Austin/Travis County Health & Human Services Department

DISEASE PREVENTION AND HEALTH PROMOTION DIVISION

EPIDEMIOLOGY AND HEALTH STATISTICS UNIT

15 Waller Street, 4th Floor
Austin, TX 78702
512-972-5555

Reporting Communicable Disease in Travis County

Austin/Travis County Health and Human Services Department
Communicable Disease Surveillance Program
15 Waller Street
Austin, Texas 78702

Reporting Package for Providers in Travis County

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Revised 05/2011

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 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 Fax (512) 972-5772
STD Reporting	(512) 972-5433 Fax (512) 972-5772
Tuberculosis Reporting	(512) 972-5448 Fax (512) 972-5451
Perinatal Hepatitis B Program	(512) 972-6218 Fax (512) 972-6287
Lead (elevated blood levels)	(512) 972-5555 Fax (512) 972-5772

OTHER ATCHHSD 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 or 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 (Provider VFC Program)	(512) 972-5414

Updated 04/2014

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/

Reporting Contacts

A – I	When to Report	I – Y	When to Report
*Acquired immune deficiency syndrome (AIDS)[1, 2]	Within 1 week	**Influenza, Novel**[3]	**Call Immediately**
Amebiasis[3]	Within 1 week	***Lead, child blood, any level & adult blood, any level**[4]	**Call/Fax Immediately**
Amebic meningitis and encephalitis[3]	Within 1 week	Legionellosis[3]	Within 1 week
Anaplasmosis[3]	Within 1 week	Leishmaniasis[3]	Within 1 week
Anthrax[3, 5]	**Call Immediately**	Listeriosis[3, 5]	Within 1 week
Arbovirus infection[3, 6]	Within 1 week	Lyme disease[3]	Within 1 week
*Asbestosis[7]	Within 1 week	Malaria[3]	Within 1 week
Babesiosis[3]	Within 1 week	**Measles (rubeola)**[3]	**Call Immediately**
***Botulism (adult and infant)**[3, 5, 8]	**Call Immediately**	**Meningococcal infections, invasive**[3, 5]	**Call Immediately**
Brucellosis[3, 5]	**Within 1 work day**	**Multi-drug resistant *Acinetobacter* (MDR-A)**[9, 10]	**Call Immediately**
Campylobacteriosis[3]	Within 1 week	Mumps[3]	Within 1 week
*Cancer[11]	See rules[11]	**Pertussis**[3]	**Within 1 work day**
Carbapenem resistant *Enterobacteriaceae* (CRE)[9, 12]	**Call Immediately**	*Pesticide poisoning, acute occupational[13]	Within 1 week
Chagas' disease[3]	Within 1 week	**Plague (*Yersinia pestis*)**[3, 5]	**Call Immediately**
*Chancroid[1]	Within 1 week	**Poliomyelitis, acute paralytic**[3]	**Call Immediately**
Chickenpox (varicella)[14]	Within 1 week	**Poliovirus infection, non-paralytic**[3]	**Within 1 work day**
**Chlamydia trachomatis* infection[1]	Within 1 week	**Q fever**[3]	**Within 1 work day**
*Contaminated sharps injury[15]	Within 1month	**Rabies, human**[3]	**Call Immediately**
***Controlled substance overdose**[16]	**Call Immediately**	Relapsing fever[3]	Within 1 week
Creutzfeldt-Jakob disease (CJD)[3]	Within 1 week	**Rubella (including congenital)**[3]	**Within 1 work day**
Coronavirus, novel causing severe acute respiratory disease[3, 17]	**Call Immediately**	Salmonellosis, including typhoid fever[3]	Within 1 week
Cryptosporidiosis[3]	Within 1 week	Shigellosis[3]	Within 1 week
Cyclosporiasis[3]	Within 1 week	*Silicosis[18]	Within 1 week
Cysticercosis[3]	Within 1 week	**Smallpox**[3]	**Call Immediately**
*Cytogenetic results (fetus and infant only)[19]	See rules[19]	*Spinal cord injury[20]	Within 10 work days
Dengue[3]	Within 1 week	Spotted fever group rickettsioses[3]	Within 1 week
Diphtheria[3]	**Call Immediately**	***Staph. aureus*, vancomycin-resistant (VISA and VRSA)**[3, 5]	**Call Immediately**
*Drowning/near drowning[20]	Within 10 work days	Streptococcal disease (group A, B, *S. pneumo*), invasive[3]	Within 1 week
Ehrlichiosis[3]	Within 1 week	***Syphilis – primary and secondary stages**[1, 21]	**Within 1 work day**
Escherichia coli infection, Shiga toxin-producing[3, 5]	Within 1 week	*Syphilis – all other stages[1, 21]	Within 1 week
*Gonorrhea[1]	Within 1 week	*Taenia solium* and undifferentiated *Taenia* infection[3]	Within 1 week
Haemophilus influenzae type b infections, invasive[3]	Within 1 week	Tetanus[3]	Within 1 week
Hansen's disease (leprosy)[3]	Within 1 week	*Traumatic brain injury[20]	Within 10 work days
Hantavirus infection[3]	Within 1 week	Trichinosis[3]	Within 1 week
Hemolytic Uremic Syndrome (HUS)[3]	Within 1 week	**Tuberculosis (includes all *M. tuberculosis* complex)**[5, 22]	**Within 1 work day**
Hepatitis A (acute)[3]	**Within 1 work day**	**Tularemia**[3, 5]	**Call Immediately**
Hepatitis B, C, and E (acute)[3]	Within 1 week	Typhus[3]	Within 1 week
Hepatitis B identified prenatally or at delivery (acute & chronic)[3]	Within 1 week	***Vibrio* infection, including cholera**[3, 5]	**Within 1 work day**
Hepatitis B, perinatal (HBsAg+ < 24 months old)[3]	**Within 1 work day**	**Viral hemorrhagic fever, including Ebola**[3]	**Call Immediately**
*Human immunodeficiency virus (HIV) infection[1, 2]	Within 1 week	**Yellow fever**[3]	**Call Immediately**
Influenza-associated pediatric mortality[3]	**Within 1 work day**	Yersiniosis[3]	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] 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.
[4] For reporting information see http://www.dshs.state.tx.us/lead/default.shtm.
[5] Lab isolate must be sent to DSHS lab. Call 512-776-7598 for specimen submission information.
[6] Reportable Arbovirus infections include neuroinvasive and non-neuroinvasive California serogroup including Cache Valley and La Crosse, Eastern Equine (EEE), Dengue, Powassan, St. Louis Encephalitis (SLE), West Nile, and Western Equine (WEE).
[7] For reporting information see http://www.dshs.state.tx.us/epitox/asbestosis.shtm.
[8] Report suspected botulism immediately by phone to 888-963-7111.
[9] CRE and MDR-A reporting is covered and encouraged as a rare or exotic disease and will be specified by Texas Administrative Code (TAC) rule with an estimated effective date of April 1, 2014. See proposed amendments at http://www.sos.state.tx.us/texreg/pdf/backview/1206/1206prop.pdf, 25 TAC §§97.1, 97.3, 97.4, 97.7.
[10] See additional reporting information at http://www.dshs.state.tx.us/IDCU/health/antibiotic_resistance/MDR-A-Reporting.doc.
[11] 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.
[12] See additional reporting information at http://www.dshs.state.tx.us/IDCU/health/antibiotic_resistance/Reporting-CRE.doc.
[13] For reporting information see http://www.dshs.state.tx.us/epitox/Pesticide-Exposure/#reporting.
[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] 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/.
[16] Contact local poison center at 1-800-222-1222. For instructions, see http://www.dshs.state.tx.us/epidemiology/epipoison.shtm#rcso.
[17] Novel coronavirus causing severe acute respiratory disease includes previously reportable Severe Acute Respiratory Syndrome (SARS).
[18] For reporting information see http://www.dshs.state.tx.us/epitox/silicosis.shtm.
[19] 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.
[20] 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.
[21] Laboratories should report syphilis test results within 3 work days of the testing outcome.
[22] MTB complex includes *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/.

