Austin Public Health

Reporting Communicable Disease in

Travis County

Austin Public Health

January 1, 2017

2017 Epidemiology and Disease Surveillance Reporting Packet

Dear Reporting Agency,

Thank you for reporting notifiable health conditions to the Austin/Travis County Health and Human Services Department (A/TCHHSD).

Timely reporting allows the Health Department to respond to and mitigate potential disease outbreaks, and also allows the department to monitor disease trends in Travis County.

The purpose of this Reporting Packet is to provide you with the 2017 list of notifiable conditions, reporting forms, and other helpful information. The packet includes:

1. 2017 List of Notifiable Conditions in Texas
2. 2017 Summary of Changes in the Texas Administrative Code regarding Notifiable Conditions
3. General Reporting
4. STD Reporting
5. HIV/AIDS Case Reporting
6. List of Helpful Websites
7. OCR HIPAA Privacy Rules

The Infectious Disease Report, found under General Reporting, is used to report most diseases. This form may be faxed to 512-972-5772.

You also may call 512-972-5555, Monday through Friday, 8 a.m. to 5 p.m.

To report diseases requiring immediate attention, this phone number 512-972-5555 also serves as our 24/7 epidemiology, emergency on-call line. For emergencies, you may call this number outside normal business hours and follow instructions that are provided.

In addition to the Morbidity Report Form, this packet also includes the STD and HIV reporting forms which also may be faxed to 512-972-5772.

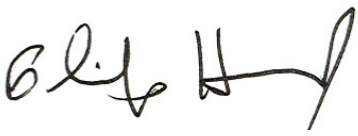
NOTE: Any report form indicating HIV/AIDS status must be reported by calling 512-972-5144 or 512-972-5145.

For more information, please contact:

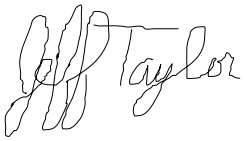
Jeffery P. Taylor, MPH
Epidemiology Program Manager
Phone 512-972-5886
E-mail, Jeff.Taylor@austintexas.gov.

Thank you again for your assistance.

Sincerely,



Philip Huang, M.D., M.P.H.
Medical Director/Health Authority
Austin Public Health Department



Jeffery P. Taylor, M.P.H.
Epidemiology Program Manager
Austin Health Public Department

Austin Public Health

2017 Reporting Communicable Disease in Austin/Travis County

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Austin Public Health

January 01, 2017

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) 972-5804; I am the HIPAA privacy officer for our unit. Thank you for your cooperation in our endeavors to provide service.

Kindest Regards,

Jeffery P. Taylor, MPH
Epidemiology Program Manager, Unit Privacy Officer
Austin Public Health Department
Epidemiology and Health Statistics Unit

Austin Public Health

REPORTING PHONE NUMBERS

Reportable diseases/conditions occurring in Travis County shall be reported to Austin Public Health. 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	(512) 972-5772 Fax
HIV/AIDS	(512) 972-5140 or 5144	
STD Reporting	(512) 972-5433	(512)972-5772 Fax
Tuberculosis Reporting	(512) 972-5448	(512) 972-5451 Fax
Perinatal Hepatitis B Program	(512) 972-6218	(512) 972-6287 Fax
Lead (elevated blood levels)	(512) 458-7269 ext. 2010	(512)776-7699 Fax

(Contact Department of Health State Services to report Lead)

OTHER USEFUL PHONE NUMBERS

Animal Control	311
Environmental Health	(512) 978-0300
Health Authority	(512) 972-5855
Immunizations	(512) 972-5520
Refugee Screening Clinic	(512) 972-6210 / 972-6239
STD Clinic	(512) 972-5430
TB Clinic	(512) 972-5460
Vital Records (Birth/Death)	(512) 972-4784
WIC Program	(512) 972-4942
Vaccines for Children Program	(512) 972-5414

Austin Public Health

WEBSITES Related to Disease Reporting

Infectious Diseases & Surveillance

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 – Infectious Disease Epidemiology & Surveillance

- Notifiable conditions with reporting instructions
- Case definitions, Center for Disease Control and Prevention
- Zika: http://texaszika.org/labs.htm
- 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

Vaccine Preventable Diseases

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, official website of the City of Austin. Click on **HEALTH** link.

- Public Health
    - Health and Human Services Department
        - Recent News
    - Disease Prevention and Health Promotion
        - Epidemiology and Disease Surveillance
            - Notifiable Conditions, Disease Reporting Information for Clinicians

    - Food Protection
        - Restaurant Scores
    - Neighborhood Centers
        - Receiving Assistance, Locations, Health Services

- Animals
    - 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

Texas Administrative Code

TITLE 25	HEALTH SERVICES
PART 1	DEPARTMENT OF STATE HEALTH SERVICES
CHAPTER 97	COMMUNICABLE DISEASES
SUBCHAPTER A	CONTROL OF COMMUNICABLE DISEASES
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, advanced practice nurse, physician assistant, or chiropractor who can assure that a designated or appointed person from the clinic or office is regularly reporting every occurrence of these diseases 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(s) or animal(s) 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(s) or animal(s).
(f) Sexually transmitted diseases including HIV and AIDS shall be reported in accordance with Subchapter F of this chapter (relating to Sexually Transmitted Diseases Including Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV)).
(g) Failure to report a notifiable condition is a Class B misdemeanor under the Texas Health and Safety Code, §81.049.
(h) The Health Insurance Portability and Accountability Act (HIPAA) allows reporting without authorization for public health purposes and where required by law. Title 45 Code of Federal Regulations §164.512(a) and (b).

