



**Austin/Travis County Health & Human Services Department**



**DISEASE PREVENTION AND HEALTH PROMOTION DIVISION**

**EPIDEMIOLOGY AND HEALTH STATISTICS UNIT**

**15 Waller Street, 4<sup>th</sup> Floor  
Austin, TX 78702  
512-972-5555**

# **Reporting Communicable Disease in Travis County**



**Austin/Travis County Health and Human Services Department**  
Disease Prevention and Health Promotion Division  
Epidemiology and Health Statistics Unit  
15 Waller Street  
Austin, Texas 78702



## **Reporting Package for Providers in Travis County**

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## **REPORTING PHONE NUMBERS**

Reportable diseases/conditions occurring in Travis County shall be reported to the Austin/Travis County Health and Human Services Department (ATCHHSD). Refer to the Texas Department of State Health Services (TDSHS) listing for names of diseases/conditions that are reportable and other information.

### **General Communicable Diseases**

**(512) 972-5555**

**Fax (512) 972-5772**

### **HIV/AIDS**

**(512) 972-5144 or 972-5145**

**Fax (512) 972-7994**

### **STD Reporting**

**(512) 972-5512 or 972-5433**

**Fax (512) 972-7994**

### **Tuberculosis Reporting**

**(512) 972-5448**

**Fax (512) 972-5451**

### **Perinatal Hepatitis B Program**

**(512) 972-6218**

**Fax (512) 972-6287**

### **Lead (elevated blood levels) -State Health Dep't 1-800-588-1248**

**Fax (512) 776-7699**

**Child (512) 776-6632**

**Adult (512) 776-7151**

## **OTHER ATCHHSD USEFUL PHONE NUMBERS**

### **Animal Control**

**311**

### **Environmental Health**

**(512) 978-0300 Fax-(512) 978-0322**

### **Health Authority**

**(512) 972-5855**

### **Immunizations**

**(512) 972-5520**

### **Refugee Screening Clinic**

**(512) 972-6210 or 972-6239**

### **STD & HIV Clinic**

**(512) 972-5430 or 972-5580**

### **TB Clinic**

**(512) 972-5460**

### **Vital Records (Birth/Death)**

**(512) 972-4784 Fax-(512) 972-5208**

### **WIC Program**

**(512) 972-4942**

### **Vaccines for Children**

**(512) 972-5414**

**(Provider VFC Program)**



# Texas Notifiable Conditions

**24/7 Number for Immediately Reportable– 1-800-705-8868**  
Report confirmed and suspected cases.



Unless noted by \*, report to your local or regional health department using number above or find contact information at <http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/>

A – I	When to Report	L – Y	When to Report
*Acquired immune deficiency syndrome (AIDS) <sup>1, 2</sup>	Within 1 week	*Lead, child blood, any level & adult blood, any level <sup>6</sup>	Call/Fax Immediately
Amebiasis <sup>3</sup>	Within 1 week	Legionellosis	Within 1 week
Amebic meningitis and encephalitis	Within 1 week	Leishmaniasis	Within 1 week
Anaplasmosis	Within 1 week	Listeriosis	Within 1 week
<b>Anthrax<sup>3, 4</sup></b>	<b>Call Immediately</b>	Lyme disease	Within 1 week
Arbovirus infection <sup>3, 5</sup>	Within 1 week	Malaria	Within 1 week
*Asbestosis <sup>6</sup>	Within 1 week	<b>Measles (rubeola)</b>	<b>Call Immediately</b>
Babesiosis	Within 1 week	<b>Meningococcal infections, invasive</b>	<b>Call Immediately</b>
<b>Botulism (adult and infant)<sup>3</sup></b>	<b>Call Immediately</b>	Mumps	Within 1 week
<b>Brucellosis<sup>3, 4</sup></b>	<b>Within 1 work day</b>	<b>Pertussis<sup>3</sup></b>	<b>Within 1 work day</b>
Campylobacteriosis	Within 1 week	*Pesticide poisoning, acute occupational	Within 1 week
*Cancer <sup>7</sup>	See rules	<b>Plague (Yersinia pestis)</b>	<b>Call Immediately</b>
Chagas' disease	Within 1 week	<b>Poliomyelitis, acute paralytic</b>	<b>Call Immediately</b>
*Chancroid	Within 1 week	<b>Poliovirus infection, non-paralytic</b>	<b>Within 1 work day</b>
Chickenpox (varicella) <sup>8</sup>	Within 1 week	<b>Q fever</b>	<b>Within 1 work day</b>
*Chlamydia trachomatis infection	Within 1 week	<b>Rabies, human</b>	<b>Call Immediately</b>
*Contaminated sharps injury <sup>9</sup>	Within 1 month	Relapsing fever	Within 1 week
<b>*Controlled substance overdose<sup>10</sup></b>	<b>Call Immediately</b>	<b>Rubella (including congenital)</b>	<b>Within 1 work day</b>
Creutzfeldt-Jakob disease (CJD)	Within 1 week	Salmonellosis, including typhoid fever	Within 1 week
Cryptosporidiosis	Within 1 week	<b>Severe Acute Respiratory Syndrome (SARS)</b>	<b>Call Immediately</b>
Cyclosporiasis	Within 1 week	Shigellosis	Within 1 week
Cysticercosis	Within 1 week	*Silicosis	Within 1 week
*Cytogenetic results (fetus and infant only) <sup>11</sup>	See rules	<b>Smallpox</b>	<b>Call Immediately</b>
Dengue	Within 1 week	*Spinal cord injury <sup>12</sup>	Within 10 work days
<b>Diphtheria</b>	<b>Call Immediately</b>	Spotted fever group rickettsioses <sup>3</sup>	Within 1 week
*Drowning/near drowning <sup>12</sup>	Within 10 work days	<b>Staph. aureus, vancomycin-resistant (VISA and VRSA)</b>	<b>Call Immediately</b>
Ehrlichiosis	Within 1 week	Streptococcal disease (group A, B, S. pneumo), invasive	Within 1 week
Escherichia coli infection, Shiga toxin-producing <sup>3, 4</sup>	Within 1 week	*Syphilis – primary and secondary stages <sup>1, 13</sup>	Within 1 work day
*Gonorrhea	Within 1 week	*Syphilis – all other stages <sup>1, 13</sup>	Within 1 week
Haemophilus influenzae type b infections, invasive <sup>3</sup>	Within 1 week	Taenia solium and undifferentiated Taenia infection	Within 1 week
Hansen's disease (leprosy) <sup>3</sup>	Within 1 week	Tetanus	Within 1 week
Hantavirus infection <sup>3</sup>	Within 1 week	*Traumatic brain injury	Within 10 work days
Hemolytic Uremic Syndrome (HUS) <sup>3</sup>	Within 1 week	Trichinosis <sup>3</sup>	Within 1 week
<b>Hepatitis A (acute)</b>	<b>Within 1 work day</b>	<b>Tuberculosis (includes all M. tuberculosis complex)<sup>4, 14</sup></b>	<b>Within 1 work day</b>
Hepatitis B, C, and E (acute) <sup>3</sup>	Within 1 week	<b>Tularemia</b>	<b>Call Immediately</b>
Hepatitis B identified prenatally or at delivery (acute & chronic) <sup>3</sup>	Within 1 week	Typhus	Within 1 week
<b>Hepatitis B, perinatal (HBsAg+ &lt; 24 months old)<sup>3</sup></b>	<b>Within 1 work day</b>	<b>Vibrio infection, including cholera</b>	<b>Within 1 work day</b>
*Human immunodeficiency virus (HIV) infection <sup>1, 2</sup>	Within 1 week	<b>Viral hemorrhagic fever, including Ebola</b>	<b>Call Immediately</b>
<b>Influenza-associated pediatric mortality</b>	<b>Within 1 work day</b>	<b>Yellow fever</b>	<b>Call Immediately</b>
<b>Influenza, Novel</b>	<b>Call Immediately</b>	Yersiniosis <sup>3</sup>	Within 1 week

In addition to specified reportable conditions, **any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported by the most expeditious means available**

