INFORMATION IS ATTACHED.

G. TARGETED ACCOUNT

ACCOUNT NUMBER (LAST 4 DIGITS): | TYPE OF ACCOUNT: ☐ DEPOSIT ☐ CREDIT ☐ OTHER | TRUST ACCOUNT: ☐ YES ☐ NO

POWER OF ATTORNEY: ☐ YES ☐ NO | DIRECT DEPOSIT: ☐ YES ☐ NO | OTHER ACCOUNTS: ☐ YES ☐ NO

H. OTHER PERSON BELIEVED TO HAVE KNOWLEDGE OF ABUSE. *(family, significant others, neighbors, medical providers and agencies involved, etc.)*

NAME | ADDRESS | TELEPHONE NO. ( ) | RELATIONSHIP

I. FAMILY MEMBER OR OTHER PERSON RESPONSIBLE FOR VICTIM'S CARE. *(If unknown, list contact person).*

*NAME | IF CONTACT PERSON ONLY ✓ CHECK ☐ | *RELATIONSHIP

*ADDRESS | *CITY | *ZIP CODE | *TELEPHONE ( )

J. TELEPHONE REPORT MADE TO: ☐ Local APS ☐ Local Law Enforcement ☐ Local Ombudsman ☐ Calif. Dept. of Mental Health ☐ Calif. Dept. of Developmental Services

NAME OF OFFICIAL CONTACTED BY PHONE | *TELEPHONE ( ) | DATE/TIME

K. WRITTEN REPORT Enter information about the agency receiving this report. Do not submit report to California Department of Social Services Adult Programs Bureau.

AGENCY NAME | ADDRESS OR FAX # | ☐ Date Mailed: | ☐ Date Faxed:

L. RECEIVING AGENCY USE ONLY ☐ Telephone Report ☐ Written Report

1. Report Received by: | Date/Time:

2. Assigned ☐ Immediate Response ☐ Ten-day Response ☐ No Initial Face-To-Face Required ☐ Not APS ☐ Not Ombudsman

Approved by: | Assigned to (optional):

3. Cross-Reported to: ☐ CDHS, Licensing & Cert.; ☐ CDSS-CCL; ☐ CDA Ombudsman; ☐ Bureau of Medi-Cal Fraud & Elder Abuse; ☐ Mental Health; ☐ Law Enforcement; ☐ Professional Board; ☐ Developmental Services; ☐ APS; ☐ Other (Specify) | Date of Cross-Report:

4. APS/Ombudsman/Law Enforcement Case File Number:_____

REPORT OF SUSPECTED DEPENDENT ADULT/ELDER ABUSE
GENERAL INSTRUCTIONS

PURPOSE OF FORM

This form, as adopted by the California Department of Social Services (CDSS), is required under Welfare and Institutions Code (WIC) Sections 15630 and 15658(a)(1). This form documents the information given by the reporting party on the suspected incident of abuse of an elder or dependent adult. **"Elder,"** means any person residing in this state who is 65 years of age or older (WIC Section 15610.27). **"Dependent Adult,"** means any person residing in this state, between the ages of 18 and 64, who has physical or mental limitations that restrict his or her ability to carry out normal activities or to protect his or her rights including, but not limited to, persons who have physical or developmental disabilities or whose physical or mental abilities have diminished because of age (WIC Section 15610.23). Dependent adult includes any person between the ages of 18 and 64 who is admitted as an inpatient to a 24-hour health facility (defined in the Health and Safety Code Sections 1250, 1250.2, and 1250.3).

COMPLETION OF THE FORM

1. This form may be used by the receiving agency to record information through a telephone report of suspected dependent adult/elder abuse. Complete items with an asterisk (*) when a telephone report of suspected abuse is received as required by statute and the California Department of Social Services.
2. If any item of information is unknown, enter "unknown."
3. Item A: Check box to indicate if the victim waives confidentiality.
4. Item C: Check box if the reporting party waives confidentiality. Please note that mandated reporters are required to disclose their names, however, non-mandated reporters may report anonymously.

REPORTING RESPONSIBILITIES

Mandated reporters (see definition below under "Reporting Party Definitions") shall complete this form for each report of a known or suspected instance of abuse (physical abuse, sexual abuse, financial abuse, abduction, neglect, (self-neglect), isolation, and abandonment (see definitions in WIC Section 15610) involving an elder or a dependent adult. **The original of this report shall be submitted within two (2) working days of making the telephone report to the responsible agency as identified below:**

- The county Adult Protective Services (APS) agency or the local law enforcement agency (if abuse occurred in a private residence, apartment, hotel or motel, or homeless shelter).
- Long-Term Care Ombudsman (LTCO) program or the local law enforcement agency (if abuse occurred in a nursing home, adult residential facility, adult day program, residential care facility for the elderly, or adult day health care center).
- The California Department of Mental Health or the local law enforcement agency (if abuse occurred in Metropolitan State Hospital, Atascadero State Hospital, Napa State Hospital, or Patton State Hospital).
- The California Department of Developmental Services or the local law enforcement agency (if abuse occurred in Sonoma Developmental Center, Lanterman Developmental Center, Porterville Developmental Center, Fairview Developmental Center, or Agnews Developmental Center).

WHAT TO REPORT

Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment has observed, suspects, or has knowledge of an incident that reasonably appears to be physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect), or is told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, abduction, or neglect, shall report the known or suspected instance of abuse by telephone immediately or as soon as practicably possible, and by written report sent within two working days to the appropriate agency.

REPORTING PARTY DEFINITIONS

Mandated Reporters (WIC) "15630 (a) Any person who has assumed full or intermittent responsibility for care or custody of an elder or dependent adult, whether or not that person receives compensation, including administrators, supervisors, and any licensed staff of a public or private facility that provides care or services for elder or dependent adults, or any elder or dependent adult care custodian, health practitioner, clergy member, or employee of a county adult protective services agency or a local law enforcement agency, is a mandated reporter."

Care Custodian (WIC) "15610.17 'Care custodian' means an administrator or an employee of any of the following public or private facilities or agencies, or persons providing care or services for elders or dependent adults, including members of the support staff and maintenance staff: (a) Twenty-four-hour health facilities, as defined in Sections 1250, 1250.2, and 1250.3 of the Health and Safety Code. (b) Clinics. (c) Home health agencies. (d) Agencies providing publicly funded in-home supportive services, nutrition services, or other home and community-based support services. (e) Adult day health care centers and adult day care. (f) Secondary schools that serve 18- to 22-year-old dependent adults and postsecondary educational institutions that serve dependent adults or elders. (g) Independent living centers. (h) Camps. (i) Alzheimer's Disease Day Care Resource Centers. (j) Community care facilities, as defined in Section 1502 of the Health and Safety Code, and residential care facilities for the elderly, as defined in Section 1569.2 of the Health and Safety Code. (k) Respite care facilities. (l) Foster homes. (m) Vocational rehabilitation facilities and work activity centers. (n) Designated area agencies on aging. (o) Regional centers for persons with developmental disabilities. (p) State Department of Social Services and State Department of Health Services licensing divisions. (q) County welfare departments. (r) Offices of patients' rights advocates and clients' rights advocates, including attorneys. (s) The Office of the State Long-Term Care Ombudsman. (t) Offices of public conservators, public guardians, and court investigators. (u) Any protection or advocacy

GENERAL INSTRUCTIONS (Continued)

agency or entity that is designated by the Governor to fulfill the requirements and assurances of the following: (1) The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000, contained in Chapter 144 (commencing with Section 15001) of Title 42 of the United States Code, for protection and advocacy of the rights of persons with developmental disabilities. (2) The Protection and Advocacy for the Mentally Ill Individuals Act of 1986, as amended, contained in Chapter 114 (commencing with Section 10801) of Title 42 of the United States Code, for the protection and advocacy of the rights of persons with mental illness. (v) Humane societies and animal control agencies. (w) Fire departments. (x) Offices of environmental health and building code enforcement. (y) Any other protective, public, sectarian, mental health, or private assistance or advocacy agency or person providing health services or social services to elders or dependent adults."

Health Practitioner (WIC) "15610.37 'Health practitioner' means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family, and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic, or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of the Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social service employee who treats an elder or a dependent adult for any condition, or a coroner."

Officers and Employees of Financial Institutions (WIC) "15630.1. (a) As used in this section, "mandated reporter of suspected financial abuse of an elder or dependent adult" means all officers and employees of financial institutions. (b) As used in this section, the term "financial institution" means any of the following: (1) A depository institution, as defined in Section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(c)). (2) An institution-affiliated party, as defined in Section 3(u) of the Federal Deposit Insurance Act (12 U.S.C. Sec. 1813(u)). (3) A federal credit union or state credit union, as defined in Section 101 of the Federal Credit Union Act (12 U.S.C. Sec. 1752), including, but not limited to, an institution-affiliated party of a credit union, as defined in Section 206(r) of the Federal Credit Union Act (12 U.S.C. Sec. 1786 (r)). (c)As used in this section, "financial abuse" has the same meaning as in Section 15610.30. (d)(1)Any mandated reporter of suspected financial abuse of an elder or dependent adult who has direct contact with the elder or dependent adult or who reviews or approves the elder or dependent adult's financial documents, records, or transactions, in connection with providing financial services with respect to an elder or dependent adult, and who, within the scope of his or her employment or professional practice, has observed or has knowledge of an incident that is directly related to the transaction or matter that is within that scope of employment or professional practice, that reasonably appears to be financial abuse, or who reasonably suspects that abuse, based solely on the information before him or her at the time of reviewing or approving the document, records, or transaction in the case of mandated reporters who do not have direct contact with the elder or dependent adult, shall report the known or suspected instance of financial abuse by telephone immediately, or as soon as practicably possible, and by written report sent within two working days to the local adult protective services agency or the local law enforcement agency."

MULTIPLE REPORTERS

When two or more mandated reporters are jointly knowledgeable of a suspected instance of abuse of a dependent adult or elder, and when there is agreement among them, the telephone report may be made by one member of the group. Also, a single written report may be completed by that member of the group. Any person of that group, who believes the report was not submitted, shall submit the report.

IDENTITY OF THE REPORTER

The identity of all persons who report under WIC Chapter 11 shall be confidential and disclosed only among APS agencies, local law enforcement agencies, LTCO coordinators, California State Attorney General Bureau of Medi-Cal Fraud and Elder Abuse, licensing agencies or their counsel, Department of Consumer Affairs Investigators (who investigate elder and dependent adult abuse), the county District Attorney, the Probate Court, and the Public Guardian. Confidentiality may be waived by the reporter or by court order.

FAILURE TO REPORT

Failure to report by mandated reporters (as defined under "Reporting Party Definitions") any suspected incidents of physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect) of an elder or a dependent adult is a misdemeanor, punishable by not more than six months in the county jail, or by a fine of not more than $1,000, or by both imprisonment and fine. Any mandated reporter who willfully fails to report abuse of an elder or a dependent adult, where the abuse results in death or great bodily injury, may be punished by up to one year in the county jail, or by a fine of up to $5,000, or by both imprisonment and fine.

Officers or employees of financial institutions (defined under "Reporting Party Definitions") are mandated reporters of financial abuse (effective January 1, 2007). These mandated reporters who fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $1,000. Individuals who willfully fail to report financial abuse of an elder or dependent adult are subject to a civil penalty not exceeding $5,000. These civil penalties shall be paid by the financial institution, which is the employer of the mandated reporter to the party bringing the action.

GENERAL INSTRUCTIONS (Continued)

EXCEPTIONS TO REPORTING

Per WIC Section 15630(b)(3)(A), a mandated reporter who is a physician and surgeon, a registered nurse, or a psychotherapist, as defined in Section 1010 of the Evidence Code, shall not be required to report a suspected incident of abuse where all of the following conditions exist:

(1) The mandated reporter has been told by an elder or a dependent adult that he or she has experienced behavior constituting physical abuse (including sexual abuse), abandonment, isolation, financial abuse, abduction, or neglect (including self-neglect).
(2) The mandated reporter is not aware of any independent evidence that corroborates the statement that the abuse has occurred.
(3) The elder or the dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia.
(4) In the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist, as defined in Section 1010 of the Evidence Code, reasonably believes that the abuse did not occur.

Per WIC Section 15630(b)(4)(A), in a long-term care facility, a mandated reporter who the California Department of Health Services determines, upon approval by the Bureau of Medi-Cal Fraud and the Office of the State Long-Term Care Ombudsman (OSLTCO), has access to plans of care and has the training and experience to determine whether all the conditions specified below have been met, shall not be required to report the suspected incident of abuse:

(1) The mandated reporter is aware that there is a proper plan of care.
(2) The mandated reporter is aware that the plan of care was properly provided and executed.
(3) A physical, mental, or medical injury occurred as a result of care pursuant to clause (1) or (2).
(4) The mandated reporter reasonably believes that the injury was not the result of abuse.