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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)[1, 2]	Within 1 week	***Lead, child blood, any level & adult blood, any level** [3]	**Call/Fax Immediately**
Amebiasis[4]	Within 1 week	Legionellosis[4]	Within 1 week
Amebic meningitis and encephalitis[4]	Within 1 week	Leishmaniasis[4]	Within 1 week
Anaplasmosis[4]	Within 1 week	Listeriosis[4,5]	Within 1 week
Anthrax[4, 5]	**Call Immediately**	Lyme disease[4]	Within 1 week
Arboviral infections[4, 6]	Within 1 week	Malaria[4]	Within 1 week
*Asbestosis[7]	Within 1 week	**Measles (rubeola)**[4]	**Call Immediately**
Ascariasis[4]	Within 1 week	**Meningococcal infection, invasive (*Neisseria meningitidis*)**[4, 5]	**Call Immediately**
Babesiosis[4]	Within 1 week	**Multidrug-resistant *Acinetobacter* (MDR-A)**[4, 8]	**Within 1 work day**
Botulism (adult and infant)[4, 5, 9]	**Call Immediately**[9]	**Mumps**[4, 10]	**Within 1 work day**[10]
Brucellosis[4, 5]	**Within 1 work day**	Paragonimiasis[4]	Within 1 week
Campylobacteriosis[4]	Within 1 week	**Pertussis**[4]	**Within 1 work day**
*Cancer[11]	See rules[11]	*Pesticide poisoning, acute occupational[12]	Within 1 week
Carbapenem-resistant *Enterobacteriaceae* (CRE)[4, 13]	**Within 1 work day**	**Plague (*Yersinia pestis*)** [4, 5]	**Call Immediately**
Chagas disease[4]	Within 1 week	**Poliomyelitis, acute paralytic**[4]	**Call Immediately**
*Chancroid[1]	Within 1 week	**Poliovirus infection, non-paralytic**[4]	**Within 1 work day**
Chickenpox (varicella)[14]	Within 1 week	Prion disease such as Creutzfeldt-Jakob disease (CJD)[4, 15]	Within 1 week
**Chlamydia trachomatis* infection[1]	Within 1 week	**Q fever**[4]	**Within 1 work day**
*Contaminated sharps injury[16]	Within 1 month	**Rabies, human**[4]	**Call Immediately**
***Controlled substance overdose**[17]	**Call Immediately**	**Rubella (including congenital)**[4]	**Within 1 work day**
Coronavirus, novel [4, 18]	**Call Immediately**	Salmonellosis, including typhoid fever[4, 5]	Within 1 week
Cryptosporidiosis[4]	Within 1 week	Shiga toxin-producing *Escherichia coli* [4, 5]	Within 1 week
Cyclosporiasis[4]	Within 1 week	Shigellosis[4]	Within 1 week
Cysticercosis[4]	Within 1 week	*Silicosis[19]	Within 1 week
*Cytogenetic results (fetus and infant only)[20]	See rules[20]	**Smallpox**[4]	**Call Immediately**
Diphtheria[4, 5]	**Call Immediately**	*Spinal cord injury[21]	Within 10 work days
*Drowning/near drowning[21]	Within 10 work days	Spotted fever group rickettsioses[4]	Within 1 week
Echinococcosis[4]	Within 1 week	***Staphylococcus aureus*, VISA and VRSA**[4, 5]	**Call Immediately**
Ehrlichiosis[4]	Within 1 week	Streptococcal disease (groups A, B; *S. pneumo.*), invasive[4,5]	Within 1 week
Fascioliasis[4]	Within 1 week	***Syphilis – primary and secondary stages** [1, 22]	**Within 1 work day**
*Gonorrhea[1]	Within 1 week	*Syphilis – all other stages[1, 22]	Within 1 week
Haemophilus influenzae, invasive[4, 5]	Within 1 week	*Taenia solium* and undifferentiated *Taenia* infection[4]	Within 1 week
Hansen's disease (leprosy) [4]	Within 1 week	Tetanus[4]	Within 1 week
Hantavirus infection[4]	Within 1 week	*Traumatic brain injury[21]	Within 10 work days
Hemolytic uremic syndrome (HUS) [4]	Within 1 week	Trichinosis[4]	Within 1 week
Hepatitis A[4]	**Within 1 work day**	Trichuriasis[4]	Within 1 week
Hepatitis B, C, and E (acute) [4]	Within 1 week	**Tuberculosis (*Mycobacterium tuberculosis* complex)** [5, 23]	**Within 1 work day**
Hepatitis B infection identified prenatally or at delivery (mother) [4]	Within 1 week	Tuberculosis infection[24]	Within 1 week
Hepatitis B, perinatal (HBsAg+ < 24 months old) (child) [4]	**Within 1 work day**	**Tularemia**[4, 5]	**Call Immediately**
Hookworm (ancylostomiasis)[4]	Within 1 week	Typhus[4]	Within 1 week
***Human immunodeficiency virus (HIV), acute infection**[1, 2, 25]	**Within 1 work day**	***Vibrio* infection, including cholera**[4, 5]	**Within 1 work day**
*Human immunodeficiency virus (HIV), non-acute infection[1, 2, 25]	Within 1 week	**Viral hemorrhagic fever (including Ebola)**[4]	**Call Immediately**
Influenza-associated pediatric mortality[4]	**Within 1 work day**	**Yellow fever**[4]	**Call Immediately**
Influenza, novel[4]	**Call Immediately**	Yersiniosis[4]	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**

[1] 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.

[2] Labs conducting confirmatory HIV testing are requested to send remaining specimen to a CDC-designated laboratory. Please call 512-533-3132 for details.

[3] For lead reporting information see http://www.dshs.state.tx.us/lead/default.shtm.

[4] Reporting forms are available at http://www.dshs.state.tx.us/idcu/investigation/forms/ and investigation forms at http://www.dshs.state.tx.us/idcu/investigation/. Call as indicated for immediately reportable conditions.