Texas Department of State Health Services – Business Hours 1-800-252-8239 / After Hours 888-963-7111

Infectious Disease Report

General Instructions

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 Disease Surveillance staff may contact you to further investigate this Infectious Disease Report.

Suspected cases and cases should be reported to your local or regional health department.

Contact information for your local department can be found at:
http://www.austintexas.gov/department/health

As needed, cases may be reported to Austin/Travis County Health Department @ (512 972-5555) .

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	

Fax form to (512) 972-5772 Attn: Austin/Travis County HHSD/Disease Surveillance Program

Austin/Travis County Health Department 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 ☐ **# of Weeks:** ____ No ☐

Address (Street, City, State, Zip): _____

Hispanic Ethnicity? Yes ☐ No ☐

Race: (Check All That Apply) W ☐ B ☐ AIS ☐ AI ☐ PI ☐

Telephone: _____

Employment: _____

Marital Status: S ☐ M ☐ W ☐ D ☐

SSN or Medical Record # _____

Provider Type:

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

Exam Date:

Exam Reason:

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

Code 200 (not 490)

☐ Genital ☐ Ophthalmia

Code 300 (not 490)

☐ Genital ☐ Pharyngeal
☐ Rectal ☐ Ophthalmia
☐ Other ☐ Resistant

Code 490

Associated with
☐ 200 ☐ 300
☐ Other/Unknown

☐ Code 100

☐ Code 600

Lab Test(s) and Results:

Collection Date	Test Type/Specimen Source	Test Result

Processing Laboratory:

Code 700:

☐ 710 * ☐ 745
☐ 720 * ☐ 750
☐ 730 ☐ 790

Neurologic Involvement
○ Yes ○ No ○ Unk

* All cases of 710 and 720 must be reported within 1 work day.