DISTRIBUTION OF SOC 341 COPIES

Mandated reporter: After making the telephone report to the appropriate agency, the reporter shall send the original and one copy to the agency; keep one copy for the reporter's file.
Receiving agency: Place the original copy in the case file. Send a copy to a cross-reporting agency, if applicable.
DO NOT SEND A COPY TO THE CALIFORNIA DEPARTMENT OF SOCIAL SERVICES ADULT PROGRAMS BUREAU.

Domestic Violence

Healthcare providers have many opportunities to identify victims of domestic violence, whether they have come for treatment of injuries or for vague somatic symptoms without clear cause, or through routine screening at initial and annual exams. Referral to community resources is always appropriate. In addition, a report is required in cases of current physical injury.

Legal Requirements

According to California law (PC 11160), a health practitioner is required to make a report if he or she "provides medical services for a physical condition to a patient whom he or she knows or reasonably suspects is:

1. "suffering from any wound or other injury inflicted by his or her own act or inflicted by another where the injury is by means of a firearm," and/or

2. "suffering from any wound or other injury inflicted upon the person where the injury is the result of assaultive or abusive conduct."

Assaultive or abusive conduct includes "murder, manslaughter, torture, battery, sexual battery, incest, assault with a deadly weapon, rape, spousal rape and abuse of spouse or cohabitant."

If the patient is being seen for another condition

If the physician sees evidence of physical injury and reasonably suspects it is the result of abuse, a report is required. If a provider is not treating a patient for a physical condition, he or she is not required to report domestic violence injuries (e.g., advice nurses not performing any physical assessment, or psychiatrists not treating any physical conditions).

If the patient reports having been raped

A report is required, regardless of whether bruises or other injuries are present. Only a forensic examination is adequate to make a physical assessment for rape. A report is required on a past rape if not filed previously.

Medical Record Documentation

The medical record should include:

-- Comments made by the patient regarding the injury, how it occurred, the name of the person who caused the injury and any past domestic violence (whenever possible, use direct quotations).

-- A map or sketch of the patient's body identifying the injuries and bruises, including shape, color, and size.

-- A copy of the law enforcement reporting form.

Referral to Community Resources

If you suspect that a patient is in an abusive relationship, whether there is evidence of physical evidence or not, it is important to refer to groups and resources that can provide assistance. Contact information for useful resources is listed here:

- CORA (Community Overcoming Relationship Abuse) Hotline
(650) 312-8515 or (800) 300-1080

- National Domestic Violence Hotline,
(800) 799-7233

- Rape Trauma Services

(650) 692-7273

- Teens Concerned About Dating and Domestic Violence
www.teenrelationships.org

- Keller Center for Family Violence Intervention (medical and social services)

(650) 573-2623

Telephone report

A telephone report must be made **immediately** or as soon as practically possible to the law enforcement agency where the injury occurred while the patient is in your office. A list of law enforcement jurisdictions is included with these guidelines.

Written report

In addition, a written report must be sent within two working days both to the law enforcement agency where the injury occurred (see list), and also to Disease Control and Prevention.

(650) 573-2919 fax
Disease Control & Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

A copy of the Domestic Violence and Assault reporting form is on the next page.

For questions on reporting, call the Keller Center Family Violence Intervention, (650) 573-2623.

Liability

Health professionals and facilities who report known or suspected assault cannot be held civilly or criminally liable for making a report. Failure to report by a mandated reporter is a misdemeanor, punishable by a $1,000 fine and/or six months in jail, and may result in civil suits or damages for subsequent injury to the patient.

SAN MATEO COUNTY

REPORT OF INJURIES BY A DEADLY WEAPON OR ASSAULTIVE OR ABUSIVE CONDUCT INCLUDING DOMESTIC VIOLENCE

(Pursuant to Penal Code Section 11160 et. seq.)

NOTE TO LAW ENFORCEMENT: PATIENT'S WHEREABOUTS MUST BE DELETED FROM ANY REPORT REQUIRED TO BE DISCLOSED TO SUSPECT OR SUSPECT'S ATTORNEY.

1. PATIENT'S NAME: (if known):_____
   SEX: ☐ M ☐ F D.O.B.: ___/___/___ AGE:___ RACE/ETHNICITY: ☐ ASIAN ☐ HISPANIC
   ☐ BLACK (non-Hispanic)
   ☐ WHITE (non-Hispanic)
   ☐ PACIFIC ISLANDER ☐ FILIPINO

2. PATIENT'S WHEREABOUTS: Specify where and when patient can be safely contacted (specify any special instructions for contacting patient)_____

3. a. REASON FOR REPORT (check all that apply):
   ☐ gunshot
   ☐ knife wound
   ☐ other deadly weapon wound (specify)_____
   ☐ assaultive or abusive conduct

   b. DESCRIBE NATURE AND EXTENT OF INJURY:
   _____

   c. DATE OF INJURY (if known):
   _____

   d. LOCATION OF INJURY (city / jurisdiction):
   _____

4. a. RELATIONSHIP OF SUSPECTED PERPETRATOR TO PATIENT:
   ☐ domestic / intimate partner
   ☐ other (please specify)_____

   b. NAME OF ANYONE PATIENT ALLEGES INFLICTED THE WOUND OR INJURY:
   _____

5. IS THE PATIENT WILLING TO BE CONTACTED BY LAW ENFORCEMENT? *(NOTE: Patient must be informed that s/he may be contacted regardless of what is checked below)*
   ☐ YES ☐ NO

6. OTHER COMMENTS: (include any special needs of patient, i.e. interpreter):
   _____

7. WAS PATIENT REFERRED TO SUPPORT SERVICES?
   ☐ YES Specify_____
   ☐ NO

Law enforcement agency contacted	
Name and I.D. No. of official contacted	
Date / time of telephone report	
Health practitioner's name	
Signature / health practitioner	
Health practitioner's title	
Health practitioner's medical facility	Department
Health practitioner's phone number	Date of written report

MAIL THIS FORM TO:

_____

_____

_____
(Agency)

THIS FORM IS NOT A SUBSTITUTE FOR COMPLETE DOCUMENTATION IN THE MEDICAL RECORD.

ORIGINAL - Medical Record **YELLOW** - Health Department - Disease Control & Prevention 225 W. 37th Ave., San Mateo, CA 94403 **PINK** - Law Enforcement Jurisdiction

Law Enforcement Jurisdictions in San Mateo County, California

Atherton Police Department	Fax	650-323-1804
83 Ashfield Road	Emergency	650-323-6131
Atherton, CA 94027	Business	650-688-6500
BART Police Department	Fax	650-464-7051
800 Madison Street	Emergency	877-679-7000
Oakland, CA 94607	Business	510-464-7040
Belmont Police Department	Fax	650-593-0265
1215 Ralston Avenue	Emergency	650-595-7400
Belmont, CA 94002	Business	650-595-7400
Brisbane Police Department	Fax	415-468-4641
150 North Hill Drive, Suite 3	Emergency	415-467-1212
Brisbane, CA 94005	Business	415-467-1212
Broadmoor Police Department	Fax	650-755-9732
388 88th Street	Emergency	650-755-3838
Broadmoor, CA 94015	Business	650-755-3840
Burlingame Police Department	Fax	650-697-8130
1111 Trousdale Avenue	Emergency	650-692-0310
Burlingame, CA 94010	Business	650-692-8440
Colma Police Department	Fax	650-997-8330
1198 El Camino Real	Emergency	650-977-8320
Colma, CA 94014	Business	650-997-8320
Daly City Police Department	Fax	650-991-8181
333 90th Street	Emergency	650-991-8092
Daly City, CA 94015	Business	650-991-8119

East Palo Alto Police Department	Fax	650-853-3106
2415 University Avenue	Emergency	650-321-1112
East Palo Alto, CA 94303	Business	650-853-3160
Foster City Police Department	Fax	650-349-0790
1030 East Hillsdale Blvd	Emergency	650-573-3333
Foster City, CA 94404	Business	650-286-3300
Half Moon Bay Police Department	Fax	650-726-8292
537 Kelly Avenue	Emergency	650-726-8286
Half Moon Bay, CA 94019	Business	650-726-8288
Hillsborough Police Department	Fax	650-375-7468
1600 Floribunda Avenue	Emergency	650-375-7470
Hillsborough, CA 94010	Business	650-375-7470
Menlo Park Police Department	Fax	650-327-4314
701 Laurel Avenue	Emergency	650-325-4424
Menlo Park, CA 94025	Business	650-858-3300
Millbrae Police Department	Fax	650-259-2344
621 Magnolia Avenue	Emergency	650-697-1212
Millbrae, CA 94030	Business	650-259-2300
Pacifica Police Department	Fax	650-355-1172
1850 Francisco Blvd	Emergency	650-355-4151
Pacifica, CA 94044	Business	650-738-7314
Redwood City Police Department	Fax	650-780-7112
1301 Maple Street	Emergency	650-369-3331
Redwood City, CA 94063	Business	650-780-7100
San Bruno Police Department	Fax	650-871-6734
567 El Camino Real	Emergency	650-877-8989
San Bruno, CA 94066	Business	650-616-7100

San Carlos Police Department	Fax	650-595-3049
600 Elm Street	Emergency	650-592-2222
San Carlos, CA 94070	Business	650-802-4277
San Mateo County Sheriff's Office Department	Fax	650-599-1563
400 County Center	Emergency	650-363-4911
Redwood City, CA 94063	Business	650-363-4911
San Mateo Police Department	Fax	650-522-7651
2000 South Delaware Street	Emergency	650-522-7700
San Mateo, CA 94402	Business	650-522-7700
South San Francisco Police Department	Fax	650-877-5982
33 Arroyo Drive	Emergency	650-873-3333
South San Francisco, CA 94080	Business	650-877-8900

Law Enforcement Jurisdictions – Outside San Mateo County

Palo Alto Police Department	Fax	650-617-3120
275 Forest Avenue	Emergency	650-329-2413
Palo Alto, CA 94301	Business	650-329-2413
San Francisco Police Department	Fax	415-553-7965
850 Bryant Street	Emergency	415-553-9225
San Francisco, CA 94103	Business	415-553-9225
Santa Clara County Sheriff's Department	Fax	408-283-0562
55 W. Younger Avenue	Emergency	408-808-4900
San Jose, CA 95110	Business	408-808-4900

Vaccine Reactions

VAERS: Vaccine Adverse Event Reporting System

VAERS is a national surveillance program co-sponsored by the Centers for Disease Control and Prevention and the Food and Drug Administration. VAERS collects and analyzes information from reports of adverse events following immunization.

By monitoring reactions, VAERS helps identify new safety concerns about immunizations, ensuring that the benefits of vaccines continue to be far greater than the risks.

Reporting by paper form

If you need to report a vaccine reaction, you can fill out the one-page paper form on the next page. Folding the form in thirds will turn it into a postage-paid mailer to send to VAERS headquarters in Rockville, Maryland.

Reporting online at http://vaers.hhs.gov

You can also report directly through the Internet. Click the "web reporting" link on the VAERS home page. To save time, record your entries on a scratch form before opening the online form.

WEBSITE: www.vaers.org E-MAIL: info@vaers.org FAX: 1-877-721-0366

VACCINE ADVERSE EVENT REPORTING SYSTEM

24 Hour Toll-Free Information 1-800-822-7967
P.O. Box 1100, Rockville, MD 20849-1100
PATIENT IDENTITY KEPT CONFIDENTIAL

For CDC/FDA Use Only

VAERS Number _____

Date Received _____

Patient Name:

Last First M.I.

Address

City State Zip

Telephone no. (____) _____

Vaccine administered by (Name):

Responsible Physician _____

Facility Name/Address

City State Zip

Telephone no. (____) _____

Form completed by (Name):

Relation to Patient ☐ Vaccine Provider ☐ Patient/Parent ☐ Manufacturer ☐ Other

Address *(if different from patient or provider)*

City State Zip

Telephone no. (____) _____

1. State

2. County where administered

3. Date of birth mm / dd / yy

4. Patient age

5. Sex ☐ M ☐ F

6. Date form completed mm / dd / yy

7. Describe adverse events(s) (symptoms, signs, time course) and treatment, if any

8. Check all appropriate:
- ☐ Patient died (date mm / dd / yy)
- ☐ Life threatening illness
- ☐ Required emergency room/doctor visit
- ☐ Required hospitalization (_____days)
- ☐ Resulted in prolongation of hospitalization
- ☐ Resulted in permanent disability
- ☐ None of the above

9. Patient recovered ☐ YES ☐ NO ☐ UNKNOWN

10. Date of vaccination mm / dd / yy Time _____ AM PM

11. Adverse event onset mm / dd / yy Time _____ AM PM

12. Relevant diagnostic tests/laboratory data

13. Enter all vaccines given on date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous Doses
a.					
b.					
c.					
d.					

14. Any other vaccinations within 4 weeks prior to the date listed in no. 10

	Vaccine (type)	Manufacturer	Lot number	Route/Site	No. Previous doses	Date given
a.						
b.						