[5] Lab isolate must be sent to DSHS lab. For specifications see section (4) at *Texas Administrative Code (TAC) §97.3(a) (4)*. Call 512-776-7598 for specimen submission information. An amendment to the Texas Administrative Code (TAC) is in progress adding a requirement that lab isolates also be sent to DSHS lab for diphtheria; invasive *Streptococcus pneumonia* in children under 5 years-of-age; and all Salmonella species. The projected effective date is March, 2017. See updated TAC after March.

[6] Arboviral infections including, but not limited to, those caused by California serogroup virus, chikungunya virus, dengue virus, Eastern equine encephalitis (EEE) virus, St. Louis encephalitis (SLE) virus, Western equine encephalitis (WEE) virus, West Nile (WN) virus, and Zika virus.

[7] For asbestos reporting information see http://www.dshs.state.tx.us/epitox/asbestosis.shtm.

[8] See additional MDR-A reporting information at http://www.dshs.state.tx.us/IDCU/health/antibiotic_resistance/MDR-A-Reporting.doc.

[9] Report suspected botulism immediately by phone to 888-963-7111.

[10] An amendment to the Texas Administrative Code is in progress to change the reporting time frame for mumps. Mumps, currently reportable in 1 week, will be required to be reported within 1 business day. The projected effective date is March, 2017. See updated *Texas Administrative Code (TAC) §97.4* after March.

[11] For more information on cancer reporting rules and requirements go to http://www.dshs.state.tx.us/tcr/reporting.shtm.

[12] For pesticide reporting information see http://www.dshs.state.tx.us/epitox/Pesticide-Exposure/%23reporting#reporting.

[13] See additional CRE reporting information at http://www.dshs.state.tx.us/IDCU/health/antibiotic_resistance/Reporting-CRE.doc.

[14] Call your local health department for a copy of the Varicella Reporting Form with their fax number. The Varicella (Chickenpox) Reporting Form should be used instead of an Epi-1 or Epi-2 morbidity report.

[15] For purposes of surveillance, CJD notification also includes Kuru, Gerstmann-Sträussler-Scheinker (GSS) disease, fatal familial insomnia (FFI), sporadic fatal insomnia (sFI), Variably Protease-Sensitive Prionopathy (VPSPr), and any novel prion disease affecting humans.

[16] 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/.

[17] To report controlled substance overdose, contact local poison center at 1-800-222-1222. For instructions, see https://www.dshs.state.tx.us/epidemiology/epipoison.shtm.

[18] Novel coronavirus causing severe acute respiratory disease includes Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS).

[19] For silicosis reporting information see http://www.dshs.state.tx.us/epitox/silicosis.shtm.

[20] 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.

[21] 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.

[22] Laboratories should report syphilis test results within 3 work days of the testing outcome.

[23] Reportable tuberculosis disease includes the following: suspected tuberculosis disease pending final laboratory results; positive nucleic acid amplification tests; clinically or laboratory-confirmed tuberculosis disease; and all *Mycobacterium tuberculosis (M. tb)* complex including *M. tuberculosis, M. bovis, M. africanum, M. canettii, M. microti, M. caprae, and M. pinnipedii.* See rules at http://www.dshs.state.tx.us/idcu/disease/tb/reporting/.

[24] TB infection is determined by a positive result from an FDA-approved Interferon-Gamma Release Assay (IGRA) test such as T-Spot® TB or QuantiFERON® - TB GOLD In-Tube Test or a tuberculin skin test, and a normal chest radiograph with no presenting symptoms of TB disease. See the *Epi Case Criteria Guide* which contains complete criteria.

[25] Any person suspected of having HIV should be reported, including HIV exposed infants.

Important Notice

About Bacterial Isolates or Specimens

Lab Test/Specimen Submission Instructions

Laboratory Services Section Forms, *Including G-2A and G-2B*

HIV/AIDS See reporting requirements for HIV/AIDS and other notifiable sexually transmitted diseases (STDs) at http://www.dshs.state.tx.us/hivstd/healthcare/reporting.shtm.

Laboratories Shall Submit pure cultures of all accompanied by a current department Specimen Submission Form to the Texas Department of State Health Services, Laboratory Services Section, 1100 West 49th Street, Austin, TX 78756-3199.

Bacillus anthracis	**Mycobacterium tuberculosis complex**
Brucella species	**Neisseria meningitidis** from normally sterile sites
Clostridium botulinum	**Staphylococcus aureus with a vancomycin MIC greater than 2 µ/mL** (VISA and VRSA)
E. coli 0157:H7 isolates **or specimens from cases where Shiga-toxin activity is demonstrated**	**Vibrio species**
Francisella tularensis	**Yersinia pestis**
Listeria monocytogenes	
VISA/VRSA ***MIC greater than 2 µg/mL*** *Immediately report isolates of **vancomycin intermediate and resistant Staphylococcus aureus (VISA) and (VRSA)** by calling (800) 252-8239 or faxing (512) 776-7616. Isolates of **VISA and VRSA** shall be submitted to the Texas Department of State Health Services, Laboratory Services Section, 1100 West 49th Street, Austin, Texas 78756-3199. All reports of **VISA and VRSA** shall include patient name; date of birth or age; sex; city of submitter; anatomic site of culture; date of culture; and minimum inhibitory concentration (MIC) if available.*	

Last updated February 26, 2015

Infectious Disease Report

This form may be used to ***report suspected cases and cases of notifiable conditions*** in Texas, listed with their reporting timeframes on the current *Texas Notifiable Conditions List* available at http://www.dshs.state.tx.us/idcu/investigation/conditions/. 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*. A health department epidemiologist may contact you to further investigate this Infectious Disease Report.

