Austin Public Health

Reporting Communicable Disease in

Travis County
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.    Jeffery P. Taylor, M.P.H.
Medical Director/Health Authority    Epidemiology Program Manager
Austin Public Health Department    Austin Health Public Department
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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
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
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
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.

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.

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.

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.

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).

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)).

Failure to report a notifiable condition is a Class B misdemeanor under the Texas Health and Safety Code, §81.049.

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).

(1) 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.

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See condition

Hookworm (Hepatitis B, perinatal (Hepatitis B, C, and E (acute)
Hemolytic

Diphtheria

Coronavirus, novel

Chickenpox (varicella)

Carbapenem-resistant Enterobacteriaceae (CRE) -

Chagas disease*

*Chancroid

Chickenpox (varicella)*

*Chlamydia trachomatis*

*Contaminated sharps injury

*Controlled substance overdose-

Coronavirus, novel

Cysticercosis

*Cytogenic results (fetus and infant only)

Diphtheria*

*Drowning/near drowning*

Echinococcoides

Ehrlichiosis

Fascioliasis

*Gonorrhea

Haeomophilus influenzae, invasive*

Hansen's disease (leprosy)*

Hantavirus infection

Hemolytic uremic syndrome (HUS) *

Hepatitis A*

Hepatitis B, C, and E (acute)

Hepatitis B infection identified prematurely or at delivery (mother)

Hepatitis B, perinatal (HBsAg < 24 months old) (child)

Hookworm (anglyostoma)l

HIV (including HIV/AIDS; syphilis, tuberculosis, hepatitis B
HIV infection

*Human immunodeficiency virus (HIV), acute infection*

*Human immunodeficiency virus (HIV), non-acute infection*

Influenza-associated pediatric mortality*

Influenza, novel

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/idcu/investigation/conditions/contacts/

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

3 For lead reporting 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/investigationCall as indicated for immediately reportable conditions.

5 Lab isolate must be sent to DBH lab for specificities see section [4] at Texas Administrative Code (TAC) §97.9. For instruction, see http://www.dshs.state.tx.us/idcu/health/infection_control/bloodborne_pathogens/reporting/.

6 Arboviral infections including, but not limited to, those caused by California serogroup virus, chikungunya virus, dengue virus, yellow fever virus, and West Nile virus. The projected effective date is March 2017. See updated TAC after March, 2017.

7 Children under 5 years

8 Within 3 work days of the testing outcome.

9 All persons

10 Any person

11 Laboratories should report syphilis test results within 1 week; see rules

12 In progress

*See rules*

13 Pesticide poisoning, acute occupational

14 Call Immediately

15 Call Immediately

16 A reporting information at the Texas Department of State Health Services’ website. Updated March 2017.

17 Please refer to specific rules and regulations for injury reporting and who to report to at http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/

18 For purposes of surveillance, CJD notification also includs, variant Creutzfeldt-Jakob disease (vCJD) and Creutzfeldt-Jakob disease (CJD) reported in people under 15 years of age.

19 See the Epi Case Criteria Guide (http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/) for instructions, see http://www.dshs.state.tx.us/idcu/investigation/conditions/contacts/.

20 Within 1 business day.

21 Laboratories should report syphilis test results within 1 week; see rules

22 For purposes of surveillance, CJD notification also includs, variant Creutzfeldt-Jakob disease (vCJD) and Creutzfeldt-Jakob disease (CJD) reported in people under 15 years of age.

23 This disease is notifiable via this reportable conditions.

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***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](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.