15. Vaccinated at:
- ☐ Private doctor's office/hospital
- ☐ Public health clinic/hospital
- ☐ Military clinic/hospital
- ☐ Other/unknown

16. Vaccine purchased with:
- ☐ Private funds
- ☐ Public funds
- ☐ Military funds
- ☐ Other/unknown

17. Other medications

18. Illness at time of vaccination (specify)

19. Pre-existing physician-diagnosed allergies, birth defects, medical conditions (specify)

20. Have you reported this adverse event previously?
- ☐ No
- ☐ To health department
- ☐ To doctor
- ☐ To manufacturer

Only for children 5 and under

22. Birth weight _____ lb. _____ oz.

23. No. of brothers and sisters

21. Adverse event following prior vaccination (check all applicable, specify)

	Adverse Event	Onset Age	Type Vaccine	Dose no. in series
☐ In patient				
☐ In brother or sister				

Only for reports submitted by manufacturer/immunization project

24. Mfr./imm. proj. report no.

25. Date received by mfr./imm.proj.

26. 15 day report? ☐ Yes ☐ No

27. Report type ☐ Initial ☐ Follow-Up

Health care providers and manufacturers are required by law (42 USC 300aa-25) to report reactions to vaccines listed in the Table of Reportable Events Following Immunization. Reports for reactions to other vaccines are voluntary except when required as a condition of immunization grant awards.

"Fold in thirds, tape & mail — DO NOT STAPLE FORM"

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES
OR APO/FPO

BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 1895 ROCKVILLE, MD

POSTAGE WILL BE PAID BY ADDRESSEE

VAERS
P.O. Box 1100
Rockville MD 20849-1100

DIRECTIONS FOR COMPLETING FORM

(Additional pages may be attached if more space is needed.)

GENERAL

- Use a separate form for each patient. Complete the form to the best of your abilities. Items 3, 4, 7, 8, 10, 11, and 13 are considered essential and should be completed whenever possible. Parents/Guardians may need to consult the facility where the vaccine was administered for some of the information (such as manufacturer, lot number or laboratory data.)
- Refer to the Reportable Events Table (RET) for events mandated for reporting by law. Reporting for other serious events felt to be related but not on the RET is encouraged.
- Health care providers other than the vaccine administrator (VA) treating a patient for a suspected adverse event should notify the VA and provide the information about the adverse event to allow the VA to complete the form to meet the VA's legal responsibility.
- These data will be used to increase understanding of adverse events following vaccination and will become part of CDC Privacy Act System 09-20-0136, "Epidemiologic Studies and Surveillance of Disease Problems". Information identifying the person who received the vaccine or that person's legal representative will not be made available to the public, but may be available to the vaccinee or legal representative.
- Postage will be paid by addressee. Forms may be photocopied (must be front & back on same sheet).

SPECIFIC INSTRUCTIONS

Form Completed By: To be used by parents/guardians, vaccine manufacturers/distributors, vaccine administrators, and/or the person completing the form on behalf of the patient or the health professional who administered the vaccine.

Item 7: Describe the suspected adverse event. Such things as temperature, local and general signs and symptoms, time course, duration of symptoms, diagnosis, treatment and recovery should be noted.

Item 9: Check "YES" if the patient's health condition is the same as it was prior to the vaccine, "NO" if the patient has not returned to the pre-vaccination state of health, or "UNKNOWN" if the patient's condition is not known.

Item 10 and 11: Give dates and times as specifically as you can remember. If you do not know the exact time, please indicate "AM" or "PM" when possible if this information is known. If more than one adverse event, give the onset date and time for the most serious event.

Item 12: Include "negative" or "normal" results of any relevant tests performed as well as abnormal findings.

Item 13: List ONLY those vaccines given on the day listed in Item 10.

Item 14: List any other vaccines that the patient received within 4 weeks prior to the date listed in Item 10.

Item 16: This section refers to how the person who gave the vaccine purchased it, not to the patient's insurance.

Item 17: List any prescription or non-prescription medications the patient was taking when the vaccine(s) was given.

Item 18: List any short term illnesses the patient had on the date the vaccine(s) was given (i.e., cold, flu, ear infection).

Item 19: List any pre-existing physician-diagnosed allergies, birth defects, medical conditions (including developmental and/or neurologic disorders) for the patient.

Item 21: List any suspected adverse events the patient, or the patient's brothers or sisters, may have had to previous vaccinations. If more than one brother or sister, or if the patient has reacted to more than one prior vaccine, use additional pages to explain completely. For the onset age of a patient, provide the age in months if less than two years old.

Item 26: This space is for manufacturers' use only.

QUICK GUIDE FOR REPORTING

Problem	Contact	Phone/Fax
Animal bite (*use Animal Bite Report on page II.D.3)*	Peninsula Humane Society	650.340.8200 *fax* 650.348.7891
Bioterrorism or chemical release (*threat or suspicious circumstance*)	Local police	9-1-1
Bioterrorism (*suspected clinical case*)	Disease Control & Prevention (DCP)	650.573.2346 after hours 650.363.4981
Child Abuse & Neglect *(use Suspected Child Abuse Report on page IV.B.2)*	Local police if child in current danger (see list of law jurisdiction phone numbers) Children & Family Services Hotline	650.595.7922 800.632.4615 *fax* 650.595.7518
Communicable disease (*use CMR on page I.B.1.a.)*	Disease Control & Prevention Unit (DCPU)	650.573.2346 *fax* 650.573.2919
Domestic Violence *(use Domestic Violence Reporting form on page IV.D.2)*	Local police Send reporting form to DCPU	9-1-1 *fax* 650.573.2919
Elder abuse & neglect *(use Suspected Dependant Adult/Elder Abuse Reporting form on IV.C.2)*	Aging & Adult Services	800.675.8437 *fax* 650.573.2310
Food poisoning, suspected	Environmental Health	650.363.4305 *fax* 650.363.7882
Housing health hazards	Environmental Health	650.363.4305 *fax* 650.363.7882
Lapse in consciousness *(use CMR on page I.B.1.a)*	Disease Control & Prevention Unit (DCPU)	650.573.2346 *fax* 650.573.2919
Pesticide illness (by phone*, and on Pesticide Illness Report form on page IV.A.2)*	Disease Control & Prevention Unit (DCPU)	650.573.2346 *fax* 650.573.2919
Poisoning	Poison Control	800.876.4766
Rabies post-exposure prophylaxis *(see Rabies Post-exposure Prophylaxis Guide on page II.D.2)*	Disease Control & Prevention Unit (DCPU)	650.573.2346 *fax* 650.573.2919 after hours 650.363.4981
Rodent, wildlife, insect infestations	Environmental Health	650.363.4305 *fax* 650.363.7882
Vaccine-associated adverse event *(use VAERS form on page IV.F.2)*	Vaccine Adverse Event Reporting System www.vaers.org	800.822.7967 *Fax* 877-721-0366

* CMR – Confidential Morbidity Report

West Nile Virus (WNV)

West Nile Virus first appeared in the United States in 1999 in New York and since then has spread across the country. It is caused by a flavivirus that infects several species of birds and is transmitted to humans, horses, and a few other mammals by mosquitoes. Rarely transmission occurs by transfusion, transplant, transplacentally, or via breast milk. The blood supply is now screened for WNV. The incubation period after mosquito bite ranges from 3 to 14 days. WNV is not transmitted from person to person.

Symptoms

Infection with WNV is usually asymptomatic. Approximately 20% of infections result in West Nile Fever, a mild to moderate nonspecific febrile illness. Less than 1% of infections lead to severe neurological illness.

■ **West Nile Fever** is a syndrome characterized by headache and fever (T ≥ 100.4F). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. Symptoms generally last 3 to 6 days but may continue for weeks. There is no specific treatment. Individuals recover fully.

■**West Nile Encephalitis/West Nile Meningitis** is a severe illness with headache, high fever, neck stiffness, stupor, disorientation, coma, tremors, convulsions, muscle weakness, and paralysis. Symptoms of severe disease (encephalitis or meningitis) may last several weeks, and neurological effects may be permanent. The most significant risk factor for developing severe neurological disease is age ≥ 50 years. I.

■**Acute Flaccid Paralysis;** atypical Guillain-Barré syndrome or transverse myelitis.

West Nile Virus Can Cause Long-term Sequelae

Survivors of WNV encephalitis/ meningitis may face a long road to recovery. In New York City, only 33% were ambulatory and only 50% were at their previous level of mental function at hospital discharge. One year later, 67% still experienced fatigue, 50% had persistent problems with memory, 49% had difficulty walking, 44% had muscle weakness and 38% had depression.

Testing

Virus-specific IgM can be detected in nearly all cerebrospinal fluid (CSF) and serum specimens received from WNV-infected patients at the time of their clinical presentation. Serum IgM antibody may persist for more than a year, but IgM antibody in CSF strongly suggests acute infection. Consider testing individuals with:

- Encephalitis
- Aseptic meningitis (if < 18 yrs, also work up for enteroviruses)
- Acute Flaccid Paralysis, Atypical Guillain Barré Syndrome, or Transverse myelitis
- West Nile Fever lasting ≥ 7 days

Prevention

Since almost all cases of West Nile Virus are the result of a bite from an infected mosquito, preventing mosquito bites is the best protection. Advise all your patients:

- **Drain** all standing water so mosquitoes won't have breeding sites
- **Dawn** and dusk are the main times for mosquito activity, so stay inside or use effective mosquito repellents
- **DEET** or Picaridin repellents should be used
- **Dress** appropriately – with long sleeves and pants
- **Doors** and windows should have screens to keep mosquitoes out

Wild birds are often the first victims when West Nile Virus reaches an area. To report a dead bird during West Nile Virus season, call

1-877-WNV-BIRD

(1-877-968-2473)

Reporting WNV

All cases of WNV infection must be reported by phone, fax or mail within 1 day

(650) 573-2346
(650) 573-2919 fax
Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

To coordinate processing of specimens by the Public Health Lab, contact the Disease Control Unit. **A West Nile Virus Specimen Submittal Form is required for testing – see next page.** If a case is confirmed by laboratory testing, a West Nile Case History Form will be needed.

For questions about mosquito control, contact:

San Mateo County Mosquito Abatement District (MAD)

(650) 344-8592 or visit www.smcmad.org

West Nile Virus (WNV) Infection Case Report 2008

Date Form Completed:___/___/___

Patient Information:

Last Name: _____ **First Name:**_____ **DOB:**___/___/___ **Age:**__ **Med Rec #:**_____

Address: _____ **City:** _____ **Zip Code:** _____

Phone: Home (_____)_____ Work (_____)_____ **Occupation:** _____

Sex: ☐ Male ☐ Female ☐ Unknown **Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Race:** ☐ White ☐ Black ☐ Unknown ☐ Asian/ Pacific Islander ☐ American Indian/Alaskan Native ☐ Other: _____

Physician Information (Mandatory):

Name: _____ **Facility:** _____

Pager/Phone: (_____)_____ **Fax:** (_____)_____ **Email:** _____

Date of first symptom(s):____/____/____ ☐ Hospitalized **or** ☐ ER / Outpatient

If hospitalized, admit date: ____/____/____ **Discharge date:** ____/____/____ **If patient died, date of death:** ____/____/____

Clinical syndrome (check all that apply):

Encephalitis ……	☐ Yes	☐ No	☐ Unk
Aseptic meningitis …….	☐ Yes	☐ No	☐ Unk
Acute flaccid paralysis ….	☐ Yes	☐ No	☐ Unk
Febrile illness ……..…..	☐ Yes	☐ No	☐ Unk
Asymptomatic ……	☐ Yes	☐ No	☐ Unk

Other _____

Do the following apply anytime during current illness:

In ICU ……..	☐ Yes	☐ No	☐ Unk
Seizures …..……..….	☐ Yes	☐ No	☐ Unk
Altered consciousness ….	☐ Yes	☐ No	☐ Unk
Fever ≥38˚C …..……	☐ Yes	☐ No	☐ Unk
Headache……	☐ Yes	☐ No	☐ Unk
Rash ……..…….	☐ Yes	☐ No	☐ Unk
Stiff neck…..……	☐ Yes	☐ No	☐ Unk
Muscle pain ……..….	☐ Yes	☐ No	☐ Unk
Muscle weakness …….	☐ Yes	☐ No	☐ Unk

Other: _____

Past medical history:

Immunocompromised:	☐ Yes	☐ No	☐ Unk
Hypertension ……	☐ Yes	☐ No	☐ Unk
Diabetes Type _____	☐ Yes	☐ No	☐ Unk

Specify: _____

Other: _____

CSF Results	CBC Results
Date: ____/____/____	Date: ____/____/____
RBC: ____	WBC: ____
WBC: ____	%Diff: _____
%Diff: _____	HCT: ____
Protein: ____	Plt: ____
Glucose: ____	

Travel/Exposures within 4 wks of onset (specify details):

Mosquito bites/exposure ……..…	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Travel outside of California ……..…	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Travel outside the U.S. ……..……..	☐ Yes	☐ No	☐ Unk
Dates/Locations:_____			
Donated blood …….	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Donated organ …….	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Received blood transfusion ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Received organ transplant: ……	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			
Currently pregnant ……..	☐ Yes	☐ No	☐ Unk
Week of gestation: ____			
Ever traveled outside the U.S. ….	☐ Yes	☐ No	☐ Unk
Dates/Locations: _____			
Ever rec'd yellow fever vaccine.....	☐ Yes	☐ No	☐ Unk
Date: ____/____/____			

Knowledge of WNV prior to illness:

Did patient do anything to avoid mosquito bites?			
If yes,	☐ Yes	☐ No	☐ Unk
- used insect repellent?	☐ Yes	☐ No	☐ Unk
- drained standing water near home?	☐ Yes	☐ No	☐ Unk

Other significant history/exposures: _____

_____

Other lab results (MRI/CT, etc.): _____

_____

West Nile Virus Test Results:

Testing Laboratory	Specimen Type	Coll Date	Test Type	Result
_____	_____	___/___/___	_____	_____
_____	_____	___/___/___	_____	_____

For questions regarding testing or specimens, call San Mateo Co. Disease Control & Prevention (650) 573-2346
Fax this form to (650) 573-2919 or mail to: San Mateo Co. Public Health Lab, 225 37th Avenue, San Mateo, Ca 94403

West Nile Virus (WNV) Infection Case Report
SUPPLEMENTAL INVESTIGATION FORM 2008

Date Form Completed:___/___/____

Beginning in 2008, the Centers for Disease Control and Prevention (CDC) will collect surveillance data on selected underlying medical conditions and therapies that have previously been identified as risk factors for severe illness, hospitalization, and/or death among persons with WNV disease. Initial reports of WNV infections should be sent to the California Department of Public Health immediately after they have been confirmed. However, this supplemental investigation form is not time-sensitive and can be submitted at any time after a case has been reported.