Report Cases to the Austin/Travic County Health & Human Services Department by Faxing (512) 972-5772 or Calling (512) 972-5555.

Mail Reports To:
Austin/Travis County HHSD
Attn:Surveillance Program
15 Waller St. RBJ 4th Flr.
Austin, TX 78702

Disease or Condition	Date: _____ (*Check type*) *(Please fill in onset or closest known date)* ☐ Onset ☐ Absence ☐ Specimen collection ☐ Office visit	
Physician Name	Physician Address ☐ See Facility address below	Physician Phone ☐ See Facility phone below (_____) _____ - _____
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)		
Patient Name (Last) (First) (MI)		Telephone (_____) _____ - _____
Address (Street) City State		Zip Code County
Date of Birth (mm/dd/yyyy) Age	Sex ☐ Male ☐ Female Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history		

Disease or Condition	Date: _____ (*Check type*) *(Please fill in onset or closest known date)* ☐ Onset ☐ Absence ☐ Specimen collection ☐ Office visit	
Physician Name	Physician Address ☐ See Facility address below	Physician Phone ☐ See Facility phone below (_____) _____ - _____
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)		
Patient Name (Last) (First) (MI)		Telephone (_____) _____ - _____
Address (Street) City State		Zip Code County
Date of Birth (mm/dd/yyyy) Age	Sex ☐ Male ☐ Female Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history		

Disease or Condition	Date: _____ (Check type) *((Please fill in onset or closest known date)* ☐ Onset ☐ Absence ☐ Specimen collection ☐ Office visit	
Physician Name	Physician Address ☐ See Facility address below	Physician Phone ☐ See Facility phone below (_____) _____ - _____
Diagnostic Criteria (Diagnostic Lab Result and Specimen Source or Clinical Indicators)		
Patient Name (Last) (First) (MI)		Telephone (_____) _____ - _____
Address (Street) City State		Zip Code County
Date of Birth (mm/dd/yyyy) Age	Sex ☐ Male ☐ Female Ethnicity ☐ Hispanic ☐ Not Hispanic	Race ☐ White ☐ Black ☐ Asian ☐ Other ☐ Unknown
Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history		

Name of Reporting Facility	Address	
Name of Person Reporting	Title	Phone Number (_____) _____ - _____ extension _____
Date of Report (mm/dd/yyyy)	E-mail	

Above Information is CONFIDENTIAL. Please notify sender if received in error, and return or destroy.

VARICELLA (chickenpox) Reporting Form

Austin Public Health Department

Epidemiology and Disease Surveillance Unit

15 Waller St. RBJ Bldg. 4th Flr. Austin, Texas 78702

Phone: (512) 972-5555 Fax: (512) 972-5772

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: Ordering Physician:	Number of lesions in total: *(circle number of lesions)* <50 50-249 250-499 500+	Did the patient attend daycare/after school care? Yes No Name of Facility:		

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: Ordering Physician:	Number of lesions in total: *(circle number of lesions)* <50 50-249 250-499 500+	Did the patient attend daycare/after school care? Yes No Name of Facility:		

Name of Person Reporting: _____ **PHONE:** _____

Agency/Organization Name: _____

Address: _____

CITY: _____ **ZIP:** _____ **COUNTY:** _____

DATE REPORTED: _____

Fax Report to (512) 972-5772 Attn: Disease Surveillance

TEXAS Department of State Health Services

Return to:

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

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

ADULT BLOOD LEAD REPORTING

INFORMATION AT TIME OF BLOOD LEAD COLLECTION

PATIENT

Last Name:	First Name:	Middle Name:	Parent/Guardian (if under 16 years of age):

Street Address:	Apt #:	City:	County:	State:	Zip Code:

Home Telephone:
( )

Medicaid / EPSDT# (optional):

Date of Birth: (mm/dd/yyyy):

Social Security # :

Sex: ☐ Male ☐ Female

Ethnicity:
☐ Hispanic
☐ Non-Hispanic
☐ Unknown
☐ Other- Explain here

Race:
☐ White
☐ Black
☐ Asian/Pacific Islander
☐ Native American/ Alaskan Native
☐ Mixed/Multi-racial
☐ Unknown

TEST

Sample Collection Date: (mm/dd/yyyy)	Blood Lead Level: mcg/dL (micrograms per deciliter)	Sample Type: ☐ Capillary ☐ Venous ☐ Unknown	Testing Initiated By: ☐ Company Routine Testing ☐ Private Physician ☐ 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):

EMPLOYER

********* If 15+ years old and NOT EMPLOYED check this box and do not fill in the rest of this block : → → → → →** ☐

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):

Childhood Blood Lead Level Report

Form F09-11709

Confidential Medical Record

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

Child Information

Last Name: First Name: M.I.

Date Birth: _____ / _____ / _____ Gender: ☐ Male ☐ Female

Age in Months: Medicaid# /CHIP ID#:

Current Address: Apartment #:

City: State: Zip:

Ethnicity: (*check one*)
☐ Hispanic ☐ Non-Hispanic ☐ Unknown

Child Race: (*check one*)
☐ White ☐ Black ☐ Asian or Pacific Islander
☐ Native American or Alaskan Native ☐ Multi-Racial ☐ Unknown

Blood Lead Level Information

Blood Lead Test Level: _____ micrograms per deciliter(mcg/dL) Blood Draw Date: _____ / _____ / _____

Type of Blood Sample: (*check one*)
☐ Capillary ☐ Venous ☐ Unknown

Testing Laboratory: Laboratory Phone: ( )	**If Using LeadCare System, Place Label Here**

Attending Physician Information

Last Name: First Name:

Location (City):