**\*See condition-specific footnote for reporting contact information**

- <sup>1</sup> Please refer to specific rules and regulations for HIV/STD reporting and who to report to at: <http://www.dshs.state.tx.us/hivstd/healthcare/reporting.shtm>.
- <sup>2</sup> Labs conducting confirmatory HIV testing are requested to send remaining specimen to a CDC-designated laboratory. Please call 512-533-3132 for details.
- <sup>3</sup> Reporting forms are available at <http://www.dshs.state.tx.us/idcu/investigation/forms/>. Investigation forms at <http://www.dshs.state.tx.us/idcu/investigation/>  
Call as indicated for immediately reportable conditions.
- <sup>4</sup> Lab isolate must be sent to DSHS lab. Call 512-776-7598 for specimen submission information.
- <sup>5</sup> Reportable Arbovirus infections include neuroinvasive and non-neuroinvasive California serogroup including Cache Valley, Eastern Equine (EEE), Dengue, Powassan, St. Louis Encephalitis (SLE), West Nile, and Western Equine (WEE).
- <sup>6</sup> Please refer to specific rules and regulations <http://www.dshs.state.tx.us/epitox/default.shtm>.
- <sup>7</sup> Please refer to specific rules and regulations for cancer reporting and who to report to at <http://www.dshs.state.tx.us/tcr/reporting.shtm>.
- <sup>8</sup> Varicella reporting form at [http://www.dshs.state.tx.us/idcu/health/vaccine\\_preventable\\_diseases/forms/NewVaricellaForm.pdf](http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/forms/NewVaricellaForm.pdf). Call local health dept for copy with their fax number.
- <sup>9</sup> Not applicable to private facilities. Initial reporting forms for Contaminated Sharps at [http://www.dshs.state.tx.us/idcu/health/infection\\_control/bloodborne\\_pathogens/reporting/](http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting/).
- <sup>10</sup> Contact local poison center at 1-800-222-1222. For instructions, forms, and fax numbers see <http://www.dshs.state.tx.us/epidemiology/epipoison.shtm#rcso>.
- <sup>11</sup> Report cytogenetic results including routine karyotype and cytogenetic microarray testing (fetus and infant only). Please refer to specific rules and regulations for birth defects reporting and who to report to at [http://www.dshs.state.tx.us/birthdefects/BD\\_LawRules.shtm](http://www.dshs.state.tx.us/birthdefects/BD_LawRules.shtm).
- <sup>12</sup> Please refer to specific rules and regulations for injury reporting and who to report to at <http://www.dshs.state.tx.us/injury/rules.shtm>.
- <sup>13</sup> Laboratories should report syphilis test results within 3 work days of the testing outcome.
- <sup>14</sup> MTB complex includes *M. tuberculosis*, *M. bovis*, *M. africanum*, *M. canettii*, *M. microti*, *M. caprae*, and *M. pinnipedii*. Please see rules at <http://www.dshs.state.tx.us/idcu/disease/tb/reporting/>.

Texas Department of State Health Services – Business Hours 1-800-252-8239 / After Hours 512-776-7111



## Notifiable Conditions Special Instructions

<sup>1</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/hivstd/reporting/default.shtm>

<sup>2</sup> Labs conducting confirmatory HIV testing are requested to send remaining specimen to a CDC-designated laboratory. Please call 512-533-3041 for details.

<sup>3</sup> Reporting and investigation forms are available at: <http://www.dshs.state.tx.us/idcu/investigation/>  
Call as indicated for immediately reportable conditions.

<sup>4</sup> Lab isolate must be sent to DSHS lab. Call 512-458-7598 for specimen submission information

<sup>5</sup> Reportable Arbovirus infections include neuroinvasive and non-neuroinvasive Cache Valley, California serogroup, Eastern Equine (EEE), Dengue, Powassan, St. Louis Encephalitis (SLE), Venezuelan equine (VEE), West Nile, and Western Equine (WEE)

<sup>6</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/epitox/default.shtm>

<sup>7</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/tcr/lawrules.shtm>

<sup>8</sup> Varicella reporting form is at:

[http://www.dshs.state.tx.us/idcu/health/vaccine\\_preventable\\_diseases/forms/f11\\_11046.pdf](http://www.dshs.state.tx.us/idcu/health/vaccine_preventable_diseases/forms/f11_11046.pdf). Call local health dept for copy with their fax number. <sup>9</sup> Not applicable to private facilities. Initial reporting forms for Contaminated Sharps at: [http://www.dshs.state.tx.us/idcu/health/bloodborne\\_pathogens/reporting/](http://www.dshs.state.tx.us/idcu/health/bloodborne_pathogens/reporting/)

<sup>10</sup> Contact local poison center at 1-800-222-1222. For instructions, forms, and fax numbers see

<http://www.dshs.state.tx.us/epidemiology/epipoison.shtm>

<sup>11</sup> Please refer to specific rules and regulations for reporting and who to report to at:

<http://www.dshs.state.tx.us/injury/default.shtm>

<sup>12</sup> M. TB complex includes M. tuberculosis, m. bovis, and m. africanum. Please refer to specific rules and regulations for reporting and who to report to at <http://www.dshs.state.tx.us/idcu/disease/tb/>

In addition to specified reportable conditions, **any outbreak, exotic disease, or unusual group expression of disease that may be of public health concern should be reported** by the most expeditious means available

Department of State Health Services Confidential Report (Fax version only)

All physicians who diagnose or treat a reportable condition and others required to report shall report it within seven (7) days. Complete all boxes as appropriate. Shaded areas are not required by law, but necessary for appropriate identification or follow-up.

**Patient's Name (Last, First, MI):** \_\_\_\_\_ **Birth Date (mm/dd/yyyy)** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:**  F  M **Pregnant: Yes**  **No**   
**Address (Street, City, State, Zip):** \_\_\_\_\_ **Hispanic Ethnicity:**  Yes  No **Race: Check all that apply**  
**Telephone:** \_\_\_\_\_ **Employment:** \_\_\_\_\_ **Marital Status:**  S  M  W  D **SSN or Medical Record #** \_\_\_\_\_  
**How Many Weeks:** \_\_\_\_\_ **W**  **B**  **AIS**  **AI**  **PI**

Exam Date (mm/dd/yyyy): \_\_\_\_\_

**Provider Codes:**

900 Clinic                       Private Phy/HMO  
 100-200-300-700 Clinic    Hospital  
 Drug Treatment                 Emergency Dept.  
 Family Planning Sites        Correctional Facility  
 Prenatal/OB Clinic            Laboratory  
 TB Clinic                          Blood/Plasma  
 Other Clinic                     Other

**Exam Reason:**

DIS Partner Referral    DIS Suspect Referral  
 Referred by Partner    Prenatal    Delivery  
 Screening in Jail/Prison    Other Screening  
 Referred by Another Provider    Volunteer

Code 100  
 Code 490:  
 Associated with  200  300  
 Other/Unknown  
 Code  900  950  
Reporting 900's on this document serves as proof of timely report; however, the health department requires additional information on 900 Patients.