Questions to Assess Underlying Medical Conditions and Medication Use

Patient Name (Last, First): _____ **DOB:**___/___/___

Clinical syndrome: ☐ Neuroinvasive disease ☐ West Nile fever ☐ Other clinical ☐ Asymptomatic infection

1. Before your West Nile virus infection, did a health care provider ever tell you that you had any of the following medical conditions?

Diabetes ……....	☐ Yes	☐ No	☐ Unknown
High blood pressure (hypertension) ……..…	☐ Yes	☐ No	☐ Unknown
Heart attack (myocardial infarction) …….	☐ Yes	☐ No	☐ Unknown
Angina or coronary artery disease ……	☐ Yes	☐ No	☐ Unknown
Congestive heart failure (CHF) …….	☐ Yes	☐ No	☐ Unknown
Stroke ……	☐ Yes	☐ No	☐ Unknown
Chronic obstructive pulmonary disease (COPD) ..	☐ Yes	☐ No	☐ Unknown
Chronic liver disease …….....	☐ Yes	☐ No	☐ Unknown
Kidney failure or chronic kidney disease ……	☐ Yes	☐ No	☐ Unknown
Alcoholism ……	☐ Yes	☐ No	☐ Unknown
Bone marrow transplant ……	☐ Yes	☐ No	☐ Unknown
Solid organ transplant ……	☐ Yes	☐ No	☐ Unknown
If yes: What organ was transplanted?: _____			
What year was the transplant?: _____			
Cancer ……..	☐ Yes	☐ No	☐ Unknown
If yes: What type(s)?: _____			
What year were you diagnosed?: _____			
Are you currently being treated for cancer?:	☐ Yes	☐ No	☐ Unknown

2. Before your West Nile infection, did a health care provider ever tell you that you had a medical condition that limited your ability to fight an infection? ☐ Yes ☐ No ☐ Unknown

If yes: What condition(s)?: _____

3. At the time you were diagnosed with West Nile virus infection, were you taking any of the following types of prescription medications or treatments?

Chemotherapy …….....	☐ Yes	☐ No	☐ Unknown
Other treatments for cancer ……...……	☐ Yes	☐ No	☐ Unknown
Hemodialysis ……..…….	☐ Yes	☐ No	☐ Unknown
Other treatments for kidney disease ……	☐ Yes	☐ No	☐ Unknown
Oral or injected steroids (not inhaled or topical) ...	☐ Yes	☐ No	☐ Unknown
Insulin or other medications to treat diabetes ……	☐ Yes	☐ No	☐ Unknown
Medications to treat high blood pressure ……..	☐ Yes	☐ No	☐ Unknown
Medications to treat coronary artery disease ….....	☐ Yes	☐ No	☐ Unknown
Medications to treat congestive heart failure …….	☐ Yes	☐ No	☐ Unknown
Medications that suppress the immune system ….	☐ Yes	☐ No	☐ Unknown

4. Which of the following sources provided the information above? (check all that apply)

Patient	☐ Yes	☐ No	Family member/friend	☐ Yes	☐ No
Provider	☐ Yes	☐ No	Medical record	☐ Yes	☐ No

For questions regarding testing or specimens, call San Mateo Co. Disease Control & Prevention (650) 573-2346
Fax this form to (650) 573-2919 or mail to: San Mateo Co. Public Health Lab, 225 37th Avenue, San Mateo, Ca 94403

Revised 8/13/07

SAN MATEO COUNTY PUBLIC HEALTH LABORATORY

Specimen Submittal Form for Suspect Avian Influenza A (H5N1)

To improve diagnostic sensitivity, testing should be performed on multiple samples types collected over several days. Given that most human cases have presented with lower respiratory tract infections, the collection of only a upper respiratory specimen, particularly single nasopharyngeal or nasal swabs, is **NOT** recommended.

- **MINIMUM SPECIMEN REQUIREMENTS INCLUDE THE FOLLOWING:**
  1. Oropharyngeal swab specimens collected in 3 cc viral transport media (VTM); AND
  2. A nasopharyngeal swab OR nasopharyngeal wash OR nasopharyngeal aspirate collected in 3 cc viral transport media (VTM)*; AND
  3. Any specimen(s) from the lower respiratory tract** (e.g., sputum, bronchoalveolar lavage, tracheal aspirate or pleural fluid tap).

  * An oropharyngeal swab may be more likely than a nasopharyngeal swab to yield a positive result. While both an oropharyngeal swab and nasopharyngeal specimen should be collected, an oropharyngeal swab should be performed preferentially if only one sample can be taken.
  ** In outpatient settings, it may be difficult to obtain samples from the lower respiratory tract in children. In these instances, two specimens from the upper respiratory tract (e.g. a nasopharyngeal wash and a throat swab) are acceptable.

- Each specimen should be labeled with ***date of collection***, ***specimen type***, and ***patient name***. Because culture is not recommended in these cases, please note clearly on the form that this is a suspect case of avian influenza A (H5N1).
- Specimens should be sent **cold** using an overnight courier.
- Send to: San Mateo County Health System
  Public Health Laboratory
  225 37th Ave.
  San Mateo, CA 94403
- Please do not send specimens on a Friday. Refrigerate over the weekend & send on Monday.

IMPORTANT: please complete the form below and submit with specimens

Patient's last name, first name			Patient's mailing address (including Zip code)	Route to:
Age or DOB:	Sex (circle): M F	Onset Date:	**This section for Virus Laboratory use only. Date received by VRDL and State Accession Number**	[ ] SERO [ ] ISOL [ ] FA [ ] _____ [ ] _____ [ ] _____ [ ] _____
1st	Specimen type and/or specimen source	Date Collected	1st	
2nd	Specimen type and/or specimen source	Date Collected	2nd	
3rd	Specimen type and/or specimen source	Date Collected	3rd	
4th	Specimen type and/or specimen source	Date Collected	4th	
Please provide clinical findings and/or pertinent laboratory data				

Questions? Call Bruce Fujikawa, Dr.P.H. at (650) 573-2500

Submitter: _____ Phone: _____ Fax: _____

Lyme Disease

We know that many people in San Mateo County work and play in areas where the risk of tick exposure is high.

Lyme disease is caused by the bacterium *Borrelia burgdorferi*. In California, the infection is transmitted to humans by the bite of infected Western black legged ticks (*Ixodes pacificus*). 3-5% of nymphs and adult black-legged ticks in San Mateo County test positive for *Borrelia burgdorferi*.

Symptoms of Lyme Disease

Untreated, Lyme Disease symptoms become more severe over time. One to two weeks after infection, many to most people will exhibit **erythema migrans** (**EM**), a red, expanding rash radiating from the attachment site.

Other signs of early Lyme Disease may be mild and non-specific, or present as flu-like symptoms of fever, malaise, fatigue, headache, muscle and joint aches.

Late manifestations of Lyme Disease can occur days, weeks, or months after the appearance of the first EM lesion. Late disease affects the:

- **musculoskeletal system**, manifesting as migratory joint and muscle pain with or without obvious swelling
- **nervous system**, manifesting as meningitis, cranial neuropathy, and encephalopathy
- **cardiovascular system**, seen as myocarditis or acute onset of atrioventricular blocks of varying degrees.

Western black legged tick, responsible for carrying Lyme Disease in the Western US.

Lab testing for Lyme Disease:

Blood tests are indicated only if history, signs and symptoms are equivocal. If there has been exposure to Western black legged ticks and typical symptoms are present, antibiotics are generally started empirically. If testing is needed, antibody testing using a two-step procedure should be performed:

1. Initial test with ELISA or IFA. If positive do confirmatory test.

2. Confirm with Western Blot test: IgG and IgM if less than 4 weeks from onset; IgG alone if more than 4 weeks. Consult with an infectious disease specialist for any questions.

Laboratories have been required to report positive tests for Lyme disease to the Health Department since 2005. Be sure to send in a CMR as well, so that we have specific information on your patient.

Phone, fax, or mail within 1 week

(650) 573-2919 fax
Disease Control and Prevention
San Mateo County Health Dept.
225 37th Avenue
San Mateo, CA 94403

Prevention

Advise your patients to take tick precautions when walking outdoors from December to June: wear long-sleeved shirts tucked in to pants, pants tucked into boots or socks. Apply permethrin products to clothes and DEET to skin to repel ticks. Check clothes and skin frequently for several days after walking outdoors. Remove ticks with tweezers, grabbing the tick close to the skin and pulling straight out. **If ticks are removed within 24 hours of attachment, the chance of contracting Lyme disease is extremely low.**

Tick Testing Services

If your patient has removed a tick, it can be submitted to our Public Health Lab for identification. If the tick is determined to be of a species capable of transmitting Lyme Disease, it will be tested for *Borrelia burgdorferi*. Call (650) 573-2500 for instructions.

SELECTED COMMUNICABLE DISEASES: GUIDELINES FOR REPORTING AND MANAGEMENT OF CASES AND CONTACTS

Persons with a communicable disease or their contacts may spread disease through the community as a result of their work duties or participation in group activities. Special restrictions, therefore, may apply. If necessary, persons in sensitive occupations or situations (SOS) shall be removed from these activities as long as they are still contagious. The Disease Control & Prevention Unit of the San Mateo County Public Health Department is responsible for supervising the restriction of infected persons and contacts in sensitive occupations or situations.

Persons employed in ***sensitive occupations*** may include health care providers, commercial food and milk handlers, teachers, child care workers, those treating, cooking for or caring for others, and other persons whose duties appreciably increase the risk of disease transmission.

Persons in ***sensitive situations*** may include: child care or nursery school children, patients in facilities for the developmentally disabled, frail elderly, immunosuppressed and institutionalized individuals, or others with selected contagious diseases.

Non-urgent communicable diseases should be reported by fax, phone or mail to:

San Mateo County DCPS
Attn: Morbidity Clerk
225 37th Avenue
Tel. 650.573.2346
Fax 650.573.2919

Please note that these guidelines address the Public Health aspects of infections. For current information on care of individual patients, consult with standard texts or specialists. Before prescribing or administering any vaccine or medication, check for contraindications and precautions.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Botulism *(infant, foodborne, wound)*			
Report immediately by phone – **Notify Health Officer on Call**	Usually 12-36 hrs after eating contanminated food; sometimes several days afterward. Wound botulism occurs within days of entry of bacteria.	**Foodborne** & **wound**: equine serum trivalent botulinum antitoxin[1] **Infant**: Human-derived botulinum immune globulin (called BIG – iv or Baby Big) if given early in course[2]	There is no evidence of person-to-person transmission. Close medical observation for anyone who ate incriminated foods.
Campylobacteriosis			
Report within 1 working day	2-5 days avg. (1-10 days range) (dose-dependent)	Case investigation will not be routinely performed, and will depend on specific circumstances (outbreaks). In cases involving food handlers, case management may involve excluding from work until asymptomatic and one negative stool.	Contact management depends on individual circumstances. In some cases, symptomatic contacts may be removed from work until asymptomatic with 1 negative stool.
Chickenpox *(varicella)*			
Only report *varicella hospitalizations and deaths* – **report** within 1 working day	14-16 days avg. (2-3 wks. range)	Isolate for at least 5 days after rash onset or until all vesicles become crusted over.	No restrictions. Susceptible unless immunized or history of disease. Refer immunocompromised people and pregnant women to physician immediately for passive immunization with varizag.
Chlamydia (CT)			
Report within 7 calendar days **For more information on Chlamydia treatment, call the STD Control Program at 650.573.2346.**	Probably 7-14+ days	All cases and sexual contacts should refrain from unprotected sexual activity until treatment 1 week post. Evaluate for other STI's. If symptomatic, treat presumptively for gonorrhea as well as Chlamydia.	Examine, test & treat anyone who had sex with the patient during the 60 days preceding the patient's diagnosis or onset of symptoms. Monitor infants born to mothers with chlamydia and treat them if infection develops.