For TX CLPPP Use Only

Person Receiving Report: Date Received: _____ / _____ / _____

CONFIDENTIAL STD CASE REPORT FORM

AUSTIN PUBLIC HEALTH

Epidemiology and Disease Surveillance Unit
15 Waller St., Room 426, Austin, TX 78702
PHONE: (512) 972-5555 | **FAX:** (512) 972-5772

PATIENT INFORMATION

Last Name	First Name	MI	Date of Birth:	Age

Address	City	State	Zip	Phone Number

Sex: ☐ Male ☐ Female
Marital Status:
☐ S ☐ M ☐ W ☐ D

Is this patient pregnant?
☐ Yes ☐ No
Weeks: _____

Emergency Contact Number:

Work Number:

Race (check all that apply):
☐ American Indian or Alaskan Native ☐ Black or African American
☐ Asian ☐ White ☐ Native Hawaiian or Pacific Islander ☐ Unknown

Ethnic Origin:
☐ Hispanic or Latino
☐ Not Hispanic or Latino

CLINICAL INFORMATION

Exam Reason:
☐ DIS Partner Referral ☐ Referred by Partner ☐ Screening Jail/Prison ☐ DIS Suspect Referral
☐ Prenatal ☐ Delivery ☐ Volunteer ☐ Referred by Another Provider
☐ Other: _____

Clinical Information (check all that apply):
☐ Asymptomatic ☐ Symptomatic ☐ Rash ☐ Chancre (sore/lesion ☐ Condyloma lata
☐ Alopecia

Exam Date:

Site / Specimen (check all that apply):
☐ Cervix ☐ Pharynx ☐ Rectum
☐ Urethra ☐ Urine ☐ Vagina
☐ Other: _____

Lab Result Date:

Lab Result(s): (Please fax lab results with report)

Lab Results: _____ Lab Results: _____
Lab Results: _____ Lab Results: _____

Code 200 (not 490) ☒ Genital ☐ Ophthalmia

Code 490 Associated with ☐ 200 ☐ 300

Code 300 (not 490) ☐ Genital ☐ Rectal ☐ Pharyngea ☐Opththalmia ☐ Other

☐ **Code 100**
☐ **Code 600**

Code 700: ☐ 710* ☐ 720* ☐ 730 ☐ 745 ☐ 750 ☐ 790
*All cases of 710 and 720 must be reported within 1 work day.

Neurological Involvement
☐ Yes ☐ No ☐ Unk

Code ☐ **900** ☐ **950** The Health Department requires additional information on 900 patients.
For all 900 Reporting, please call (512)-972-5144.

Notes:

Date of Treatment:

Treatment: (check all that apply)
☐ Ceftriaxone - 250 mg IM ☐ Azithromycin - 1 gram
☐ Bicillin 2.4MU ☐ Other _____

FACILITY INFORMATION

Physician or Facility Name	Contact Person	Phone Number

Facility Address

CONFIDENTIAL STD CASE REPORT FORM
AUSTIN PUBLIC HEALTH
Epidemiology and Disease Surveillance Unit
15 Waller St., Room 426, Austin, TX 78702
PHONE: (512) 972-5555 | FAX: (512) 972-5772

Please use form S-27 to report all notifiable Sexually Transmitted Diseases. Please complete all sections of this form using available data. If a response is unknown, please leave that value blank. Reporting rules mandate that positive lab results and disease diagnoses must be reported within the indicated time frames, regardless of treatment status. A second report should be sent as needed to document successful treatment.

Codes for form STD-27

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

Special Instructions

- Please use the provided "Notes/Symptoms" section to document all symptoms of 710/720, both observed and as reported by patient, as this will assist in properly staging this infection.
- Please document the last known RPR titer, or any previous negative testing for 700.
- Please note all other STD laboratory results (including non-reactive results) when positive lab is collected in conjunction with additional STD testing.
- Please document all lab results (including non-reactive results) when positive lab was ordered as part of a comprehensive testing algorithm (e.g.: 700 RPR + 700 Confirmatory).
- While reporting on this document serves as proof of timely report, additional information is required on 900 patients. Please call 512-972-5145 or 512-972-5144, and staff will assist you with reporting all of the required information.
- It is normal for various representatives of the Health Department to contact you during all stages of the Public Health Follow-up process to obtain additional patient information.

Please call 512-972-5555 with any additional questions regarding HIV/STD reporting.

Please fax all completed forms to 512-972-5772. Alternately, this form may be mailed to:

City of Austin HHSD

Austin Public Health Department
15 Waller St. RBJ Bldg. 4th Flr Austin, Texas 78702
Phone: (512) 972-5555 Fax: (512) 972-5772

(Name of Laboratory) (Address) (City) (State) (Zip) (Phone Number)

REPORT PERIOD: FROM _____TO_____ .

Submit form weekly to local or regional health departments.

Test Name	Results (Titer if applicable)	Date of Specimen Collection	Date of Lab Analysis	Patient's Name (Last, First, MI):	Patient's Address (Including, City, County & Zip)	DOB	Sex	Race	Hisp Y/N	Physician/Facility's Name, Address, City, Zip & Phone No.	Preg/ Mat *

NOTIFICATION OF LABORATORY TEST FINDINGS INDICATING PRESENCE OF CHLAMYDIA TRACHOMATIS, GONORRHEA, SYPHILIS, CHANCROID, HIV INFECTIONS OR SUPRESSED CD4 COUNTS

_____ Laboratory Supervisor

_____ Date

Austin Public Health Department
Tuberculosis Elimination Division
Report of Case and Patient Services

12630608

Appointment Date __ / __ / ____

Appointment Time __ : __ ○ AM ○ PM

Date reported to Health Department __ / __ / ____

CT to Case#

☐ Initial Report ☐ Hospital Admission

☐ Address Change ☐ Other Change (please circle)

☐ Name Change (show new name and draw single line through old)