**Neurologic Involvement**

Yes  
 No  
 Unk

**Name of lab:** \_\_\_\_\_  
**Lab Test(s) and Results:**

**No Treatment Given**  
**Date:** \_\_\_/\_\_\_/\_\_\_  
**Treatment Given (Drug & Dosage):**

**Code 200 (not 490)**

Genital  
 Ophthalmia  
**Code 300 (not 490)**  
 Genital     Pharyngeal  
 Rectal       Ophthalmia  
 Other        Resistant

Code 600

Code:

710                       745  
 720                       750  
 730                       790  
 740

For all 900 reporting please  
 contact 972-5144 or  
 972-5145

**Contact Information:**  
 Austin/Travis County HHS  
**Fax:** 512-972-5772  
**Phone:** 512-972-5512  
 512-972-5144  
 512-972-5145

Reported by: \_\_\_\_\_ Office Address & Phone Number: \_\_\_\_\_

# Codes for form S-27

- 100- Chancroid
- 200-Chlamydia
- 300-Gonorrhea
- 490-Pelvic Inflammatory Disease (Syndrome)
- 600-Lymphogranuloma Venereum
- 700-Syphilis
- 710-Primary Syphilis (lesions)
- 720-Secondary Syphilis (symptoms)
- 730-Early Latent Syphilis (<1 year)
- 740- Latent Syphilis, Unknown Duration
- 745- Late Latent Syphilis (>1 Year)
- 750-Late Syphilis with Symptomatic Manifestations
- 790- Congenital Syphilis
- 900- HIV (non-AIDS)
- 950- AIDS (Syndrome)

## **Codes for form S-27**

**100- Chancroid**

**200- Chlamydia**

**300- Gonorrhea**

**490- Pelvic Inflammatory Disease (Syndrome)**

**600- Lymphogranuloma Venereum**

**700- Syphilis**

**710- Primary Syphilis (lesions)**

**720- Secondary Syphilis (symptoms)**

**730- Early Latent Syphilis (<1 year)**

**740- Latent Syphilis, Unknown Duration**

**745- Late Latent Syphilis (>1 year)**

**750- Late Syphilis with Symptomatic Manifestations**

**790- Congenital Syphilis**

**900- HIV (non-AIDS)**

**950- AIDS (Syndrome)**



## VARICELLA (chickenpox) Reporting Form

Please use this form to report cases of varicella to your local or regional health office. You can fax a copy of this document to the Texas Department of State Health Services in Austin at (512) 776-7616 at the end of every week. Please complete as many of the questions as possible. A report can still be submitted if all questions cannot be answered.

Onset Date ____/____/____ Last day of school attended ____/____/____	History of Disease?                      Yes      No                      Date of Disease ____/____/____ Vaccinated against Varicella?        Yes      No                      Number of Doses Received?    1        2 Date(s) Varicella Vaccine Administered: (1) ____/____/____ (2) ____/____/____			
LAST NAME	FIRST	DOB	AGE	SEX
ADDRESS		CITY		ZIP CODE
PHONE		RACE		HISPANIC? Yes                      No
Is this patient a contact to another known Varicella case? Name of contact:  Phone:		Was the patient hospitalized? Yes                      No		Did the patient have a fever? Yes                      No Date:
Was lab testing done for Varicella?    Yes      No Lab test: DFA    PCR    IgM    IgG    Other Date: _____                      Result:		Number of lesions in total: <i>(circle number of lesions)</i> <50                      50-249  250-499                      500+		Did the patient attend daycare/after school care? Yes                      No Name of Facility:
Ordering Physician:				

Onset Date ____/____/____ Last day of school attended ____/____/____	History of Disease?                      Yes      No                      Date of Disease ____/____/____ Vaccinated against Varicella?        Yes      No                      Number of Doses Received?    1        2 Date(s) Varicella Vaccine Administered: (1) ____/____/____ (2) ____/____/____			
LAST NAME	FIRST	DOB	AGE	SEX
ADDRESS		CITY		ZIP CODE
PHONE		RACE		HISPANIC? Yes                      No
Is this patient a contact to another known Varicella case? Name of contact:  Phone:		Was the patient hospitalized? Yes                      No		Did the patient have a fever? Yes                      No Date:
Was lab testing done for Varicella?    Yes      No Lab test: DFA    PCR    IgM    IgG    Other Date: _____                      Result:		Number of lesions in total: <i>(circle number of lesions)</i> <50                      50-249  250-499                      500+		Did the patient attend daycare/after school care? Yes                      No Name of Facility:
Ordering Physician:				

Name of Person Reporting: \_\_\_\_\_ PHONE: \_\_\_\_\_

Agency/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_ COUNTY: \_\_\_\_\_

DATE REPORTED: \_\_\_\_\_

**Texas Department of Health  
Tuberculosis Elimination Division  
Report of Case and Patient Services**

Date reported to health department \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date form sent to region \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date form sent to central office \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Initial Report     Drug Resistance     Followup or Medical Review     Hospital Admission or Discharge

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle)    DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM    DD    YY

Street \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_    SSN \_\_\_\_\_

Facility/Care Provider Name \_\_\_\_\_  
Facility responsible for patient care  Public Health Clinic     Private Physician     Hospital     Other (Specify) \_\_\_\_\_  
Name of person completing this form \_\_\_\_\_

**Signs/Symptoms at DX**

Fever  Y  N  
Chills  Y  N  
Cough  Y  N  
Productive Cough  Y  N  
Hemoptysis  Y  N  
Night Sweats  Y  N  
Weight Loss (≥ 10%)  Y  N  
Other: \_\_\_\_\_

**Chest X-Ray**

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Results:  Normal     Abnormal     Not Done     Unk  
**If Abnormal, check abnormality Status**  
 Cavitory     Stable  
 Non-cavitory, consistent with TB     Worsening  
 Non-cavitory, not consistent with TB     Improving  
**Comments:** \_\_\_\_\_  
 Unknown

**If Pediatric TB Case (<15 Years Old)**

Country of birth for primary guardians:  
Guardian 1) \_\_\_\_\_  
Guardian 2) \_\_\_\_\_  
Patient lived outside US for > 3 months  
 Yes     No     Unknown  
If yes, Country \_\_\_\_\_

**Status**  New     Recurrent     Reopen  
**Prior Therapy**  Yes     No    Start Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Stop Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**AFB Smear Results**  
Current \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Negative     Positive  
 Pending     Not done  
Specimen type:  sputum     urine     bronchial washing  
 biopsy     other  
If biopsy or other, list anatomic site of specimen: \_\_\_\_\_  
If other than sputa, type of exam \_\_\_\_\_  
Collection date of initial positive AFB smear: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Collection date of first consistently negative AFB smear: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**ATS Classification**

- 0 No M. TB Exposure, Not TB Infected
- 1 M. TB Exposure, No Evidence of TB Infection
- 2 M. TB Infection, No Disease
- 3 M. TB Infection, Current Disease
- 4 M. TB, No Current Disease
- 5 M. TB Suspect, Diagnosis Pending

**Predominant Site: (Class 3, 4)**

- Significant Sites other than Predominant**
- |   |   |
|---|---|
| 00 <input type="checkbox"/> Pulmonary     | 30 <input type="checkbox"/> Bone and/or Joint     |
| 10 <input type="checkbox"/> Pleural       | 40 <input type="checkbox"/> Genitourinary         |
| 20 <input type="checkbox"/> Lymphatic     | 50 <input type="checkbox"/> Miliary/Disseminated  |
| 21 <input type="checkbox"/> Cervical      | 60 <input type="checkbox"/> Meningeal             |
| 22 <input type="checkbox"/> Intrathoracic | 70 <input type="checkbox"/> Peritoneal            |
| 23 <input type="checkbox"/> Other         | 80 <input type="checkbox"/> Other (Specify) _____ |

**Nucleic Acid Amplification Test**  
Current \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Negative     Positive  
 Indeterminate     Not done

**Other Diagnosis**

**Treatment for Active TB Disease**    Weight \_\_\_\_\_    Height \_\_\_\_\_  
Regimen Start \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Regimen Stop \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Restart \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Stop \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Directly Observed Therapy (DOT) Doses:**

Yes     No    If no, specify reason \_\_\_\_\_

**DOT Site:**  Clinic or other medical facility     Field     Both  
**Frequency:**  Daily     Twice Weekly     Three X's Weekly

<input type="checkbox"/> Isoniazid _____ mgs	<input type="checkbox"/> Rifater _____ mgs
<input type="checkbox"/> Rifampin _____ mgs	<input type="checkbox"/> Levofloxacin _____ mgs
<input type="checkbox"/> Rifamate _____ mgs	<input type="checkbox"/> Gatifloxacin _____ mgs
<input type="checkbox"/> Pyrazinamide _____ mgs	<input type="checkbox"/> Moxifloxacin _____ mgs
<input type="checkbox"/> Ethambutol _____ mgs	<input type="checkbox"/> Rifapentine _____ mgs
<input type="checkbox"/> Streptomycin _____ mgs	<input type="checkbox"/> Clofazimine _____ mgs
<input type="checkbox"/> Ethionamide _____ mgs	<input type="checkbox"/> Cycloserine _____ mgs
<input type="checkbox"/> Capreomycin _____ mgs	<input type="checkbox"/> PAS _____ mgs
<input type="checkbox"/> Amikacin _____ mgs	<input type="checkbox"/> B6 _____ mgs
<input type="checkbox"/> Ciprofloxacin _____ mgs	_____ mgs
<input type="checkbox"/> Ofloxacin _____ mgs	_____ mgs
<input type="checkbox"/> Rifabutin _____ mgs	_____ mgs