Treatment Information:

Date Treatment Given:

Drug & Dosage:

☐ **No Treatment Given**

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.

For all 900 reporting, please call 512-972-5144

Notes/Symptoms:

Reported by: _____ Office Address & Phone Number: _____

Please Fax Completed Form To 512-972-5772

Rev. 4/2014

Faxable S-27 Form

Austin/Travis County HHSD: 512-972-5772 **(fax)** 512-972-5555 **(ph)**

Form S-27 Instructions

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 S-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 Syphillis 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 512-972-5144, 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 512-972-5512. Alternately, this form may be mailed to:

City of Austin HHSD
Attn: Disease Surveillance
15 Waller St, 4th floor
Austin, TX 78702

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

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

REPORT PERIOD: FROM _____TO_____ SEE THE *TEXAS DEPARTMENT OF STATE HEALTH SERVICES* INSTRUCTIONS ON THE BACK OF THIS FORM. ( ) NO POSITIVE TEST THIS QUARTER.

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 *

( ) REQUEST ADDITIONAL FORMS BE PROVIDED * CHECK THIS BOX IF PREGNANT/MATERNITY PATIENT

Texas Department of State Health Services
Form STD-28 (Rev. 01/06)

_____ Laboratory Supervisor

_____ Date

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?	Was the patient hospitalized?	Did the patient have a fever?
Name of contact: Phone:	Yes No	Yes No Date:

Was lab testing done for Varicella? Yes No	Number of lesions in total: *(circle number of lesions)*	Did the patient attend daycare/after school care?
Lab test: DFA PCR IgM IgG Other Date:_____ Result: Ordering Physician:	<50 50-249 250-499 500+	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?	Was the patient hospitalized?	Did the patient have a fever?
Name of contact: Phone:	Yes No	Yes No Date:

Was lab testing done for Varicella? Yes No	Number of lesions in total: *(circle number of lesions)*	Did the patient attend daycare/after school care?
Lab test: DFA PCR IgM IgG Other Date:_____ Result: Ordering Physician:	<50 50-249 250-499 500+	Yes No Name of Facility:

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 ☐ 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 _____ AKA _____
(Last) (First) (Middle)

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) _____

Country of Birth _____
If foreign born,
Date of entry into U.S. ___/___/___

Preferred Language _____

Notice of Arrival of Alien with TB Class
☐ A ☐ B1
☐ B2 ☐ B3

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 ☐ Unknown
☐ Hispanic or Latino
☐ Not Hispanic or Latino

SEX
☐ Male
☐ Female

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

OCCUPATION (within past 2 years)
☐ Unemployed during last 2 yrs ☐ Unknown ☐ Other
☐ Employed (If employed, check all that apply) ☐ Student ☐ Child
☐ Migrant/Seasonal Worker ☐ Retiree ☐ Disabled
☐ Health Care Worker (Specify) _____ ☐ Homemaker
☐ Correctional Emp ☐ Other Occupation ☐ 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

POPULATION RISKS
☐ Low Income
☐ Inner-city resident
☐ Foreign born
☐ Binational (US-Mexico)
***Within past 2 years**
☐ 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*
☐ None of the above risks apply

MEDICAL RISKS
☐ Diabetes mellitus
☐ 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 malabsorption syndromes
☐ Leukemia
☐ Lymphoma
☐ Cancer of head
☐ Cancer of neck
☐ Drug abuse within past year:
☐ Injecting
☐ Non-injecting
☐ Unknown if injecting
☐ HIV seropositive (check only if laboratory confirmed)
☐ Tuberculin skin test conversion within 2 years
☐ Fibrotic lesions (on chest x-ray) consistent with old, healed TB
☐ Chronic renal failure
☐ Organ Transplant
☐ Other _____
☐ None of these medical risks apply

HIV TEST RESULTS
Date HIV Test ___/___/___
☐ Positive ☐ Negative
☐ Pending ☐ Refused
☐ Not Offered

Date CD4 Count ___/___/___
Results CD4 Count _____

TUBERCULIN SKIN TEST Documented history of positive TST? ☐ Yes ☐ No

___/___/___ ___ mm ☐ Positive ☐ Negative ☐ Not Read

___/___/___ ___ mm ☐ Positive ☐ Negative ☐ Not Read

PRIOR LTBI TREATMENT ☐ Yes ☐ No

Start Date ___/___/___

Stop Date ___/___/___

FOR TREATMENT OF LTBI ONLY

___/___/___ Date Normal Chest X-ray Weight _____ Height _____

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

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

___/___/___ 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: _____

ProtectTexas Texas Department of Health

TB-400A (11/03)