Date form sent to region __ / __ / ____

Date form sent to central office __ / __ / ____

CI

NCM

Medicaid#

ID#

Social Security Number ___ - __ - ____

Date of Birth (mm/dd/yy) __ / __ / ____

Last Name

First Name

Middle Name

Suffix

AKA (LastName FirstName)

Phone Number (___) ___ - ____ ○ Home ○ Work ○ Cell

Address

Apartment Number

City

County

Zip Code

Facility/Care Provider Name

Name of person completing this form

Primary Reason Evaluated for TB Disease:

☐ Contact Investigation ☐ Immigration Med Exam ☐ Health Care Worker ☐ Employment/Admin Testing ☐ Targeted Testing ☐ TB Symptoms ☐ Abnormal Chest Radiography ☐ Incidental Lab Result

Initial Reporting Source:

☐ Health Dept ☐ Military Hospital ☐ Private Physician ☐ TDCJ ☐ Public Hospital ☐ VA Hospital ☐ Other (Specify)

Country of Birth

Different from birth, Country of Origin?

US BORN (or born abord to a parent who was a US citizen) ○ Yes ○ No

If foreign born, date of entry in U.S. __ / __ / ____

Preferred Language

Marital Status

☐ S ☐ M ☐ D

Sex

☐ Male ☐ Female

Race - Check all that apply

☐ American Indian ☐ Unknown

☐ Alaskan Native ☐ Black or African American

☐ Asian *specify* ________ ☐ Native Hawaiian or Pacific Islander

☐ White *specify* ________

Notice of Arrival of Alien with TB Class

☐ A ☐ B2

☐ B1 ☐ B3

TB CARD?

○ Yes ○ No

Reported at Death

○ Yes ○ No

If YES, Death Date __ / __ / ____

Was TB cause of death?

○ Yes ○ No ○ Unk

Reported Out of State or Country

○ Yes (specify)

○ No

Ethnicity

☐ Hispanic or Latino

☐ Not Hispanic or Latino

☐ Unknown

Primary Occupation (within last yr.)

☐ Unemployed

☐ Employed

○ Migrant/Seasonal Worker

○ Health Care Worker

(specify)

○ Correctional Employee

○ Other Occupation (specify): ________

☐ Unknown

☐ Not Seeking Employment

○ Student ○ Child

○ Retiree ○ Disabled

○ Homemaker

○ Institutionalized

Homeless within the last year: ☐ Yes ☐ No ☐ Unknown

Resident of Correctional Facility at Time of Dx ☐ Yes ☐ No ☐ Unknown

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 ☐ Drug Treatment Facility ☐ Alcohol Treatment Facility ☐ Hospital-Based Facility

☐ Other Long Term Care Facility ☐ Residential Facility ☐ Mental Health Residential Facility

Incarceration Date __ / __ / ____

Testing activities to find latent TB infections

☐ Patient referred, TB Infection

☐ Project targeted testing

☐ Individual targeted testing

☐ Administrative: Not at risk for TB

12630608

POPULATION RISKS

- ☐ Low Income
- ☐ Inner-city resident
- ☐ Foreign born
- ☐ Binational (US-Mexico)

*Within past year

- ☐ Correctional employee*
- ☐ Health Care Worker*
- ☐ Prison/Jail inmate*
- ☐ Long-term facility for elderly/resident*
- ☐ Health care facility/resident*
- ☐ Shelter for homeless persons*
- ☐ Migrant farm worker*
- ☐ Dorm/Resident
- ☐ Colonia/Resident
- ☐ None of the above risks apply

MEDICAL RISKS

- ☐ Diabetes mellitus ○ I ○ II
- ☐ Alcohol Abuse (within past year)
- ☐ Tobacco use
- ☐ Silicosis
- ☐ Corticosteroids or other immunosuppressive therapy
- ☐ Gastrectomy or jejunoileal bypass
- ☐ age<5 years
- ☐ Recent exposure to TB (contact to TB case)
- ☐ Contact to MDR-TB case
- ☐ Weight at least 10% less than ideal body weight
- ☐ Chronic metabsorption syndromes
- ☐ Leukemia
- ☐ Contact of Infectious TB
- ☐ Missed Contact
- ☐ Incomplete LTBI Therapy
- ☐ TNF Therapy
- ☐ Obesity
- ☐ Immunosuppression (not 900)
- ☐ Lymphoma
- ☐ Cancer of head
- ☐ Cancer of neck
- ☐ Drug abuse within past year:
  - ○ Injecting
  - ○ Unknown if injecting
  - ○ Non-injecting
- ☐ HIV seropositive *(check only if laboratory)*
- ☐ Tuberculin skin test conversion within 2 years
- ☐ Fibrotic lesions (on chest x-ray) consistent with old, healed TB
- ☐ Chronic renal failutre
- ☐ Organ Transplant
- ☐ Other
- ☐ None of these medical risks apply

HIV TEST RESULTS

Date HIV Test ☐☐ / ☐☐ / ☐☐☐☐

○ Positive ○ Refused
○ Negative ○ Not Offered
○ Pending

Date CD4 Count ☐☐ / ☐☐ / ☐☐☐☐

Results CD4 Count ☐☐☐☐☐ ○ Rapid ○ Conventional

Immigration Status at First Entry to the US: ☐ Not Applicable
-US Born/born abroad to a parent who was a US citizen
-Born in US Territory, US Island Area, US Outlying Area

☐ Immigrant Visa ☐ Tourist Visa ☐ Family/Fiance Visa ☐ Asylee or Parolee
☐ Student Visa ☐ Employment Visa ☐ Refugee Visa ☐ Unk ☐ Other _____