**Culture Results**  
Current \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Negative     Positive for M. TB  
 Positive for Non-M. TB     Pending     Not done  
Specimen type:  sputum     urine     bronchial washing  
 biopsy     other  
If biopsy or other, list anatomic site of specimen: \_\_\_\_\_  
Collection date of initial positive MTB culture: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Collection date of first consistently negative MTB culture: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Sputum culture conversion documented?  Yes     No     NA  
If no, then reason \_\_\_\_\_

**Susceptibility Results**  
Date initial susceptibility culture was collected \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Initial culture was resistant to:  Isoniazid     Rifampin     Ethambutol  
Date last positive culture was collected \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Last culture was resistant to:  Isoniazid     Rifampin     Ethambutol  
 Other quinolone(s) \_\_\_\_\_  
 Other(s) \_\_\_\_\_

Reason Therapy Extending > 12 months: \_\_\_\_\_  
Hospitalization Advised:  Yes     No    Control Order \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Quarantine Advised:  Yes     No    Court Action \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Return for chest x-ray: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Compliant:  Yes     No  
Collect next sputum on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Other lab studies: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Return to MD clinic on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Return to Nurse clinic on: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Prescribed for: \_\_\_\_\_ months    Maximum refills authorized: \_\_\_\_\_

**Closure:**  
Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    \_\_\_\_\_ % doses taken by DOT  
\_\_\_\_\_ # doses taken    \_\_\_\_\_ # doses recommended  
\_\_\_\_\_ # months on Rx    \_\_\_\_\_ # months recommended

Completion of adequate therapy     Lost to followup  
 Patient chose to stop     Adverse drug reaction  
 Deceased (Cause) \_\_\_\_\_  
 Moved out of state/country to: \_\_\_\_\_  
Date referral sent to Austin \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Provider decision:  Pregnant     Non-TB     Other: \_\_\_\_\_

Nurse Signature \_\_\_\_\_ Date \_\_\_\_\_  
Physician Signature \_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Authorize nurse to obtain informed consent  
**General Comments:** \_\_\_\_\_

**Texas Department of Health  
Tuberculosis Elimination Division  
Report of Case and Patient Services**

Date reported to health department \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date form sent to region \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Date form sent to central office \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

- Initial Report       Hospital Admission  
 Address Change       Name Change (show new name and draw single line through old)       Other Change (please circle)

SSN \_\_\_\_\_ Medicaid # \_\_\_\_\_ ID# \_\_\_\_\_ DOB \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MM DD YY

Name \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle) \_\_\_\_\_ AKA \_\_\_\_\_

Street \_\_\_\_\_ Apt# \_\_\_\_\_ City \_\_\_\_\_ County \_\_\_\_\_ Zip Code \_\_\_\_\_ Patient's Tel.# \_\_\_\_\_

Facility/Care Provider Name \_\_\_\_\_  
Initial Reporting Source  Health Dept       Private Physician       Public Hospital       VA Hospital      Name of person completing this form \_\_\_\_\_  
 Military Hospital       TDCJ       Other (Specify) \_\_\_\_\_

<b>Country of Birth</b> _____ If foreign born, Date of entry into U.S. _____ / _____ / _____	<b>Notice of Arrival of Alien with TB Class</b> <input type="checkbox"/> A <input type="checkbox"/> B1 <input type="checkbox"/> B2 <input type="checkbox"/> B3	<b>Reported at Death</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Death Date _____ / _____ / _____ Was TB cause of death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<b>Reported Out of State or Country</b> <input type="checkbox"/> Yes Specify _____ <input type="checkbox"/> No
<b>Preferred Language</b> _____	<b>ETHNICITY</b> <input type="checkbox"/> Unknown <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		<b>SEX</b> <input type="checkbox"/> Male <input type="checkbox"/> Female

<b>RACE (check all that apply)</b> <input type="checkbox"/> White <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> Black or African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Unknown	<b>OCCUPATION (within past 2 years)</b> <input type="checkbox"/> Unemployed during last 2 yrs <input type="checkbox"/> Unknown <input type="checkbox"/> Employed (If employed, check all that apply) <input type="checkbox"/> Migrant/Seasonal Worker <input type="checkbox"/> Student <input type="checkbox"/> Child <input type="checkbox"/> Health Care Worker (Specify) _____ <input type="checkbox"/> Retiree <input type="checkbox"/> Disabled <input type="checkbox"/> Correctional Emp <input type="checkbox"/> Other Occupation <input type="checkbox"/> Homemaker <input type="checkbox"/> Institutionalized
---	--

**Resident of Correctional Facility at Time of Dx**  Yes     No     Unknown    Incarceration Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
If Yes  Federal Prison     State Prison     County Jail     City Jail     Juvenile Correctional Facility     ICE     Other

**Resident of Long Term Care Facility at Time of Dx**  Yes     No     Unknown  
If Yes  Nursing Home     Hospital-Based Facility     Residential Facility     Mental Health Residential Facility  
 Alcohol/Drug Treatment Facility     Other Long Term Care Facility

**Testing activities to find latent TB infections**  
 Patient referred, TB infection     Project targeted testing     Individual targeted testing     Administrative: Not at risk for TB

<b>POPULATION RISKS</b> <input type="checkbox"/> Low Income <input type="checkbox"/> Inner-city resident <input type="checkbox"/> Foreign born <input type="checkbox"/> Binational (US-Mexico) <b>*Within past 2 years*</b> <input type="checkbox"/> Correctional employee* <input type="checkbox"/> Health care worker* <input type="checkbox"/> Prison/Jail inmate* <input type="checkbox"/> Long-term facility for elderly/resident* <input type="checkbox"/> Health care facility/resident* <input type="checkbox"/> Shelter for homeless persons* <input type="checkbox"/> Migrant farm worker* <input type="checkbox"/> None of the above risks apply	<b>MEDICAL RISKS</b> <input type="checkbox"/> Diabetes mellitus <input type="checkbox"/> Alcohol Abuse (within past year) <input type="checkbox"/> Tobacco use _____ <input type="checkbox"/> Silicosis <input type="checkbox"/> Corticosteroids or other immunosuppressive therapy <input type="checkbox"/> Gastrectomy or jejunioleal bypass <input type="checkbox"/> age < 5 years <input type="checkbox"/> Recent exposure to TB (Contact to TB case) <input type="checkbox"/> Contact to MDR-TB case <input type="checkbox"/> Weight at least 10% less than ideal body weight <input type="checkbox"/> Chronic malabsorption syndromes <input type="checkbox"/> Leukemia <input type="checkbox"/> Lymphoma <input type="checkbox"/> Cancer of head <input type="checkbox"/> Cancer of neck <input type="checkbox"/> Drug abuse within past year: <input type="checkbox"/> Injecting <input type="checkbox"/> Non-injecting <input type="checkbox"/> Unknown if injecting <input type="checkbox"/> HIV seropositive (check only if laboratory confirmed) <input type="checkbox"/> Tuberculin skin test conversion within 2 years <input type="checkbox"/> Fibrotic lesions (on chest x-ray) consistent with old, healed TB <input type="checkbox"/> Chronic renal failure <input type="checkbox"/> Organ Transplant <input type="checkbox"/> Other _____ <input type="checkbox"/> None of these medical risks apply
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**HIV TEST RESULTS**  
Date HIV Test \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Positive     Negative  
 Pending     Refused  
 Not Offered  
Date CD4 Count \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Results CD4 Count \_\_\_\_\_

<b>TUBERCULIN SKIN TEST</b> Documented history of positive TST? <input type="checkbox"/> Yes <input type="checkbox"/> No _____ / _____ / _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Read _____ / _____ / _____ mm <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Not Read	<b>PRIOR LTBI TREATMENT</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Start Date _____ / _____ / _____ Stop Date _____ / _____ / _____
--	---