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 _____ DOB ___/___/___
(Last) (First) (Middle) MM DD YY

_____ SSN _____
Street Apt# City County Zip Code

Facility/Care Provider Name _____ _____
Facility responsible for patient care ☐ Public Health Clinic ☐ Private Physician ☐ Hospital Name of person completing this form
☐ Other (Specifiy) _____

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
☐ Cavitary
☐ Non-cavitary, consistent with TB
☐ Non-cavitary, not consistent with TB
Comments:

Status
☐ Stable
☐ Worsening
☐ Improving
☐ 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 ___/___/___

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	☐ Pulmonary	30	☐ Bone and/or Joint
10	☐ Pleural	40	☐ Genitourinary
20	☐ Lymphatic	50	☐ Miliary/Disseminated
21	☐ Cervical	60	☐ Meningeal
22	☐ Intrathoracic	70	☐ Peritoneal
23	☐ Other	80	☐ Other (Specify)_____

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

☐ Isoniazid	_____ mgs	☐ Rifater	_____ mgs
☐ Rifampin	_____ mgs	☐ Levofloxacin	_____ mgs
☐ Rifamate	_____ mgs	☐ Gatifloxacin	_____ mgs
☐ Pyrazinamide	_____ mgs	☐ Moxifloxacin	_____ mgs
☐ Ethambutol	_____ mgs	☐ Rifapentine	_____ mgs
☐ Streptomycin	_____ mgs	☐ Clofazimine	_____ mgs
☐ Ethionamide	_____ mgs	☐ Cycloserine	_____ mgs
☐ Capreomycin	_____ mgs	☐ PAS	_____ mgs
☐ Amikacin	_____ mgs	☐ B6	_____ mgs
☐ Ciprofloxacin	_____ mgs	☐ _____	_____ mgs
☐ Ofloxacin	_____ mgs	☐ _____	_____ mgs
☐ Rifabutin	_____ mgs	☐ _____	_____ mgs

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:_____

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:___/___/___

Nucleic Acid Amplification Test
Current ___/___/___ ☐ Negative ☐ Positive
☐ Indeterminate ☐ Not done

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: ___/___/___

_____
Nurse Signature Date

_____
Physician Signature Date
_____ Authorize nurse to obtain informed consent
General Comments:

ProtectTexas
Texas Department of Health

TB-400B (11/03)

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/EPSDT #:

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) Test 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: _____ / _____ / _____

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):

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

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	**poliomyelitis**
St. Louis encephalitis virus	St. Louis encephalitis
Venezuelan equine encephalomyelitis virus	Venezuelan equine encephalitis
Western equine encephalomyelitis virus	Western equine encephalitis
yellow fever virus	**yellow fever**

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
Entamoeba histolytica	amebiasis
Plasmodium species †	malaria
Cryptosporidium parvum	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)[1]
hepatitis B (anti-HBc IgM)[1]
hepatitis C (anti-HCV)[1]
hepatitis D (anti-HDV, HbsAg)[1]
hepatitis E (anti-HEV)[1]
HIV infection
legionellosis[2]
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

[1] Refer positive results for hepatitis to infection control practitioner who will determine whether they are reportable.

[2] 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 *C. botulinum* *
005.4	Food poisoning due to *V. parahaemolyticus*
006	Amebiasis
008.04	*E. coli* 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	*H. influenzae* 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 *C. trachomatis*
100.81	Leptospiral meningitis
104.8	Lyme disease
124	Trichinosis
130.0	Meningoencephalitis due to toxoplasmosis
136.2	Meningoencephalitis due to *Naegleria*
136.8	Cryptosporidiosis
283.11	Hemolytic uremic syndrome
290.1	Dementia in Creutzfeldt-Jakob disease
320.0	Meningitis due to *H.influenzae* *
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 *Streptococcus*
501	Asbestosis
502	Silicosis
692.3	Occupational pesticide poisoning (adults)
692.4	Occupational pesticide poisoning (adults)
729.4	Fasciitis due to *Streptococcus*
771.0	Congenital rubella syndrome **
771.2	Congenital listeriosis, malaria, tuberculosis**
790.7	Bacteremia due *Streptococcus*
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 μg/dL in children
blood lead levels of $\geq$25 μg/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 *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 *Streptococcus pneumoniae.*

TEXAS
Department of
State Health Services

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. 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 medially 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, 4th Floor
Austin, TX 78702

April 21, 2014

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,

Heather Cooks-Sinclair

Heather Cooks-Sinclair, MS
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 – 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
- 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 -Center for Disease Control

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 – 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