TUBERCULIN SKIN TEST Documented History of Positive TST? ○ Yes ○ No

☐☐ / ☐☐ / ☐☐☐☐ ☐☐ mm ○ Positive ○ Negative ○ Not Read ○ Not Done Test Place

☐☐ / ☐☐ / ☐☐☐☐ ☐☐ mm ○ Positive ○ Negative ○ Not Read ○ Not Done Test Place

PRIOR LTB1 Treatment? ○ Yes ○ No Start Date ☐☐ / ☐☐ / ☐☐☐☐ Stop Date ☐☐ / ☐☐ / ☐☐☐☐

FOR TREATMENT OF LTBI ONLY

○ CT Scan ○ Radiograph ○ Other Chest imaging Date ☐☐ / ☐☐ / ☐☐☐☐ ○ Normal ○ Abnormal (Not Suggestive of TB)

DOPT: ☐ Yes, totally observed ☐ No, self-administered ☐ Both
DOPT Site: ☐ Clinic or medical facility ☐ Field ☐ Both
Frequency: ☐ Daily ☐ Twice Weekly ☐ Three X's Weekly

Was Treatment Recommended? ○ Yes ○ No

Weight ☐☐☐.☐☐ Height ☐☐ Medication Change Date ☐☐ / ☐☐ / ☐☐☐☐

Date Regimen Start ☐☐ / ☐☐ / ☐☐☐☐ Date Regimen Stop ☐☐ / ☐☐ / ☐☐☐☐ Prescribed for (months): ☐☐

Date Regimen Restart ☐☐ / ☐☐ / ☐☐☐☐ Date Regimen Stop ☐☐ / ☐☐ / ☐☐☐☐ Maximum refills authorized: ☐☐

	Dosage	Unit	Duration in weeks		Dosage	Unit	Duration in weeks
☐ Isoniazid		☐☐	☐☐	☐ Other (specify)		☐☐	☐☐
☐ Rifampin		☐☐	☐☐	☐ Other (specify)		☐☐	☐☐
☐ B6		☐☐	☐☐				

IGRA TEST

Test Date ☐☐ / ☐☐ / ☐☐☐☐

Test Type ☐ QFT ☐ T-SPOT ☐ Other _____

☐ Positive ☐ Not Done
☐ Negative ☐ Unknown
☐ Indeterminate

Result ☐☐ Percent ☐☐

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
- ☐ 4 M, TB, No Current Disease

Physician Signature Date ☐☐ / ☐☐ / ☐☐☐☐ **Physician Signature**

CLOSURE

Provider Decision: ☐ Pregnant ☐ Non - TB

Date ☐☐ / ☐☐ / ☐☐☐☐ Close Episode? ☐ Yes ☐ No # months on Rx ☐☐ # months recommended ☐☐

- ☐ Lost to followup
- ☐ Patient chose to stop
- ☐ Adverse drug reaction
- ☐ Completion of adequate therapy
- ☐ Deceased
- ☐ Moved out of state/country
- ☐ Other

Deceased Cause:

Death Date ☐☐ / ☐☐ / ☐☐☐☐

Country State/Name:

Other Reason:

GENERAL COMMENTS:

Austin Public Health Department
Tuberculosis Elimination Division
Report of Case and Patient Services

12152354

Appointment Date __ / __ / ____

Appointment Time __ : __ ○ AM ○ PM

Date reported to Health Department __ / __ / ____

CI

NCM

Date form sent to region __ / __ / ____

Date form sent to central office __ / __ / ____

☐ **Initial Report** ☐ **Drug Resistance** ☐ **Followup or Medical Review** ☐ **Hospital Admission or Discharge** ☐ **New Classification/Change**

Social Security Number - -

Date of Birth (mm/dd/yyyy) / /

Phone Number ( ) - ○ **Home** ○ **Work** ○ **Cell**

Last Name

Suffix

Sex: ☐ **Male** ☐ **Female**

First Name

Middle Name

Address

Apartment Number

City

County

Zip Code

Facility/Care Provider Name

Name of person completing this form

Facility responsible for patient care: ☐ Public Health Clinic ☐ Private Physician ☐ Public Hospital ☐ TDCJ ☐ Military Hospital ☐ VA ☐ Other (Specify)

Signs/Symptoms at DX

	Y	N	weeks
Fever	☐ Y	☐ N	weeks
Chills	☐ Y	☐ N	weeks
Cough	☐ Y	☐ N	weeks
Lymph Node	☐ Y	☐ N	weeks
Productive Cough	☐ Y	☐ N	weeks
Hemoptysis	☐ Y	☐ N	weeks
Night Sweats	☐ Y	☐ N	weeks
Weight Loss (>10%)	☐ Y	☐ N	weeks

Other:

Status ☐ **New** ☐ **Recurrent** ☐ **Reopen**

Prior Therapy? ☐ Yes ☐ No

Start Date / /

Stop Date / /

Chest X-Ray

○ **CT Scan** ○ **Radiograph** ○ **Other Chest imaging**

Date / /

Result

☐ Normal ☐ Abnormal ☐ Unknown ☐ Not Done
☐ Not suggestive of TB

If Abnormal: *(check abnormality)*
☐ Cavitary
☐ Non-cavitary, (consistent with TB)
☐ Non-cavitary, (not consistent with TB)

If Abnormal, evidence of Miliary TB?
☐ **Yes** ☐ **No** ☐ **UNK**

If Abnormal, *(check status)*
☐ **Stable** ☐ **Worsenig** ☐ **Improving** ☐ **UNK**

If Pediatric TB Case (<15 Years Old) *Country of birth for primary guardians:*

Guardian 1

Guardian 2

Patient lived outside US for >2 months: ☐ Yes ☐ No ☐ Unknown

If yes, Country

Chest X-Ray Comments:

ATS Classifications

☐ 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, Current Disease
☐ 4 M, TB, No Current Disease
☐ 5 M. TB Suspect, Diagnosis Pending