**FOR TREATMENT OF LTBI ONLY**  
DOPT:  Yes, totally observed     No, self-administered     Both    Date Normal Chest X-ray \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_    Weight \_\_\_\_\_    Height \_\_\_\_\_  
DOPT Site:  Clinic or medical facility     Field     Both    **ATS Classification**  
Frequency:  Daily     Twice Weekly     Three X's Weekly  
 0 No M. TB Exposure, Not TB Infected  
 1 M. TB Exposure, No Evidence of TB Infection  
 2 M. TB Infection, No Disease  
 4 M. TB, No Current Disease  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Regimen Start    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Regimen Stop  
\_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Restart    \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Date Regimen Stop  
 Isoniazid \_\_\_\_\_ mgs     Other (specify) \_\_\_\_\_ mgs  
 Rifampin \_\_\_\_\_ mgs     Other (specify) \_\_\_\_\_ mgs  
 B6 \_\_\_\_\_ mgs    Prescribed for: \_\_\_\_\_ months    Maximum refills authorized: \_\_\_\_\_    Physician Signature \_\_\_\_\_    Date \_\_\_\_\_

**CLOSURE:** Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_     Completion adequate therapy \_\_\_\_\_ # months on Rx    \_\_\_\_\_ # months recommended  
 Lost to followup     Patient chose to stop     Deceased (Cause) \_\_\_\_\_  
 Adverse Drug Reaction     Moved out of state/country to: \_\_\_\_\_  
Provider decision:  Pregnant     Non-TB     Other: \_\_\_\_\_

## Confidential Medical Record

<p><b>Send to:</b> Texas Childhood Lead Poisoning Prevention Program Texas Department of State Health Services PO Box 149347, MC1964 Austin, TX 78714</p> <p>Fax Number: (512) 776-7699 Phone Number: (512) 776-6632 or 1-800-588-1248 (Toll-free)</p>	<p><b>From:</b> Provider Name:</p> <p>City/State/ZIP:</p> <p>Phone Number: ( ) Fax Number: ( )</p>
--	--

Child Information		
Last Name:	First Name:	M.I.
Date Birth: ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Age in Months:	Medicaid/EPSTDT #:	
Current Address:	Apartment #:	
City:	State:	Zip:
Ethnicity: <i>(check one)</i>		
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Unknown
Child Race: <i>(check one)</i>		
<input type="checkbox"/> White	<input type="checkbox"/> Black	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> Native American or Alaskan Native	<input type="checkbox"/> Multi-Racial	<input type="checkbox"/> Unknown

Blood Lead Level Information	
Blood Lead Test Level: _____ micrograms per deciliter(mcg/dL)	Test Date: ____ / ____ / ____
Type of Blood Sample: <i>(check one)</i>	
<input type="checkbox"/> Capillary	<input type="checkbox"/> Venous <input type="checkbox"/> Unknown
Testing Laboratory:	<b>If Using LeadCare System, Place Label Here</b>
Laboratory Phone: ( )	

Attending Physician Information	
Last Name:	First Name:
Location (City):	

For TX CLPPP Use Only	
Person Receiving Report:	Date Received: ____ / ____ / ____



Return to:

Blood Lead Surveillance Group MC1964  
 Environmental and Injury Epidemiology  
 and Toxicology Unit  
 PO Box 149347  
 Austin, Texas 78714-9347

# ADULT BLOOD LEAD REPORTING

Fax : (512) 776-7699  
 Phone: (512) 776-7151  
 1-800-588-1248 (Toll-free)

## INFORMATION AT TIME OF BLOOD LEAD COLLECTION

P A T I E N T	Last Name:		First Name:		Middle Name:	Parent/Guardian (if under 16 years of age):			
	Street Address:		Apt #:	City:		County:	State:	Zip Code:	
	Home Telephone: ( )					Ethnicity:		Race:	
	Medicaid / EPSDT# (optional):			Date of Birth: (mm/dd/yyyy):			<input type="checkbox"/> Hispanic	<input type="checkbox"/> White	
							<input type="checkbox"/> Non-Hispanic	<input type="checkbox"/> Black	
							<input type="checkbox"/> Unknown	<input type="checkbox"/> Asian/Pacific Islander	
Social Security # :			Sex:	Male		<input type="checkbox"/> Other- Explain here	<input type="checkbox"/> Native American/ Alaskan Native		
				Female			<input type="checkbox"/> Mixed/Multi-racial		
							<input type="checkbox"/> Unknown		

T E S T	Sample Collection Date: (mm/dd/yyyy)		Blood Lead Level: mcg/dL (micrograms per deciliter)		Sample Type:		Testing Initiated By:	
					<input type="checkbox"/> Capillary	<input type="checkbox"/> Company Routine Testing		
					<input type="checkbox"/> Venous	<input type="checkbox"/> Private Physician		
					<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:		
Physician Requesting Blood Lead Test and Clinic Name:		Street	City	State/Zip	Phone: ( )			
					Fax: ( )			
Testing Laboratory:		Street	City	State/Zip	Phone: ( )			
					Fax: ( )			
Symptoms (describe if any):								

***** If 15+ years old and NOT EMPLOYED check this box and do not fill in the rest of this block : → → → → →									
E M P L O Y E R	Company Name:						Phone: ( )		
							FAX: ( )		
	Exposure Site Street Address:		City:	County:	State:	Zip Code:			
Type of Business (i.e. demolition, radiator repair, painting):									
Job Title (at the time of this blood lead testing):									
Employment Hire Date: (mm/dd/yyyy)		Employment Termination Date: (mm/dd/yyyy)		If non-occupational activities resulted in exposure, please describe (e.g., hobby- pistol marksmanship):					

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day. Isolates of organisms marked with a dagger (†) should be sent to the Texas Department of Health Laboratory.

### Positive Bacterial Cultures or Direct Examinations

Result	Reportable Disease
any bacterial agent in CSF	bacterial meningitis
<i>Bacillus anthracis</i> †	anthrax
<i>Bordetella pertussis</i>	<b>pertussis</b>
<i>Borrelia burgdorferi</i> †	Lyme disease
<i>Borrelia species</i> †	relapsing fever
<i>Brucella species</i>	brucellosis
<i>Campylobacter species</i>	campylobacteriosis
<i>Chlamydia trachomatis</i>	lymphogranuloma venereum
<i>Clostridium botulinum</i> †	<b>botulism</b>
<i>Clostridium tetani</i>	tetanus
<i>Corynebacterium diphtheriae</i> †	<b>diphtheria</b>
<i>Ehrlichia species</i>	ehrlichiosis
<i>Escherichia coli</i> O157:H7 †	<i>E. coli</i> O157:H7 infection
<i>Haemophilus ducreyi</i>	chancroid
<i>Haemophilus influenzae</i> type b (not from throat, sputum)	<b>H. influenzae type b infection, invasive</b>
<i>Legionella species</i> †	legionellosis
<i>Listeria monocytogenes</i> †	listeriosis
<i>Mycobacterium tuberculosis</i> †	tuberculosis *
<i>Neisseria gonorrhoea</i>	gonorrhoea
<i>Neisseria meningitidis</i> † (not from throat, sputum)	<b>meningococcal infection, invasive</b>
<i>Rickettsia species</i> within the spotted fever group	spotted fever group rickettsioses
<i>Rickettsia species</i> within the typhus group	typhus
<i>Salmonella species</i> , not <i>S. typhi</i>	salmonellosis
<i>Salmonella typhi</i> †	typhoid fever
<i>Shigella species</i>	shigellosis
<i>Streptococcus species</i> . (not from throat, sputum)	Streptococcus infection, invasive
<i>Vibrio cholerae</i> O1†	<b>cholera</b>
<i>Vibrio species</i> †	<i>Vibrio</i> infection
<i>Yersinia enterocolitica</i>	yersiniosis
<i>Yersinia pseudotuberculosis</i>	yersiniosis
<i>Yersinia pestis</i> †	<b>plague</b>

Contact the Texas Department of Health Laboratory at (512) 458-7581  
for appropriate tests when considering a diagnosis of botulism.