1 Available from CDPH (510.620.3434) or the CDC (404.639.3670).
2 To obtain human-derived Botulinum Immune Globulin, call the Infant Botulism Prevention Program (510.540.2646).
SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Diptheria			
Report immediately by phone	2-5 days, sometimes longer	Immediate hospitalization. Treat with antibiotics and antitoxin[1]. Strict isolation until cleared by DCP.	**Test & prophylax all contacts regardless of immunization status.** Exclude contacts in SOS until negative nose and throat culture results obtained. Observe contacts carefully for 7 days after last exposure.
E. coli: shiga toxin producing (STEC) including E coli: 0157:H7			
Report immediately by phone	3-4 days avg. (2-8 days range)	If symptomatic and in SOS exclude from SOS until 2 consecutive negative specimens obtained (not less than 24 hrs apart and at least 48 hours after completion of antibiotic therapy, if given). Requires clearance from DCP to return to work.	
Giardiasis			
Report within 7 calendar days	7-10 days avg. (3-25+ days range)	Case investigation will not be routinely performed, and will depend on specific circumstances (outbreaks). In cases involving food handlers, case management may involve excluding from work until 5 days of treatment is completed and diarrhea resolved.	Case investigation will not be routinely performed, and will depend on specific circumstances (outbreaks). In some cases, symptomatic contacts may be tested to rule out infection.

[1] Antitoxin available from CDPH at 510.620.3434 or CDC 404.639.8200.

SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Gonorrhea (GC)			
Report within 7 calendar days **For more information on gonorrhea treatment, call the STD Control Program at 650.573.2346.**	2-7 days	All cases and sexual contacts should refrain from unprotected sexual activity until 1 week post treatment. Treat for Chlamydia as well as GC.	See www.cdc.gov/std Examine, test & treat anyone who had sex with the patient during the 60 days preceding the patient's diagnosis or onset of symptoms. Treat all infants born to mothers with gonococcal infections. Prophylax all infants after birth with ophthalmic ointment (erythromycin). **Note: Fluoroquinolones are no longer recommended for treatment of GC in fections in California due to resistance to this class of drugs.**
Haemophilus influenzae, *invasive disease (e.g., HIB meningitis)*			
Report within 1 working day if patient is less than 15 years of age.	Probably 2-4 days	Isolate until 24 hrs of antibiotic therapy is completed. Give rifampin or equivalent antibiotic prior to hospital discharge to eliminate nasal carriage.	If household has one or more infants (< 12 mo. of age) other than index case or inadequately-immunized 1-3 y/o child, prophylax all household contacts (adults & children). Rifampin prophylaxis of staff & children in daycare classrooms is discretionary when 1 case has occurred, but is recommended when 2 or more cases of invasive disease have occurred within 60 days. Observe all contacts under 6 years of age for signs of illness.
Hepatitis A			
Report within 1 working day	Average 28-30 days (15-50 days range)	Exclude from SOS during illness and for 1 week after onset of jaundice.	No restrictions. Contacts are susceptible unless they are immunized or have a history of disease. Susceptible household and/or other close contacts should receive Hepatitis A vaccine and/or immune globulin depending on their age and immune status within 2 weeks of last exposure.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Hepatitis B			
Report within 7 calendar days (specify acute vs. chronic when reporting)	Average 2-3 months (variable)	No restrictions. Use universal blood/body fluid precautions.	No restrictions. Contacts are susceptible unless they are immunized or have a history of disease. Vaccinate with HBV vaccine & HBIG: 1) infants born to HBsAg+ mothers within 12 hrs of birth 2) sexual contacts to acute cases (if > 2 wks. since last exposure or exposure to chronic carrier, give HBV vaccine only) 3) other percutaneous transmucosal exposure to known infectious blood within 24 hrs.
Hepatitis C			
Report within 7calendar days (specify acute vs. chronic when reporting)	Average 40 days (2 wks. - 6 mo. range)	No restrictions. Use universal blood/body fluid precautions.	No restrictions.
Measles *(rubeola, 10-day measles, hard measles)*			
Report within 1 working day	About 10 days But may be 7 to 18 days from exposure to onset of fever, usually 14 days until rash appear; rarely as long as 19-21 days.	Isolate until 5 days after rash onset.	Susceptible unless adequately immunized or history of disease. Vaccinate susceptibles within 72 hours with live virus vaccine. If immuniized or pregnant, may give IG within 6 days of exposure, preferably within 72 hours for maximum protection.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Meningococcal infections			
Report immediately by phone	Average 3-4 days (2-10 days range)	Respiratory isolation for 24 hours after start of chemo treatment. Give rifampin or offer appropriate equivalent antibiotic prior to hospital discharge to eliminate nasal carriage.	Prophylax household, child care center and other intimate contacts with rifampin, or ciprofloxacin (ceftriaxone if pregnant) preferably within 24 hours of diagnosis of primary case. Observe contacts carefully for development of febrile illness.
Mumps			
Report within 7 calendar days	Average 15-18 days (14-25 days range)	Respiratory isolation for 9 days after onset of karotitis.	Susceptible unless immunized, history of disease or born before 1957. Exclude susceptibles from school or workplace from 12th-25th day after exposure.
Pertussis *(whooping cough)*			
Report within 1 working day	Average 9-10 days (range 6-20 days).	Isolate for 3 weeks after paroxysmal cough onset or 5 days of appropriate antibiotic treatment.	**Prophylax household & close contacts regardless of age and immunization status within 21 days of exposure.** Immunize if under 7 and received less than 4 doses of a pertussis-containing vaccine (e.g., DTaP) or 4th dose ≥ 3 years ago. Carefully observe for respiratory symptoms for 21 days after last contact.

Reporting Requirement	Incubation Period	Case Management	Contact Management
Plague *(Yersinia pestis)*			
Report immediately by phone **Notify or call Health Officer immediately.**	1-7 days. 1-4 days in pneumonic plague.	Pneumonic plague: strict isolation with precautions against airborne spread until 48 hours of effective antibiotic therapy completed and clinical improvement. Bubonic plague: drainage and secretion precautions are indicated for 48 hours after start of effective treatment. Rid all patients, their clothing and baggage of fleas.	Prophylax household or face-to-face contacts of all of pneumonic plague. Observe carefully for 7 days after last exposure. If contact refuses prophylaxis, strict isolation for 7 days.
Rabies, *human or animal*			
Report immediately by phone **Notify or call Health Officer.**	3-8 weeks average. (9 days - 7 years range)	See **Rabies Post-exposure Prophylaxis Guide** on page II.D.2.	
Rubella *(German measles)*			
Report within 7 calendar days	14-17 days average. (14-21 days range)	Isolate for 7 days after rash onset.	Susceptible unless immunized or history of disease. Refer to MD if contacts are pregnant or immunocompromised.
Salmonellosis *(other than typhoid fever)*			
Report within 1 working day	*12-36 hours average.* *(6-72 hrs range)*	*Exclude case from SOS until 2 consecutive negative specimens obtained (not less than 24 hours apart and at least 48 hours after completion of antibiotic therapy, if given). Requires clearance from DCP to return to work in SOS.*	Test all symptomatic contacts. Exclude symptomatic contacts from SOS until 2 consecutive negative specimens obtained (not less than 24 hrs apart and at least 48 hours after completion of antibiotic therapy, if given).

SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Shigellosis			
Report within 1 working day	1-3 days average. (12-96 hours range)	Exclude from SOS until 2 consecutive negative specimens obtained (not less than 24 hourrs apart and at least 48 hours after completion of antibiotic therapy, if given). Requires clearance from DCP to return to work in SOS	Test all symptomatic contacts. Exclude symptomatic contacts from SOS until 2 consecutive negative specimens obtained (not less than 24 hours apart and at least 48 hours after completion of antibiotic therapy, if given).
Syphilis			
Report within 1 working day **For more information on Syphilis treatment, call the STD Control Program at 650.573.2346.**	1° Syphilis: Average 3 weeks. for 1º infection (10 days - 3 months range) 2° Syphilis: Average 4 weeks. (2-6 week range)	Advise to refrain from unprotected sexual activity until treatment of case & contacts is complete. Use universal precautions for blood and body secretions for hospitalized patients and for infants with congenital syphilis	Identify all sex partners of 1º, 2º and early latent (< 1 yr. duration) syphilis cases. For late and late latent syphilis identify sexual partners and children of infected mother. If exposure is within 90 days of the primary case's dx, treat regardless of contacts' serology results. All other contacts outside the 90-day exposure window should be evaluated with syphilis serology & treated if infected. Treat all infants born to untreated or inadequately treated seroreactive mothers.
Tetanus			
Report within 7 calendar days **Note: Prevention of tetanus infections by early wound care and administration of TIG and/ or DTap, Td, or Tdap is most important.**	Average 10 days (1-21 days range). Depends on character, extent and location of wound.	IM Tetanus immune globulin (TIG) is the treatment of choice. If TIG is not available give equine tetanus antitoxin in a single large dose following appropriate testing for hypersensitivity. Observe for anaphylaxis. Active immunication should be initiated concurrently with treatment. Separate syringes and separate sites must be used..	Not transmissible person-to-person. Maintain active protection by administering Td booster doses every 10 years. (Tdap once).

SOS = Sensitive occupation or situation

Reporting Requirement	Incubation Period	Case Management	Contact Management
Tuberculosis			
Report confirmed or suspected cases of active disease within 1 working day. Report TB infection in converters and in children < 2 y/o within 7 days.	2-10 weeks from infection to development of positive TST reaction. Months to years between infection and active disease. **For more information on TB management, contact the TB Control Program at 650.573.2346.**	Respiratory isolation for cases of active pulmonary disease.	Identify and administer TST to household and other close contacts. If negative, a repeat stain first should be performed 2-3 months after exposure has ended. CXRs should be obtained for positive reactors and for some initially negative reactors at a high risk of developing active disease, specially young children, at least until the repeat stain test is shown to remain negative.

CALIFORNIA CASE REPORT FORM FOR LABORATORY-CONFIRMED AVIAN (H5N1) INFLUENZA

- For use in the World Health Organization Pandemic Phase 3 (no or very limited human-to-human transmission)
- Refer to http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm and click on "GRAPH" at the top for a list of affected countries.
- Please report any suspect or laboratory-confirmed cases to the San Mateo County Disease Control and Prevention at (650) 573-2346 or San Mateo County On-call Health Officer 24/7 at (650) 363-4981.

FAX completed form to (650) 573-2919

Date of Initial report to LHD: _____/_____/_____ **State ID#_____**

Section 1. Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____

Current Street Address: _____

Current Residence City: _____State: _____ County: _____

Home telephone: _____ Work telephone: _____

Age at onset: _____ ☐ Years ☐ Months Date of Birth ___/___/___ Gender: ☐ Male ☐ Female

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino

Race: ☐ Native American/Alaskan Native ☐ Asian ☐ Pacific Islander ☐ African-American/Black ☐ White ☐ Other ☐ Unk

Nationality/Citizenship: _____ Residency: ☐ U.S. Resident ☐ Non-U.S. Resident

Specify patient occupation: _____

Is individual a health care worker with close contact to patients, patient care areas or patient care items (e.g., linens or clinical specimens)?