Significant Sites (Class 3, 5) (select all that apply)

☐ Pulmonary	☐ Laryngeal
☐ Pleural	☐ Bone and/or Joint
☐ Lymphatic: Cervical	☐ Genitourinary
☐ Lymphatic: Intrathoracic	☐ Meningeal
☐ Lymphatic: Axillary	☐ Peritoneal
☐ Lymphatic: Other	☐ Site Not Stated
☐ Lymphatic: Unknown	☐ Other: Specify

Specify other significant sites

From the selected significant sites, Primary Site is:

AFB Smear Results

Current Collect Date / /

Current Report Date / /

Specimen Type
☐ sputum ☐ urine ☐ biopsy
☐ bronchial washing ☐ other

If biopsy or other, list anatomic site of specimen

If other than sputa, type of exam:
☐ Smear ☐ Pathology ☐ Cytology

LabType
☐ ATCHHSD
☐ DSHS State Lab
☐ Lab Corp
☐ Clinical Pathology Lab
☐ Hospital Lab
☐ Private Lab

Result
☐ Negative
☐ Positive
☐ Pending
☐ Not done

Culture Results

Current Collect Date / /

Current Report Date / /

Specimen Type: ☐ sputum ☐ urine ☐ biopsy ☐ bronchial washing ☐ other

If biopsy or other, list anatomic site of specimen

Sputum culture conversion documented?
☐ Yes ☐ No ☐ NA

If no, reason:

Result
☐ Negative ☐ Positive for M.TB ☐ Postive for Non-M.TB
☐ Pending ☐ Not done

If Positive, Bacteria Type

LabType
☐ ATCHHSD ☐ DSHS State Lab ☐ Lab Corp
☐ Clinical Pathology Lab ☐ Hospital Lab ☐ Private Lab

Nucleic Acid Amplification Test

Current Collect Date / /

Current Report Date / /

TestType: ○ **MTD** ○ **PCR**

Specimen Type
☐ sputum ☐ urine ☐ biopsy ☐ bronchial washing ☐ other

If biopsy or other, list anatomic site of specimen

LabType
☐ ATCHHSD
☐ DSHS State Lab
☐ Lab Corp
☐ Clinical Pathology Lab
☐ Hospital Lab
☐ Private Lab

Result
☐ Negative
☐ Positive
☐ Indeterminate
☐ Not done

Episode Genotyping Accession Number

Genotyping: Isolate Submitted for genotyping? ☐ **Yes** ☐ **No**

TB400B (01/08)

[redacted]

12152354

Susceptibility Results

Current Collect Date / /

Current Report Date / /

Specimen Type: ☐ sputum ☐ urine ☐ biopsy ☐ bronchial washing ☐ other

If biopsy or other, list anatomic site of specimen

LabType

☐ ATCHHSD ☐ DSHS State Lab ☐ Lab Corp ☐ Clinical Pathology Lab ☐ Hospital Lab ☐ Private Lab

Culture was sensitive to:

☐ Isoniazid ☐ Rifampin ☐ Ethambutol ☐ Other Quinolones ☐ Other

Culture was resistant to:

☐ Isoniazid ☐ Rifampin ☐ Ethambutol ☐ Other Quinolones ☐ Other

TREATMENT FOR ACTIVE TB DISEASE

Date Regimen Start / /

Date Regimen Stop / /

Weight .

Prescribed for (months):

Maximum refills authorized:

Date Regimen Restart / /

Date Regimen Stop / /

Height

Medication Change Date / /

	Dosage	Unit	Duration (in weeks)		Dosage	Unit	Duration (in weeks)
☐ Isoniazid				☐ Rifater			
☐ Rifampin				☐ Levofloxin			
☐ Rifamate				☐ Gatifloxacin			
☐ Pyrazinamide				☐ Moxifloxacin			
☐ Ethambutol				☐ Rifapentene			
☐ Streptomycin				☐ Clofazimine			
☐ Ethionamide				☐ Cycloserine			
☐ Capreomycin				☐ PAS			
☐ Amikacin				☐ B6			
☐ Ciprofloxacin							
☐ Ofloxin							
☐ Rifabutin							
☐ Other							
☐ Other							
☐ Other							

Directly Observed Therapy (DOT) Doses

☐ Yes, totally observed
☐ No, self-administered
☐ Both

DOT Frequency

☐ Daily
☐ Twice Weekly
☐ Three X's Weekly

If No, self_administered, specify reason

DOT Site

☐ Clinic or medical facility ☐ DOT/Field ☐ Both

Control Order / /

Court Action / /

Chest Xray Return / /

Reason Therapy Extending > 12 months

TB Net Enrolled ☐ Yes ☐ No

Compliant ☐ Yes ☐ No

Hospitalization Advised ☐ Yes ☐ No

Consult ☐ Yes ☐ No

Quarantine Advised ☐ Yes ☐ No

Quarantine Location:

Collect next sputum on / /

Other Lab Studies / /

Return to Nurse clinic on / /

Return to MD clinic on / /

CLOSURE

Date / /

Close Episode? ☐ Yes ☐ No

% doses taken by DOT

doses taken

doses recommended

months on Rx

months recommended

☐ Lost to followup

☐ Patient chose to stop

☐ Adverse drug reaction

☐ Completion of adequate therapy

Provider Decision: ☐ Pregnant ☐ Non - TB

☐ Deceased

☐ Moved out of state/country

☐ Other

Deceased Cause:

Country State/Name:

Other Reason:

Death Date / /

Date referred to Austin / /

GENERAL COMMENTS:

Authorized Nurse to Obtain Informed Consent

☐ Yes

Nurse Signature

Nurse Signature Date / /

Physician Signature

Physician Signature Date / /