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone.

### Positive Viral Cultures or Direct Examinations

Result	Reportable Disease Condition
any virus in CSF	aseptic meningitis or encephalitis
California group virus	California encephalitis or encephalitis due to virus within California group
dengue virus, type 1,2,3, or 4	dengue
Eastern equine encephalomyelitis virus	Eastern equine encephalitis
enteroviruses (only if patient has aseptic meningitis or encephalitis)	
poliovirus, type 1,2, or 3	<b>poliomyelitis</b>
St. Louis encephalitis virus	St. Louis encephalitis
Venezuelan equine encephalomyelitis virus	Venezuelan equine encephalitis
Western equine encephalomyelitis virus	Western equine encephalitis
yellow fever virus	<b>yellow fever</b>

**Contact the Texas Department of Health at (512) 458-7676 for appropriate tests when considering a diagnosis of hantavirus infection, rabies, or viral hemorrhagic fever.**

### Positive Fungal Cultures or Direct Examinations

Result	Reportable Disease Condition
any fungus in CSF	fungal meningitis

### Positive Parasitic Cultures or Direct Examinations

Result	Reportable Disease Condition
any parasite in CSF †	parasitic meningitis
<i>Entamoeba histolytica</i>	amebiasis
<i>Plasmodium species</i> †	malaria
<i>Cryptosporidium parvum</i>	cryptosporidiosis

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day. Confirmatory tests for most of these diseases are available through the Texas Department of Health.

### Positive Serologic Tests For:

amebiasis  
brucellosis  
California encephalitis  
chickenpox  
cholera  
dengue  
Eastern equine encephalitis  
ehrlichiosis  
hantavirus  
hepatitis A (anti-HAV IgM)<sup>1</sup>  
hepatitis B (anti-HBc IgM)<sup>1</sup>  
hepatitis C (anti-HCV)<sup>1</sup>  
hepatitis D (anti-HDV, HbsAg)<sup>1</sup>  
hepatitis E (anti-HEV)<sup>1</sup>  
HIV infection  
legionellosis<sup>2</sup>  
Lyme disease  
lymphogranuloma venereum  
malaria  
**measles**  
mumps  
**plague**  
**poliomyelitis**  
relapsing fever  
spotted fever group rickettsioses (such as Rocky Mountain spotted fever)  
rubella\*  
St. Louis encephalitis  
syphilis  
typhus group rickettsioses (such as flea- or louse-borne typhus)  
Venezuelan equine encephalitis  
Western equine encephalitis  
**yellow fever**

<sup>1</sup> Refer positive results for hepatitis to infection control practitioner who will determine whether they are reportable.

<sup>2</sup> Serologic confirmation of an acute case of legionellosis can not be based on a single titer. There must be a four-fold rise in titer to  $\geq 1:128$  between acute and convalescent specimens.

## ICD-9 Codes That Must be Reported to the Local Health Authority

When any of the following ICD-9 codes are listed in a patient's discharge summary, a report shall be made to the local health authority (local health department) via the reporting officer for the hospital. Reports shall be made at least **WEEKLY**. Diseases marked with an asterisk (\*) shall be reported immediately by telephone. Diseases marked with a double asterisk (\*\*) shall be reported within one working day.

ICD-9 Code(s)	Disease/Condition
001	Cholera *
002.0	Typhoid fever
003	Salmonellosis
004	Shigellosis
005.1	Food poisoning due to <i>C. botulinum</i> *
005.4	Food poisoning due to <i>V. parahaemolyticus</i>
006	Amebiasis
008.04	<i>E. coli</i> O157:H7 infection
008.43	Campylobacteriosis
010 - 018	Tuberculosis**
020	Plague *
022	Anthrax
023	Brucellosis
027.0	Listeriosis
027.8	Yersiniosis
030	Leprosy (Hansen's disease)
032	Diphtheria *
033	Pertussis *
036	Meningococcal infections, invasive *
037	Tetanus
038.0	Streptococcal septicemia
038.2	Pneumococcal septicemia
040.8	Botulism, infant
041.0	Streptococcal disease (invasive)
041.5	<i>H. influenzae</i> infection, invasive *
042-044	HIV infection
045	Poliomyelitis, paralytic *
046.1	Creutzfeldt-Jakob disease
047	Meningitis due to enterovirus
049	Viral encephalitis
052	Chickenpox (by age group & number)
055	Measles *
056	Rubella **
060	Yellow fever *
061	Dengue
062	Mosquito-borne viral encephalitis
063	Tick-borne viral encephalitis
064	Viral encephalitis by unknown vector
065	Arthropod-borne hemorrhagic fever
066.2	Venezuelan equine encephalitis
070	Viral hepatitis (acute)
071	Rabies *
072	Mumps
078.6	Hemorrhagic nephrosonephritis
078.7	Arenaviral hemorrhagic fever
078.89	Ebola-Marburg viral diseases

ICD-9 Code(s)	Disease/Condition
080	Typhus, epidemic
081.0	Typhus, murine
082	Tick-borne rickettsioses
083.2	Rickettsial pox
083.8	Ehrlichiosis
084	Malaria
087	Relapsing fever
088.81	Lyme disease
090	Congenital syphilis
091-097	Syphilis
098	Gonococcal infections
099.0	Chancroid
099.1	Lymphogranuloma venereum
099.5	Venereal diseases caused by <i>C. trachomatis</i>
100.81	Leptospiral meningitis
104.8	Lyme disease
124	Trichinosis
130.0	Meningoencephalitis due to toxoplasmosis
136.2	Meningoencephalitis due to <i>Naegleria</i>
136.8	Cryptosporidiosis
283.11	Hemolytic uremic syndrome
290.1	Dementia in Creutzfeldt-Jakob disease
320.0	Meningitis due to <i>H.influenzae</i> *
320.1 - 320.9	Bacterial meningitis
321	Meningitis
323	Viral encephalitis
480.8	Hantavirus pulmonary syndrome
481	Pneumococcal pneumonia
482.8	Legionellosis
482.30 - 482.39	Pneumonia due to <i>Streptococcus</i>
501	Asbestosis
502	Silicosis
692.3	Occupational pesticide poisoning (adults)
692.4	Occupational pesticide poisoning (adults)
729.4	Fasciitis due to <i>Streptococcus</i>
771.0	Congenital rubella syndrome **
771.2	Congenital listeriosis, malaria, tuberculosis**
790.7	Bacteremia due <i>Streptococcus</i>
806	Spinal cord injuries
952	Spinal cord injuries
984	Lead poisoning
989.2-989.4	Occupational pesticide poisoning (adults)
994.1	Drowning

## Laboratory Results That Must be Reported to the Local Health Authority

Hospital laboratories shall report these laboratory findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day

### Positive Blood Chemistries

blood lead levels of  $\geq 10$   $\mu\text{g}/\text{dL}$  in children  
blood lead levels of  $\geq 25$   $\mu\text{g}/\text{dL}$  in adults  
pesticide poisoning in adults

### Surgical Pathology Results

asbestosis  
silicosis  
Hansen's disease  
tuberculosis \*  
**human rabies**  
Creutzfeldt-Jakob disease

## Laboratory Results That Must be Reported Directly to the Texas Department of Health

Laboratories shall report these findings to the Infectious Disease Epidemiology and Surveillance Division, Texas Department of Health. Isolates in **bold type** shall be reported **immediately** by calling **(800)252-8239**; in addition, isolates in **bold type** should be sent to the Texas Department of Health Laboratory. Reports of the other resistant organisms listed below may be faxed to (512) 458-7616 no later than the last working day of March, June, September, and December. All reports should include patient name, date of birth or age, sex, anatomic site of culture, and city of submitter.

Penicillin-resistant *Streptococcus pneumoniae*.  
Vancomycin resistant *Enterococcus*,  
**Vancomycin resistant *Staphylococcus aureus***  
**Vancomycin resistant coagulase negative *Staphylococcus* species**

**In addition**, laboratories shall report the following findings, **by numeric totals**, no later than the last working day of March, June, September, and December:

All isolates of *Enterococcus* species  
All isolates of *Streptococcus pneumoniae*.