☐ Yes ☐ No ☐ Unk *If yes*, specify:

Health care worker type: ☐ Physician ☐ Nurse/ PA ☐ Laboratory ☐ Other _____

Place of employment: ☐ Hospital ☐ Long Term Care Facility ☐ Laboratory ☐ Ambulatory Care ☐ Other_____

Does patient have DIRECT patient care responsibilities? ☐ Yes ☐ No ☐ Unk

Section 2. Risk Factors for Influenza Complications

☐ Cardiac disease _____

☐ Chronic lung disease (e.g, asthma) _____

☐ Chronic metabolic/renal disease (e.g., diabetes) _____

☐ Chronic neurologic disease (e.g. seizure disorder) _____

☐ Immunosuppression (e.g., HIV, transplant, malignancy, steroids) _____

☐ Child < 18 yrs old on chronic aspirin therapy _____ ☐ Hemoglobinopathy (e.g., SCD) _____

☐ Pregnancy (note 1st, 2nd or 3rd trimester) _____ ☐ Nursing home resident / institutionalized _____

☐ Other underlying illness (specify): _____

Section 3. Signs and Symptoms

Date of initial symptom onset: _____/_____/_____

Fever (subjective or objective): ☐ Yes ☐ No ☐ Unk

If yes, date of fever onset: _____/_____/_____ ***If yes,* temperature >38º C (>100.4º F):** ☐ Yes ☐ No ☐ Unk

Influenza-associated symptoms: ☐ Chills ☐ Rigors ☐ Myalgias ☐ Headache ☐ Sore throat ☐ Runny nose/congestion

☐ Conjunctivitis ☐ Cough ☐ Wheezing ☐ Shortness of breath ☐ Bloody respiratory secretions ☐ Otitis ☐ Diarrhea

☐ Nausea/vomiting ☐ Abdominal pain ☐ Apnea ☐ Lethargy ☐ Altered mental status ☐ Other: _____

Complications: ☐ Viral pneumonia ☐ Encephalitis ☐ Myocarditis ☐ Seizures ☐ Sepsis ☐ Reyes Syndrome

☐ Multi-organ failure ☐ 2º bacterial pneumonia ☐ Other_____

Antiviral medications: ☐ Yes ☐ No ☐ Unk

If yes, specify: ☐ Amantadine ☐ Rimantadine ☐ Oseltamivir ☐ Zanamavir Dose: _____

Date started: ____ /_____/_____ Date completed: ____ /_____/_____

Received flu vaccine for current/most recent season: ☐ Yes ☐ No ☐ Unk *If yes*, specify date: ____/_____/_____

Comments: _____

CDHS ID#: _____

Section 4. Clinical Status

Date of first clinical evaluation for this illness: ____ /____/____

Laboratory results (note most abnormal value): Hct: _____ Platelet: _____ WBC: _____ Differential: _____

AST: _____ ALT: _____ Alk phos: _____ Tbili: _____ LDH: _____ CPK: _____ BUN: _____ Creatinine: _____

Was a chest X-ray or chest CAT scan performed? ☐ Yes ☐ No ☐ Unk
If yes, date: _____ /_____/_____
If yes, was there evidence **of pneumonia or respiratory distress syndrome**? ☐ Yes ☐ No ☐ Unk
Comments/interpretation: _____

Was the patient **hospitalized for > 24 hours?** ☐ Yes ☐ No ☐ Unk
If yes: Name of hospital: _____ Medical Record Number:_____
City: _____ County/State: _____
Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____

Was the patient seen or transferred from another clinic or facility after first symptom onset? ☐ Yes ☐ No ☐ Unk
If yes, clinic or facility name: _____ Dates seen/hospitalized: _____/_____/_____ - _____/_____/_____
(If more, please list on back of page).

Was the patient ever in the ICU? ☐ Yes ☐ No ☐ Unk
Was the patient ever on mechanical ventilation? ☐ Yes ☐ No ☐ Unk

Did the patient **die** as a result of this illness? ☐ Yes ☐ No ☐ Unk
If yes, date of death: _____/_____/_____
If yes, was an autopsy performed? ☐ Yes ☐ No ☐ Unk
If yes, please forward autopsy report.

Pathologist name: _____ Phone number: _____

Section 5. Avian (H5N1) Influenza Epidemiological Risk Factors

In the 10 days prior to symptom onset:

1. Did the patient travel to an area with documented avian (H5N1) influenza in poultry, wild birds and/or humans?
   ☐ Yes ☐ No ☐ Unk *If yes,* complete section 6.
2. Did the patient have history of any of the following exposures in an H5N1-affected country?
   a. Direct contact with (e.g. touching) sick or dead domestic poultry* ☐ Yes ☐ No ☐ Unk
   b. Consumption of raw or incompletely cooked poultry* or poultry* products ☐ Yes ☐ No ☐ Unk
   c. Direct contact with surfaces contaminated with poultry* feces ☐ Yes ☐ No ☐ Unk
   d. Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1 ☐ Yes ☐ No ☐ Unk
   e. Close contact (within 1 meter) of a person who was hospitalized or died due to unexplained respiratory illness ☐ Yes ☐ No ☐ Unk
3. Did the patient come in close contact (within 1 meter) of an ill patient who was confirmed or suspected to have H5N1
   ☐ Yes ☐ No ☐ Unk *If yes*, please fill out source case information in ANNEX 1.
4. Did the patient work with live influenza H5N1 virus in laboratory? ☐ Yes ☐ No ☐ Unk *If yes*, please give further detail below.

Comment on exposures listed above: _____

_____

_____

*The definition of poultry is domestic fowls, such as chickens, turkeys, ducks, or geese, raised for meat or eggs.

Section 6. Travel History

Complete if travel to area with documented or suspected transmission of H5N1 in birds or humans. Use additional pages if necessary.

Leg 1

Departure Date: ____/____/____ Departure City/Country: _____

Arrival Date: ____/____/____ Arrival City/Country: _____

Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____

Transport company: _____ Transport number: _____

Residence at arrival city (e.g., hotel, relative's home):_____ Purpose/activities:_____

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: _____

Section 6 continued:

Leg 2

Departure Date: ____/____/____ Departure City/Country: _____

Arrival Date: ____/____/____ Arrival City/Country: _____

Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____

Transport company: _____ Transport number: _____

Residence at arrival city (e.g., hotel, relative's home):_____ Purpose/activities:_____

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: _____

Leg 3

Departure Date: ____/____/____ Departure City/Country: _____

Arrival Date: ____/____/____ Arrival City/Country: _____

Transport type: ☐ Airline ☐ Train ☐ Auto ☐ Cruise ☐ Bus ☐ Tour group ☐ Other _____

Transport company: _____ Transport number: _____

Residence at arrival city (e.g., hotel, relative's home):_____ Purpose/activities:_____

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: _____

Section 7. Local Clinic/Hospital Laboratory Results

*****NOTE: VIRAL CULTURE SHOULD NOT BE PERFORMED IN SUSPECT AVIAN INFLUENZA CASES*****

☐ Rapid influenza test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

If positive, result: ☐ Influenza A ☐ Influenza B ☐ Influenza A/B, not distinguished

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify _____

Test performed: ☐ Directigen Flu ☐ FLU OIA ☐ QuickVue Influenza Test ☐ ZstatFlu ☐ NOW Flu Test

☐ Rapid RSV test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ Respiratory culture: ☐ Neg ☐ Pos ☐ Unk Organism isolated: _____ Collection Date: _____/_____/_____

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ Blood culture: ☐ Neg ☐ Pos ☐ Unk Organism isolated: _____ Collection Date: _____/_____/_____

☐ Other test results:

Test: _____ Result: _____ Collection date: _____/_____/_____

Test: _____ Result: _____ Collection date: _____/_____/_____

Were other respiratory co- pathogens/bacterial infections detected in the patient? ☐ Yes ☐ No ☐ Unk

If yes, indicate which pathogen(s): _____

Comments: _____

CDHS ID#: _____

Section 8. Local Public Health Laboratory Results

Influenza A Results (check all tests that were performed):

☐ Rapid influenza test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

Test performed: ☐ Directigen Flu ☐ FLU OIA ☐ QuickVue Influenza Test ☐ ZstatFlu ☐ NOW Flu Test

☐ DFA: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ PCR for influenza ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

If subtyping available: ☐ H1 positive ☐ H3 positive ☐ H5 positive ☐ untypeable ☐ other, specify _____

Were respiratory co-pathogens other than influenza A detected by PCR or other testing? ☐ Yes ☐ No ☐ Unk

If yes, check pathogen: ☐ influenza B ☐ RSV ☐ adenovirus ☐ human metapneumovirus ☐ other _____

Method of detection: ☐ EIA ☐ DFA ☐ PCR ☐ other, specify _____

Comments: _____

Section 9. Trace Forward Contact Information

Trace –forward contact information refers to those individuals the patient has had contact with **since** becoming ill. In WHO Pandemic Phase 3, CDPH recommends that information be collected on all "trace-forward" contacts for the purposes of symptom monitoring, laboratory testing and possible administration of antiviral medication. A sample template for recording trace-forward contact information is provided in Annex 2.

Section 10. Submitted by:

Last Name: _____ First Name: _____ Phone: (____)_____

Affiliation: _____ County: _____Fax:_____ E-mail: _____

If you would like to consult with a member of the avian influenza team at CDHS, please contact the CDHS Duty Officer of the Day, or the CDPH Viral and Rickettsial Disease Laboratory (Janice Louie or Carol Glaser).

Section 11. Additional Comments

CDHS ID#: _____

Annex 1. Source Case Information

Please complete Annex 1 to provide source case information for a patient with *any* history of contact with a known or suspected human case of influenza A (H5N1) within 10 days of symptom onset.

Was the source case a laboratory-confirmed case of influenza A (H5N1)? ☐ Yes ☐ No ☐ Unk

List country/area(s) where contact with the source case occurred: _____

_____

Name: _____ Age:_____ ☐ Years ☐ Months Gender: ☐ Male ☐ Female

Address: _____

City/Province: _____ Telephone: (____)_____

Nature of contact: ☐ Household ☐ Co-worker ☐ Health care ☐ Other, specify _____

Please describe the nature of the contact: _____

Date of patient's last exposure to source case: _____/_____/_____

Comments: _____

_____

_____

ANNEX 2: AVIAN INFLUENZA A (H5N1) CONTACT FOLLOW-UP SHEET

For use in WHO Pandemic Phase 3

For each contact to a laboratory-confirmed influenza A (H5N1) case, record the information itemized below. Besides household contacts, consider best friends and the information they can provide about contacts that the case may have had. Medical personnel who had contact with the case's oral secretions should also be reported.

Full Name of Contact/Associate Last First	DOB or Age	Type of Contact[1]	Contact Information Phone Number Address	Symptoms[2]	Influenza Test Result		Antivirals		Vaccinated	Quarantined	Isolation
							Prophylaxis	Treatment			
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: ______________ No Reason: _______ __________________	Yes Date: ________ Drug: ______________ No Reason:_______ __________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: ______________ No Reason:_______ __________________	Yes Date: ________ Drug: ______________ No Reason:________ __________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: ______________ No Reason:________ __________________	Yes Date: ________ Drug: ______________ No Reason:________ __________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: ______________ No Reason:________ __________________	Yes Date: ________ Drug: ______________ No Reason:________ __________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					

1. Type of contact:
(1) Health care worker (HCW) providing direct patient care to suspect cases;
(2) Close contacts: persons in close proximity (1 meter) and with prolonged exposure to the case such as those who have shared a defined setting (household, extended family, hospital or other residential institution);
(3) Close contacts: persons who otherwise had direct contact with respiratory, oral or nasal secretions (e.g. face to face during coughing or sneezing, sharing water bottles or kissing) during the infectious period (1 day prior to symptom onset to 14 days after symptom onset).

2. Symptoms: Monitor for fever and/or respiratory symptoms for 10 days after the last date of exposure to the confirmed case.
   - Close contacts/HCWs with fever should be placed on isolation precautions for suspect H5N1 patients. After specimen collection, treat with antivirals on the assumption of H5N1 infection; complete clinical evaluation.
   - Close contacts/HCWs with respiratory symptoms but no fever should remain at home in isolation until H5N1 is ruled out by laboratory testing. Decisions on whether to treat a close contact/HCW with other symptoms but no fever should be made on a case-by-case basis but a specimen should be collected prior to treatment. Consider arranging for H5N1 testing if respiratory symptoms are present.
   - Consider post-exposure prophylaxis for asymptomatic close contacts/HCWs who have had an unprotected exposure to infectious aerosols or other secretions. Collect appropriate specimens prior to starting treatment.
   - If testing of contact is positive for H5N1, fill out a new case report form. Continue precautions for 14 days post-onset and if not already done, start treatment with antivirals for case and treat complications, as indicated

Annex 3. **(To be filled out by DHS personnel)**

VRDL Results:

☐ DFA: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum
☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify_____

☐ PCR for influenza ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum
☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid
☐ biopsy/autopsy tissue, specify source_____
☐ other specimen type, specify_____

Subtyping result: ☐ H1 positive ☐ H3 positive ☐ H5 positive ☐ untypeable ☐ other _____

☐ PCR for other pathogens ☐ Neg ☐ Pos ☐ Not done ☐ Unk

If yes, check pathogen: ☐ influenza B ☐ RSV ☐ adenovirus ☐ human metapneumovirus ☐ parainfluenza 1-3
☐ enterovirus ☐ coronavirus ☐ Legionella ☐ Chlaymdia ☐ Mycoplasma
☐ other _____

☐ Other test results:

Test: _____ Result: _____ Collection date: _____/_____/_____

Test: _____ Result: _____ Collection date: _____/_____/_____

Notes: _____

_____

_____

_____

CDC Results (if available):

Date of specimen: ____/_____/____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ endotracheal asp
☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid ☐ blood/serum
☐ biopsy/autopsy tissue, specify source _____
☐ other specimen type, specify_____

Results:_____

_____

_____

CDC Contact:

Last Name: _____ First Name: _____ Phone: (____)_____

E-mail: _____ Date reported to CDC: _____/____/_____ CDC ID#: _____

BT Categories and Resources

Bioterrorism agents are classified into three main categories, ranked in order of potential threat:

Category A

These are the Big 6 in bioterror: anthrax, botulism, plague, smallpox, tularemia, and viral hemorrhagic fevers (Ebola, Crimean-Congo, Lassa, or Marburg viruses).