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone.

### Positive Viral Cultures or Direct Examinations

Result	Reportable Disease Condition
any virus in CSF	aseptic meningitis or encephalitis
California group virus	California encephalitis or encephalitis due to virus within California group
dengue virus, type 1,2,3, or 4	dengue
Eastern equine encephalomyelitis virus	Eastern equine encephalitis
enteroviruses (only if patient has aseptic meningitis or encephalitis)	
poliovirus, type 1,2, or 3	<b>poliomyelitis</b>
St. Louis encephalitis virus	St. Louis encephalitis
Venezuelan equine encephalomyelitis virus	Venezuelan equine encephalitis
Western equine encephalomyelitis virus	Western equine encephalitis
yellow fever virus	<b>yellow fever</b>

Contact the Texas Department of Health at (512) 458-7676 for appropriate tests when considering a diagnosis of hantavirus infection, rabies, or viral hemorrhagic fever.

### Positive Fungal Cultures or Direct Examinations

Result	Reportable Disease Condition
any fungus in CSF	fungal meningitis

### Positive Parasitic Cultures or Direct Examinations

Result	Reportable Disease Condition
any parasite in CSF †	parasitic meningitis
<i>Entamoeba histolytica</i>	amebiasis
<i>Plasmodium species</i> †	malaria
<i>Cryptosporidium parvum</i>	cryptosporidiosis

## Laboratory Results That Must be Reported to the Local Health Authority

Laboratories shall report these findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day. Confirmatory tests for most of these diseases are available through the Texas Department of Health.

### Positive Serologic Tests For:

amebiasis  
brucellosis  
California encephalitis  
chickenpox  
cholera  
dengue  
Eastern equine encephalitis  
ehrlichiosis  
hantavirus  
hepatitis A (anti-HAV IgM)<sup>1</sup>  
hepatitis B (anti-HBc IgM)<sup>1</sup>  
hepatitis C (anti-HCV)<sup>1</sup>  
hepatitis D (anti-HDV, HbsAg)<sup>1</sup>  
hepatitis E (anti-HEV)<sup>1</sup>  
HIV infection  
legionellosis<sup>2</sup>  
Lyme disease  
lymphogranuloma venereum  
malaria  
**measles**  
mumps  
**plague**  
**poliomyelitis**  
relapsing fever  
spotted fever group rickettsioses (such as Rocky Mountain spotted fever)  
rubella\*  
St. Louis encephalitis  
syphilis  
typhus group rickettsioses (such as flea- or louse-borne typhus)  
Venezuelan equine encephalitis  
Western equine encephalitis  
**yellow fever**

<sup>1</sup> Refer positive results for hepatitis to infection control practitioner who will determine whether they are reportable.

<sup>2</sup> Serologic confirmation of an acute case of legionellosis can not be based on a single titer. There must be a four-fold rise in titer to  $\geq 1:128$  between acute and convalescent specimens.

## ICD-9 Codes That Must be Reported to the Local Health Authority

When any of the following ICD-9 codes are listed in a patient's discharge summary, a report shall be made to the local health authority (local health department) via the reporting officer for the hospital. Reports shall be made at least **WEEKLY**. Diseases marked with an asterisk (\*) shall be reported immediately by telephone. Diseases marked with a double asterisk (\*\*) shall be reported within one working day.

ICD-9 Code(s)	Disease/Condition
001	Cholera *
002.0	Typhoid fever
003	Salmonellosis
004	Shigellosis
005.1	Food poisoning due to <i>C. botulinum</i> *
005.4	Food poisoning due to <i>V. parahaemolyticus</i>
006	Amebiasis
008.04	<i>E. coli</i> O157:H7 infection
008.43	Campylobacteriosis
010 - 018	Tuberculosis**
020	Plague *
022	Anthrax
023	Brucellosis
027.0	Listeriosis
027.8	Yersiniosis
030	Leprosy (Hansen's disease)
032	Diphtheria *
033	Pertussis *
036	Meningococcal infections, invasive *
037	Tetanus
038.0	Streptococcal septicemia
038.2	Pneumococcal septicemia
040.8	Botulism, infant
041.0	Streptococcal disease (invasive)
041.5	<i>H. influenzae</i> infection, invasive *
042-044	HIV infection
045	Poliomyelitis, paralytic *
046.1	Creutzfeldt-Jakob disease
047	Meningitis due to enterovirus
049	Viral encephalitis
052	Chickenpox (by age group & number)
055	Measles *
056	Rubella **
060	Yellow fever *
061	Dengue
062	Mosquito-borne viral encephalitis
063	Tick-borne viral encephalitis
064	Viral encephalitis by unknown vector
065	Arthropod-borne hemorrhagic fever
066.2	Venezuelan equine encephalitis
070	Viral hepatitis (acute)
071	Rabies *
072	Mumps
078.6	Hemorrhagic nephrosonephritis
078.7	Arenaviral hemorrhagic fever
078.89	Ebola-Marburg viral diseases

ICD-9 Code(s)	Disease/Condition
080	Typhus, epidemic
081.0	Typhus, murine
082	Tick-borne rickettsioses
083.2	Rickettsial pox
083.8	Ehrlichiosis
084	Malaria
087	Relapsing fever
088.81	Lyme disease
090	Congenital syphilis
091-097	Syphilis
098	Gonococcal infections
099.0	Chancroid
099.1	Lymphogranuloma venereum
099.5	Venereal diseases caused by <i>C. trachomatis</i>
100.81	Leptospiral meningitis
104.8	Lyme disease
124	Trichinosis
130.0	Meningoencephalitis due to toxoplasmosis
136.2	Meningoencephalitis due to <i>Naegleria</i>
136.8	Cryptosporidiosis
283.11	Hemolytic uremic syndrome
290.1	Dementia in Creutzfeldt-Jakob disease
320.0	Meningitis due to <i>H.influenzae</i> *
320.1 - 320.9	Bacterial meningitis
321	Meningitis
323	Viral encephalitis
480.8	Hantavirus pulmonary syndrome
481	Pneumococcal pneumonia
482.8	Legionellosis
482.30 - 482.39	Pneumonia due to <i>Streptococcus</i>
501	Asbestosis
502	Silicosis
692.3	Occupational pesticide poisoning (adults)
692.4	Occupational pesticide poisoning (adults)
729.4	Fasciitis due to <i>Streptococcus</i>
771.0	Congenital rubella syndrome **
771.2	Congenital listeriosis, malaria, tuberculosis**
790.7	Bacteremia due <i>Streptococcus</i>
806	Spinal cord injuries
952	Spinal cord injuries
984	Lead poisoning
989.2-989.4	Occupational pesticide poisoning (adults)
994.1	Drowning

## Laboratory Results That Must be Reported to the Local Health Authority

Hospital laboratories shall report these laboratory findings to the local health authority (local health department) at least **WEEKLY**. Diseases in **bold type** shall be reported immediately by telephone. Diseases marked with an asterisk (\*) shall be reported within one working day

### Positive Blood Chemistries

blood lead levels of  $\geq 10$   $\mu\text{g/dL}$  in children  
blood lead levels of  $\geq 25$   $\mu\text{g/dL}$  in adults  
pesticide poisoning in adults

### Surgical Pathology Results

asbestosis  
silicosis  
Hansen's disease  
tuberculosis \*  
**human rabies**  
Creutzfeldt-Jakob disease

## Laboratory Results That Must be Reported Directly to the Texas Department of Health

Laboratories shall report these findings to the Infectious Disease Epidemiology and Surveillance Division, Texas Department of Health. Isolates in **bold type** shall be reported **immediately** by calling **(800)252-8239**; in addition, isolates in **bold type** should be sent to the Texas Department of Health Laboratory. Reports of the other resistant organisms listed below may be faxed to (512) 458-7616 no later than the last working day of March, June, September, and December. All reports should include patient name, date of birth or age, sex, anatomic site of culture, and city of submitter.