Category A agents are considered highest risk because they:

- can be easily disseminated or transmitted from person to person
- result in high mortality rates and have the potential for major public health impacts
- cause panic and social disruption
- require special public health preparedness (for example, your reading this document right now).

Category B

Diseases and agents in this category have these properties:

- moderately easy to disseminate
- moderate morbidity rates and low mortality rates
- require specific enhancements of CDC's diagnostic capacity and enhanced disease surveillance.

Examples in this category include: brucellosis, glanders, Q fever, typhus fever, psittacosis, and viral encephalitis. Also included are food safety threats like E. coli O157:H7, salmonella, and shigella; water safety threats like cryptosporidium and cholera; and the toxins ricin and Epsilon toxin of Clostridium perfringens.

Category C

These are emerging pathogens that could be bio-engineered for mass dissemination. These agents:

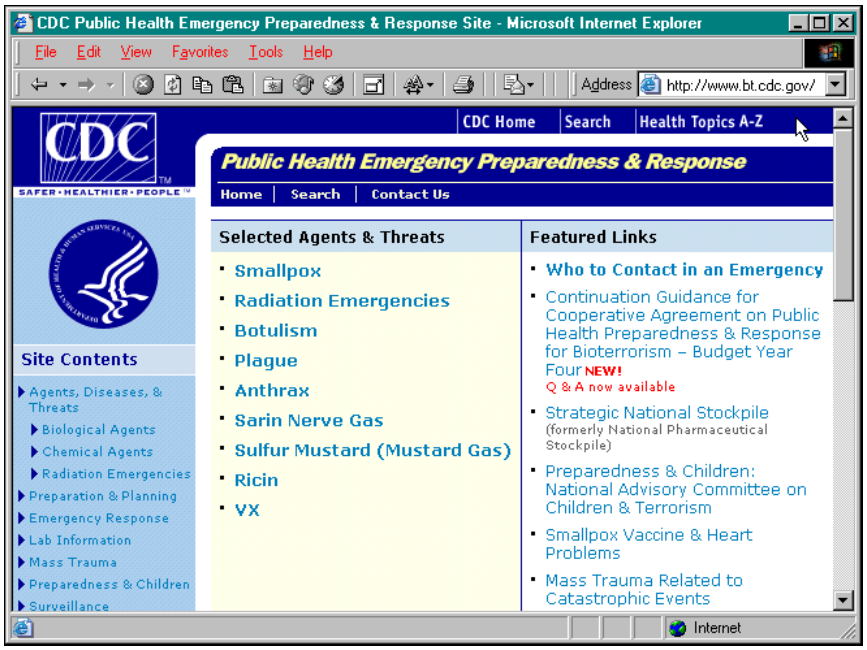
- are readily available
- are relatively easy to produce and disseminate
- have the potential for high morbidity and mortality rates and major health impacts.

Examples include emerging diseases such as Nipah virus and hantavirus.

Staying current

Information about BT agents is constantly evolving. Stay up to date by visiting the following authoritative websites:

www.bt.cdc.gov



Website of the federal **Centers for Disease Control & Prevention (CDC)**, which leads the nation's public health emergency preparedness and response.

www.usamriid.army.mil/education/instruct.html
BT reference library maintained by the US Army Medical Research Institute of Infectious Diseases.

www.dhs.ca.gov/ps/dcdc/bt/pdf/CA_BT_Surv_Epi_Plan-2002b.pdf
The detailed **Bioterrorism Surveillance and Epidemiologic Response Plan** prepared by California Department of Health Services.

Note: *Web addresses above may change, so if you don't find a specific web page, try going to the organization's home page and drilling down from there.*

CDC Bioterrorism Hotline
(770) 488-7100

Suspected Bioterrorism (BT)

Bioterrorism agents are likely to cause acute outbreaks of unusual syndromes or they can present common illnesses in an unusual setting like the "wrong" season or geographic area. Health care providers are likely to be the first to identify a case related to bioterrorism. If you can check one or more boxes in both categories below (syndrome and setting), consider BT. If you have any suspicion that a situation is related to bioterrorism, call us immediately.

Syndrome

- ☐ Acute severe pneumonia or respiratory distress
- ☐ Encephalopathy
- ☐ Acute onset of neuromuscular symptoms
- ☐ Unexplained rash with fever
- ☐ Fever with mucous membrane bleeding
- ☐ Unexplained acute icteric syndrome
- ☐ Massive diarrhea, dehydration, and collapse

Setting

***Atypical host characteristics*:**

- ☐ Patient <50 years old
- ☐ Immunologically intact
- ☐ No underlying illness
- ☐ No recent travel or unusual exposure

***Serious, unexplained, acute illness*:**

- ☐ Abrupt onset
- ☐ Prostration
- ☐ Cardiovascular collapse
- ☐ Respiratory distress
- ☐ Obtundation
- ☐ Change in mental status
- ☐ Disseminated intravascular coagulation

***Multiple cases with same symptoms, especially if*:**

- ☐ Geographically associated
- ☐ Closely clustered in time

***Out of season syndromes, such as*:**

- ☐ Influenza-like illness during summer

Phone Disease Control and Protection immediately!

(650) 573-2346 workdays
(650) 363-4981 after hours, weekend, & holidays

Public Health Lab

(650) 573-2500 for specimen submission.

Preventing panic

If you suspect bioterror, recognize the possible **psychological impact** of premature public disclosure of your findings.

Limit discussion with your staff on a **need-to-know basis** so they can prepare your organization and your day's patients. When you call us with your report, do so in private. After all, we all hope it turns out to be a false alarm.

Please do not talk to the **media** - refer them to Public Health officials.

If you maintain a **calm demeanor**, so will your associates and patients. Battling a bioterror agent is work enough without the complications of rumors and hysteria.

For up-to-date, detailed information on bioterrorism, go to http://www.bt.cdc.gov

Suspected Avian Influenza

Early identification of any individual with H5N1 avian influenza will be vital to preventing its spread.

When evaluating patients with fever and respiratory symptoms, it is essential to consider the possibility of avian flu. If they meet either of the criteria listed below, they should be placed in respiratory isolation and tested for H5N1 influenza.

1) An illness that requires hospitalization or is fatal and,

2) has a documented fever >38°C (100.4°F) and,

3) has radiographically- confirmed pneumonia, acute respiratory distress syndrome (ARDS) or other respiratory illness with no alternate diagnosis established and,

4) has at least one of the following exposures within 10 days of symptom onset:

A. Travel to an area with documented avian (H5N1) influenza in poultry, wild birds and/or humans with at least one of the following: • Direct contact with (e.g. touching sick or dead domestic poultry); OR

- Direct contact with surfaces contaminated with poultry feces; OR
- Consumption of raw or incompletely cooked poultry or poultry products; OR
- Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1; OR
- Close contact (within 1 meter or 3 feet) of a person who was hospitalized or died due to unexplained respiratory illness.
- List country(ies) and dates of travel
- List details of suspect H5N1 poultry, wild bird or human exposure history:

B. Close contact (within 1 meter) of an ill patient who was confirmed or suspected to have H5N1; OR

C. Worked with live influenza H5N1 virus in a laboratory.

Testing for H5N1 virus

If H5N1 influenza is suspected, specimens should be obtained and sent to the Public Health Laboratory for sub-typing.

This should be done regardless of rapid flu test results, because the sensitivity of the rapid flu test is not high enough to rule out influenza.

Collect a naso-pharyngeal swab and a throat swab and send them on viral transport medium to the Health Laboratory.
Mark all respiratory specimens "Suspect Avian Flu" so that cultures will not be done.

A surgical mask and tissues should be given to any patient in your waiting area with a cough to protect other patients and staff.

Report to Disease Control and Prevention immediately!

(650) 573-2346 workdays, 8 am - 5 pm

(650) 363-4981 for after hours emergencies ask for the on-call Health Officer.

See the Avian Influenza Algorithm and Specimen Submittal Form on the next two pages for more specific information.

San Mateo County Health System

EMERGENCY DEPARTMENT/OUTPATIENT GUIDELINES FOR AVIAN INFLUENZA SPECIMEN COLLECTION AND TESTING

Patient enters ED/Clinic with cough:
Provide surgical mask to patient to wear over mouth and nose; provide facial tissue and hand sanitizer. Place in separate room if possible.

Test for avian influenza H5N1 virus infection for any patient who:

1. Has an illness that requires hospitalization or is fatal; **AND**
2. Has/had documented fever≥38˚; **AND**
3. Has radiographically confirmed pneumonia, ARDS or a severs respiratory illness for which an alternate diagnosis is not established; **AND**

Has at least one of the following potential exposures within 10 days of symptom onset:

1. Travel history to a county with documents avian (H5N1) influenza in poultry, wild birds, and/or humans (updated listing at http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm) **AND** at least one of the following potential exposures during travel:
   - Direct contact with sick or dead domestic poultry
   - Direct contact with surfaces contaminates with poultry feces
   - Consumption of raw or incompletely cooked poultry or poultry produces
   - Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1
   - Close contact (approximately 3 feet) of a person who was hospitalized or died due to a severe unexplained respiratory illness
2. Close contact of an ill patient with confirmed or suspected H5N1
3. Worked with live influenza H5N1 virus in a laboratory

Complete the California Department of Public Health screening form for suspect Avian (H5N1) Influenza (www.cdph.ca.gov/programs/vrdl/Documents/CA_AVFLU_Case_screeningform.pdf) and consult with the San Mateo County Disease Control and Prevention Unit. Call (650) 573-2346 Monday through Friday 8 am to 5 pm. After hours call (650) 363-4981; ask for the Health Officer.

Infection Control Measures

1. Place patient in strict respiratory isolation, preferably a negative pressure room. Health care workers should wear fit-tested N-95 respirators, gloves, gown, and eye protection, especially during bronchoalveolar lavage, which is considered to be a high-risk aerosol-generating procedure.
2. **DO NOT DISCHARGE** suspect avian flu cases without Health Department clearance. Outpatients or discharged patients must be isolated at home under a Health Officer Isolation Order that will be served to the patient by calling the Disease Control and Prevention Unit at (650) 573-2346 or the on-call Health Officer at (650) 363-4981 24/7.

PUBLIC HEALTH SPECIMEN COLLECTION GUIDELINES

- To improve diagnostic sensitivity, testing should be performed on multiple samples types. Oropharyngeal swab specimens and lower respiratory tract specimens (e.g. bronchalveolar lavage or tracheal aspirates) are preferred because they appear to contain the highest quantity of influenza A (H5N1) virus based on current data. Given that most human cases have presented with lower respiratory tract infections, the collection of only an upper respiratory specimen, particularly a single nasopharyngeal or nasal swab, is NOT recommended. Respiratory specimens are optimally collected within the first 3 days of illness onset. If possible, serial specimens should be obtained over several days from the same patient.

- **At a minimum the following should be collected:**
  1. Oropharyngeal swab specimens collected in 3 cc viral transport media (VTM**); AND**
  2. A nasopharyngeal swab OR nasopharyngeal wash OR nasopharyngeal aspirate collected in 3 cc viral transport media (VTM)**; AND**
  3. Any specimen(s) from the lower respiratory tract (e.g., sputum, bronchoalveolar lavage, tracheal aspirate or pleural fluid tap).
     - Oropharyngeal swabs may have better yield than nasopharyngeal specimens. While both types of specimens should be collected, an oropharyngeal swab should be performed preferentially if only one sample can be taken.
     - In outpatient settings, it may be difficult to obtain samples from the lower respiratory tract in children. In these instances, two specimens from the upper respiratory tract (e.g. a nasopharyngeal wash and a throat swab) are acceptable.

- **Collecting specimens from the upper respiratory tract**
  1. **Nasopharyngeal wash/aspirate**
     - Have the patient sit with head tilted slightly backward.
     - Instill 1 ml–1.5 ml of nonbacteriostatic saline (pH 7.0) into one nostril. Flush a plastic catheter or tubing with 2 ml–3 ml of saline. Insert the tubing into the nostril parallel to the palate. Aspirate nasopharyngeal secretions. Repeat this procedure for the other nostril.
     - Collect the specimens in sterile vials.
     - For shipping, use cold packs to keep the sample at 4°C.

  2. **Nasopharyngeal or oropharyngeal swabs**
     - Use only sterile dacron swabs with aluminum or plastic shafts. Do **not** use calcium alginate or cotton swabs or swabs with wooden sticks, as they may contain substances that inactivate some viruses and inhibit PCR testing.
     - To obtain a **nasopharyngeal swab**, insert a swab into the nostril parallel to the palate. Leave the swab in place for a few seconds to absorb secretions. Swab both nostrils.
     - To obtain an **oropharyngeal swab**, swab the posterior pharynx and tonsillar areas, avoiding the tongue.
     - Place each swab immediately into two separate sterile vials containing 2 ml of viral transport media (VTM, either commercially available, herpes buffere tryptose gelatin meium or Hanks' balanced salt solution with gelatin). Break the applicator sticks off near the tip to permit tightening of the cap. Place at

4°C immediately after collection.
- For shipping, use cold packs to keep the sample at 4°C.

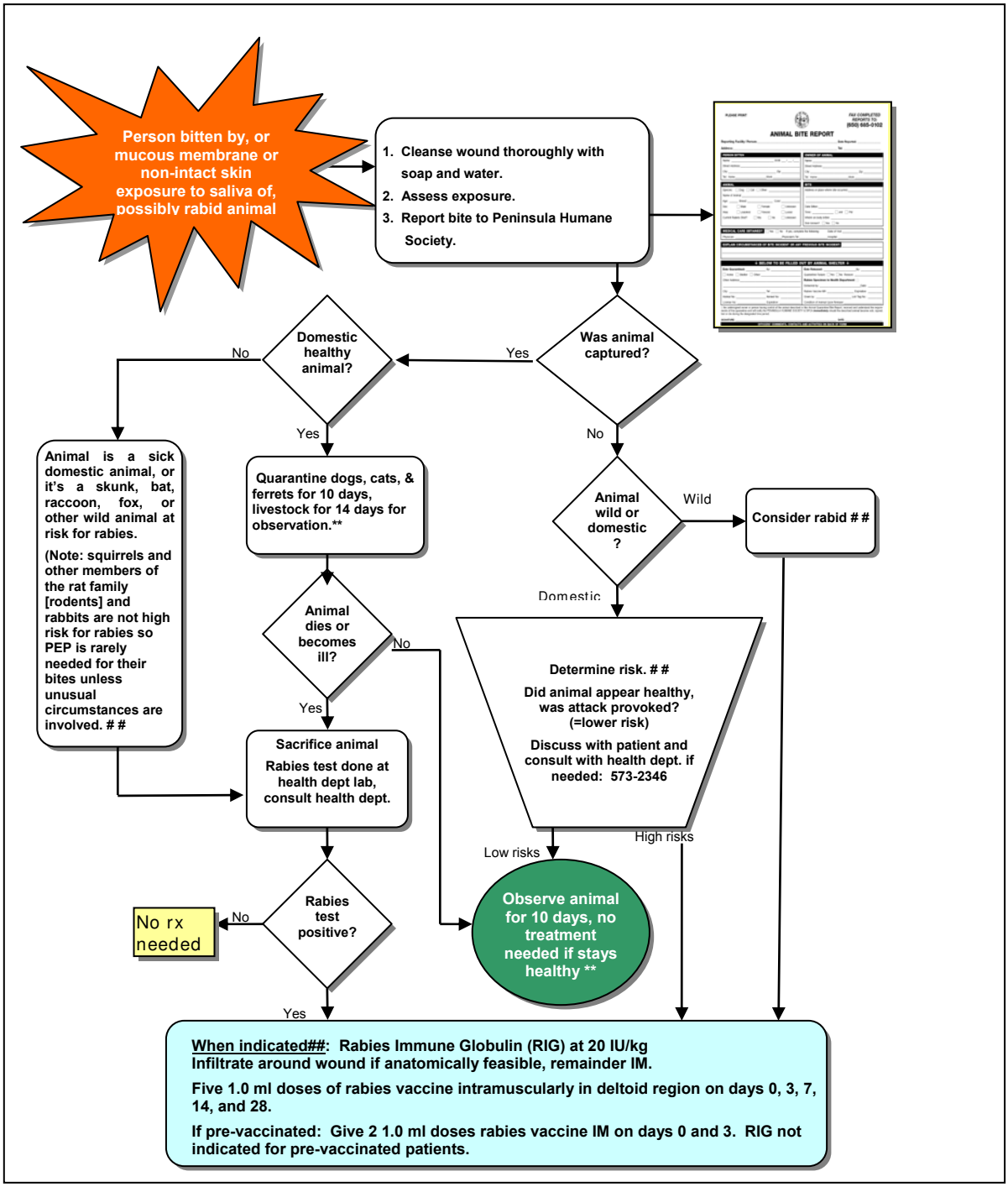
- **Collecting specimens from the lower respiratory tract**
  1. **Broncheoalveolar lavage, tracheal aspirate, or pleural fluid tap**
     - During bronchoalveolar lavage or tracheal aspirate, use a double-tube system to maximum shielding from oropharyngeal secretions.
     - Place the unspun fluid in sterile vials with external caps and internal O-ring seals. If there is no internal O-ring seal, then seal tightly with the available cap and secure with Parafilm®.
     - For shipping, use cold packs to keep the sample at 4°C.

  2. **Sputum**
     - Educate the patient about the difference between sputum and oral secretions.
     - Have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile screw-cap sputum collection cup or sterile dry container.
     - For shipping, use cold packs to keep the sample at 4°C.

- **BLOOD COMPONENTS (optional)**
  Collection of sera for serologic testing for influenza as well as other respiratory viruses can be considered, but should not replace collection of respiratory specimens, which are highly recommended for influenza A (H5N1) testing. Serologic testing for influenza H5N1-specific antibody can be considered if other influenza H5N1 diagnostic testing methods are unsuccessful (for example, due to delays in respiratory specimen collection). For serologic testing, paired blood samples are ideal. Collect an acute phase blood specimen (5-10 ml whole clotted blood) on each patient within the first week of illness, complete a San Mateo County Public Health Lab Specimen Submittal Form for Suspect Avian Influenza A (H5N1), and schedule patient to return in 14-21 days for a convalescent blood specimen. A demonstrated rise in the H5N1-specific antibody level is required for a diagnosis of H5N1 infection. Serum specimens will be forwarded to the Centers for Disease Control and Prevention where the micro-neutralization assay, which requires live virus, can be performed to test for H5N1-specific antibody.

  1. **To collect serum for antibody testing:**
     - Collect 5 ml–10 ml of whole blood in a serum separator tube. Allow the blood to clot, centrifuge briefly, and collect all resulting sera in vials with external caps and internal O-ring seals. If there is no internal O-ring seal, then seal tightly with the available cap and secure with Parafilm®.
     - The minimum amount of serum preferred for each test is 200 microliters, which can easily be obtained from 5 ml of whole blood. A minimum of 1 cc of whole blood is needed for testing of pediatric patients. If possible, collect 1 cc in an EDTA tube and in a clotting tube. If only 1cc can be obtained, use a clotting tube.
     - If unfrozen, ship with cold packs to keep the sample at 4°C. If frozen, ship on dry ice.

Rabies Post-exposure Prophylaxis (PEP) Guide



****Detain and clinically observe for 10 days** any healthy-appearing dog, cat, or ferret known to have bitten a person (unwanted dogs and cats may be euthanized immediately and examined for rabies by fluorescent microscopy). **Dogs and cats showing signs suspicious for rabies should be sacrificed and tested for rabies.** If the biting animal was infective at the time of the bite, rabies will usually develop within 4-7 days, followed by death. **All wild mammals that have bitten a person should be sacrificed immediately so the brain can be examined for evidence of rabies.**

Bites from squirrels, rats, mice, chipmunk, gophers, other rodents, hamsters, guinea pigs, gerbils, rabbits and hares <u>almost never call for rabies prophylaxis</u>. However, each case should be reviewed to ensure that abnormal behavior or unusual circumstances are not involved with the animal, as any mammal can develop rabies. **Bats should be considered rabid unless captured, tested, and results are negative.**

Animal Bites & Rabies

Why Report?

Rabies is endemic in wildlife in San Mateo County, and can affect domestic animals as well. Any bite that breaks the skin, and any exposure of mucus membranes or broken skin to saliva of potentially rabid animals, can cause human rabies. Prophylaxis with Rabies Immune Globulin and Rabies Vaccine is effective at preventing this deadly disease.

Bats and Rabies

Bats are important reservoirs for rabies, and their bites are often imperceptible. Therefore, if there is any contact with a bat or if a bat is found in a room with children or where people are sleeping, rabies prophylaxis should be considered. Call the DCP or the health officer on call to discuss specific cases.

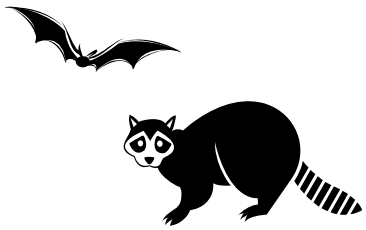
Dog Bite Facts

Number of licensed dogs in San Mateo County in 2004: 55,452

Number of dog bites reported in San Mateo County in 2004: 619

Fewer than half of these dogs had been vaccinated against rabies!

Many more people are bitten by other animals, wild or domestic. Because bites may spread rabies, health care providers must report all animal bites.



Testing Animals for Rabies

The Public Health Laboratory performs rabies testing on domestic or wild animals at risk for rabies, such as bats, skunks, foxes, raccoons, and opossums. Animals like mice, rats, gophers, rabbits and squirrels are unlikely to transmit rabies. As testing involves examination of the brain tissue, it's necessary to euthanize the animal to perform rabies testing. Please call Disease Control and Prevention at 573-2346 to discuss whether testing is indicated.

Rabies testing is done at least weekly. Additional testing will be done on recommendation of a public health physician. Dead animals may be brought in between 8 am and 4 pm, Monday through Friday.

Non-owned Animals

The Peninsula Humane Society will attempt to catch stray animals that have bitten humans and bring them to the lab for testing.

General Information on Human Rabies

Incubation period is usually 3-8 weeks, rarely as short as 9 days or as long as 7 years; depends on the severity of the wound, site of the wound in relation to the richness of the nerve supply and its distance from the brain, amount and strain of virus introduced, protection provided by clothing and other factors. Prolonged incubation periods have occurred in prepubertal individuals.

Report all animal bites immediately to:

Peninsula Humane Society & SPCA
12 Airport Boulevard
San Mateo, CA 94401
(650) 348-7891
(650) 340-7022

For questions on management of animal bites, or if you suspect rabies disease, call:

Disease Control and Prevention

(650) 573-2346
(650) 363-4981 for after-hours emergencies)

Other useful numbers:

To obtain Rabies Vaccine, call

1-800-CHIRON or

1-800-VACCINE

For Rabies Immune Globulin (RIG), call

1-800-VACCINE or
1-800-243-4153

Public Health Lab

225 37th Avenue, Room 113
San Mateo, CA 94403
(650) 573-2500

... for questions about where and when to bring an animal for testing.

See next page for guidelines for determining whether rabies vaccine and RIG (Rabies Immune Globulin) are needed for a patient.

California Department of Public Health – Viral and Rickettsial Disease Laboratory

WEST NILE VIRUS SPECIMEN SUBMITTAL FORM

PLEASE USE ONE FORM PER PATIENT

West Nile virus testing is recommended on individuals with the following:

A. Encephalitis

B. Aseptic meningitis (Note: Consider enterovirus for individuals ≤ 18 years of age)

C. Acute flaccid paralysis; atypical Guillain-Barré Syndrome; transverse myelitis; or

D. Febrile illness compatible with West Nile fever* and lasting ≥ 7 days (must be seen by health care provider):

** The West Nile fever syndrome can be variable and often includes headache and fever (T≥38C). Other symptoms include rash, swollen lymph nodes, eye pain, nausea or vomiting. After initial symptoms, the patient may experience several days of fatigue and lethargy.*

---

1. **Required specimens**:
   - ❑ **Acute Serum:** ≥ 2cc serum
   - ❑ **Cerebrospinal Fluid (CSF):** 1-2cc CSF if lumbar puncture is performed
2. If West Nile virus is highly suspected and acute serum is negative or inconclusive:
   - ❑ **2nd Serum:** ≥ 2 cc serum collected 3-5 days after acute serum

---

- ❑ Refrigerated specimens should be sent on **cold pack** using an overnight courier
- ❑ If CSF is frozen, send on dry ice (all specimens may be sent on dry ice)
- ❑ Each specimen should be labeled with **date of collection**, **specimen type**, and **patient name**
- ❑ Please do not send specimens on Fridays (Specimen Receiving Hours: M-F 8-5)
- ❑ Send specimens to CDPH VRDL: **Specimen Receiving – West Nile**
  850 Marina Bay Parkway
  Richmond, CA 94804
- ❑ Local Public Health Laboratory West Nile **IFA/EIA IgM results** (or attach copy of results):

Specimen	Date Collected	IgM Assay Method	Results			
			Negative	Reactive	Indeterminate	Not Tested
		o IFA o EIA				
		o IFA o EIA				

**** IMPORTANT: THE INFORMATION BELOW MUST BE COMPLETED AND SUBMITTED WITH SPECIMENS ****

Patient's last name, first name:			**Patient Information** **Address** _____ **City**_____ **Zip**_____ **County**_____ **Phone Number (_____)**_____
Age or DOB:	Sex (circle): M F	Onset Date:	
Clinical findings: o Encephalitis o Meningitis o Acute flaccid paralysis o Febrile illness o Other: _____ Other tests requested:			Other information (immunocompromised, travel hx, hx of flavivirus infection, etc.):

	Specimen type and/or specimen source	Date Collected	**This section for Laboratory use only. Date received by VRDL and State Accession Number**
1st			1st
2nd			2nd
3rd			3rd

Questions? Call Cynthia Jean at (510) 307-8606

Submitting Physician_____ Phone Number (_____) _____

Submitting Facility_____ Phone Number (_____) _____