Penicillin-resistant *Streptococcus pneumoniae*.  
Vancomycin resistant *Enterococcus*,  
**Vancomycin resistant *Staphylococcus aureus***  
**Vancomycin resistant coagulase negative *Staphylococcus* species**

**In addition**, laboratories shall report the following findings, **by numeric totals**, no later than the last working day of March, June, September, and December:

All isolates of *Enterococcus* species  
All isolates of *Streptococcus pneumoniae*.



## **IMPORTANT NOTICE**

**Effective March 1, 2007**, the following bacterial isolates or specimens shall be submitted to the Texas Department of State Health Services, Laboratory Services Section, 1100 West 49th Street, Austin, TX 78756-3199.

*Bacillus anthracis*

*Brucella species*

*Clostridium botulinum* – adult and infant

*Escherichia coli* O157:H7 or any specimen demonstrating Shiga toxin activity

*Francisella tularensis*

*Listeria monocytogenes*

*Neisseria meningitidis* - from normally sterile sites

*Staphylococcus aureus* with vancomycin-resistance (MIC greater than 2 µg/ml) (VISA/VRSA)

*Vibrio species*

*Yersinia pestis*

Isolates and specimens shall be submitted using a current department Specimen Submission Form (G-2B).

For more information, go to [www.dshs.state.tx.us/lab](http://www.dshs.state.tx.us/lab). Under the “Guidelines for Collecting & Handling Specific Types of Specimens”, click on “Bacteriology Collection, Transport and Storage Guidelines”. Laboratory Services Section telephone number: 512-458-7318 or 888-963-7111 ext. 7318 FAX number: 512-458-7294

# Communicable Disease Control

*These sections are adopted from the Texas Administrative Code, Chapter 97. The provisions for this chapter are issued under the Communicable Disease Prevention and Control Act, Health and Safety Code, Chapter 81, which provides the Board of Health with the authority to adopt rules concerning the reporting of communicable diseases; and §12.001, which provides the Texas Board of Health with the authority to adopt rules for the performance of every duty imposed by law on the Texas Board of Health, the Texas Department of Health, and the Commissioner of Health.*

## **RULE §97.2 Who Shall Report**

- A. A physician, dentist, veterinarian, chiropractor, advanced practice nurse, physician assistant, or person permitted by law to attend a pregnant woman during gestation or at the delivery of an infant shall report, as required by these sections, each patient (person or animal) he or she shall examine and who has or is suspected of having any notifiable condition, and shall report any outbreak, exotic disease, or unusual group expression of illness of any kind whether or not the disease is known to be communicable or reportable. An employee from the clinic or office staff may be designated to serve as the reporting officer. A physician, dentist, veterinarian, or chiropractor who can assure that a designated or appointed person from the clinic or office is regularly reporting every occurrence of these disease or health conditions in their clinic or office does not have to submit a duplicate report.
- B. The chief administrative officer of a hospital shall appoint one reporting officer who shall be responsible for reporting each patient who is medically attended at the facility and who has or is suspected of having any notifiable condition. Hospital laboratories may report through the reporting officer or independently in accordance with the hospital's policies and procedures.
- C. Except as provided in subsection (b) of this section, any person who is in charge of a clinical laboratory, blood bank, mobile unit, or other facility in which a laboratory examination of any specimen derived from a human body yields microscopic, bacteriologic, virologic, parasitologic, serologic, or other evidence of a notifiable condition, shall report as required by this section.
- D. School authorities, including a superintendent, principal, teacher, school health official, or counselor of a public or private school and the administrator or health official of a public or private institution of higher learning should report as required by these sections those students attending school who are suspected of having a notifiable condition. School administrators who are not medical directors meeting the criteria described in §97.132 of this title (relating to Who

Shall Report Sexually Transmitted Diseases) are exempt from reporting sexually transmitted diseases.

- E. Any person having knowledge that a person or animal is suspected of having a notifiable condition should notify the local health authority or the department and provide all information known to them concerning the illness and physical condition of such person or persons.
- F. Sexually transmitted diseases including HIV and AIDS shall be reported in accordance with §97.132 of this title.
- G. Failure to report a notifiable condition is a Class B misdemeanor under the Texas Health and Safety Code, §81.049.

**\*Source note:** The provisions of the §97.2 adopted to be effective March 16, 1994, 19TexReg 1453; amended to be effective March 5, 1998, 23 TexReg 1954; amended to be effective January 1, 1999, 23 TexReg 12663; amended to be effective March 26, 2000, 25 TexReg 2343; amended to be effective December 20, 2000, 25 TexReg 12426; amended to be effective August 5, 2001, 26 TexReg 5658.



Austin/Travis County Health & Human Services Department

**DISEASE PREVENTION AND HEALTH PROMOTION  
DIVISION**

**EPIDEMIOLOGY AND HEALTH STATISTICS UNIT**

15 Waller Street, 4<sup>th</sup> Floor  
Austin, TX 78702



February 15, 2013

To Whom It May Concern:

We understand that there may be some confusion regarding HIPAA and release of protected health information to public health authorities. Therefore, we would like to provide this letter to help clarify the relationship between HIPAA and public health functions. The Epidemiology and Health Statistics Unit's Disease Surveillance Program is an agency of the City of Austin and is conducting the activity described here in its capacity as a public health authority as defined by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information; Final Rule (Privacy Rule)[45 CFR 164.501].

**Pursuant to 45 CFR 164.512(b) of the Privacy Rule, covered entities such as your organization may disclose, without individual authorization, protected health information to public health authorities "... authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions..."**

The Disease Surveillance Program is conducting disease surveillance and reporting, a public health activity as described by 45 CFR 164.512(b), and is authorized by law. The information being requested represents the minimum necessary to carry out the public health purposes of this project pursuant to 45 CFR 154.514(d) of the Privacy Rule.

If you have any questions or concerns, please contact me at (512) 972-5487; I am the HIPAA privacy officer for our unit. Enclosed for your use is a reporting form specific to the disease for which the Disease Surveillance Program is requesting information. Thank you for your cooperation in our endeavors to provide service.

Kindest Regards,

A handwritten signature in cursive script that reads "Jill Campbell, RN".

Jill Campbell, RN, MPH  
Interim Unit Privacy Officer  
Epidemiology and Health Statistics Unit



**Austin/Travis County Health and Human Services Department**  
**DISEASE PREVENTION AND HEALTH PROMOTION DIVISION**  
**EPIDEMIOLOGY and HEALTH STATISTICS UNIT**  
15 WALLER ST  
Austin, Texas 78702



**WEBSITES Related to Disease Reporting**

**Infectious Diseases & Surveillance**

[www.dshs.state.tx.us](http://www.dshs.state.tx.us) – Texas Department of State Health Services

- Latest News and updates
- Links to disease reporting

[www.dshs.state.tx.us/idcu](http://www.dshs.state.tx.us/idcu) – Infectious Disease Epidemiology & Surveillance

- Notifiable conditions with reporting instructions
- Case definitions, Center for Disease Control and Prevention
- Infectious Disease Topics
- Related Rules and Regulations
- Blood lead reporting
- HIV and STD reporting
- TB reporting
- Contaminated Sharps Injury Reporting
- Links to community preparedness, immunizations and laboratory services
- Communicable Disease Chart for Schools and Childcare Centers
  - Criteria for exclusion and readmission to schools and daycare in Texas

[www.cdc.gov](http://www.cdc.gov) -Center for Disease Control

**Vaccine Preventable Diseases**

[www.dshs.state.tx.us/immunize](http://www.dshs.state.tx.us/immunize)

- Information for parents and providers
- Immunization schedules
- ImmTrac- Texas
- Surveillance guidelines and forms
- Statistics

**Local Services**

[www.austintexas.gov](http://www.austintexas.gov) – Austin City Connection Home Page. Click on **HEALTH** link.

- Public health and community sources
  - Environmental and Consumer Health
  - Restaurant inspection scores
  - Public Health Emergency Preparedness and Response
- Health and Human Services
- Animal Services
- Community Health Centers
  - Locations
  - Eligibility
  - Homeless health services
- Medical Assistance Program
- Austin Women’s Hospital