<table>
<thead>
<tr>
<th>Bacillus anthracis</th>
<th>Mycobacterium tuberculosis complex</th>
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<tbody>
<tr>
<td>Brucella species</td>
<td>Neisseria meningitidis from normally sterile sites</td>
</tr>
<tr>
<td>Clostridium botulinum</td>
<td>Staphylococcus aureus with a vancomycin MIC greater than 2 µ/mL (VISA and VRSA)</td>
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<tr>
<td>E. coli 0157:H7 isolates or specimens from cases where Shiga-toxin activity is demonstrated</td>
<td>Vibrio species</td>
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<tr>
<td>Francisella tularensis</td>
<td>Yersinia pestis</td>
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<td>Listeria monocytogenes</td>
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<tr>
<td><strong>VISA/VRSA</strong></td>
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<tr>
<td><strong>MIC greater than 2 µg/mL</strong></td>
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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/Travis 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

<table>
<thead>
<tr>
<th>Date</th>
<th>Onset</th>
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<th>Absence</th>
<th>Office visit</th>
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### Physician Name

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<th>Physician Phone</th>
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###Diagnostic Criteria

*Diagnostic Lab Result and Specimen Source or Clinical Indicators*

### Patient Name

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### Address

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### Date of Birth

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### Age

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### Sex

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### Ethnicity

### Race

### Notes, comments, or additional information such as other lab results/clinical info, pregnancy status, occupation (food handler), school name/grade, travel history

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<tr>
<th>Disease or Condition</th>
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### Name of Reporting Facility

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### Name of Person Reporting

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<td>(___) ___ - ___ extension ___</td>
</tr>
</tbody>
</table>

### Date of Report

<table>
<thead>
<tr>
<th>mm/dd/yyyy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Onset Date</th>
<th>History of Disease?</th>
<th>Yes</th>
<th>No</th>
<th>Date of Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Last day of school attended</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaccinated against Varicella?</td>
<td>Yes</td>
<td>No</td>
<td>Number of Doses Received?</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date(s) Varicella Vaccine Administered:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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 lab testing done for Varicella?**  
Yes | No |  
Lab test: DFA | PCR | IgM | IgG | Other |  
Date: | Result: |  

**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:  

**Ordering Physician:**

---

**Name of Person Reporting:**  
PHONE:  

**Agency/Organization Name:**  

**Address:**  
CITY:  
ZIP:  
COUNTY:  

**DATE REPORTED:**  

Fax Report to (512) 972-5772  Attn: Disease Surveillance
**INFORMATION AT TIME OF BLOOD LEAD COLLECTION**

<table>
<thead>
<tr>
<th>Patient Information</th>
<th>Blood Lead Information</th>
<th>Sample Information</th>
<th>Company Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
<td>Blood Lead Level: mcg/dL (micrograms per deciliter)</td>
<td>Sample Collection Date: (mm/dd/yyyy)</td>
<td>Company Name:</td>
</tr>
<tr>
<td>First Name:</td>
<td></td>
<td>Testing Initiated By:</td>
<td>Phone: ( )</td>
</tr>
<tr>
<td>Middle Name:</td>
<td></td>
<td>Testing Initiated By:</td>
<td>Fax: ( )</td>
</tr>
<tr>
<td>Parent/Guardian (if under 16 years of age):</td>
<td>Sample Type:</td>
<td>Testing Initiated By:</td>
<td>Exposure Site Street Address:</td>
</tr>
<tr>
<td>Street Address:</td>
<td>Capillary</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Apt #:</td>
<td>Venous</td>
<td>Testing Initiated By:</td>
<td>City:</td>
</tr>
<tr>
<td>City:</td>
<td>Unknown</td>
<td>Testing Initiated By:</td>
<td>County:</td>
</tr>
<tr>
<td>County:</td>
<td>Unknown</td>
<td>Testing Initiated By:</td>
<td>State:</td>
</tr>
<tr>
<td>State:</td>
<td>Unknown</td>
<td>Testing Initiated By:</td>
<td>Zip Code:</td>
</tr>
<tr>
<td>Zip Code:</td>
<td>Unknown</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Home Telephone:</td>
<td>Medicaid / EPSDT# (optional):</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Date of Birth: (mm/dd/yyyy):</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Ethnicity:</td>
<td>( )</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>Other- Explain here</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Other- Explain here</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Social Security #:</td>
<td>Race:</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>White</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Black</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Asian/Pacific Islander</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Native American/ Alaskan Native</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Mixed/Multi-racial</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Unknown</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Sex:</td>
<td>Male</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>( )</td>
<td>Female</td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Physician Requesting Blood Lead Test and Clinic Name:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Street:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>State/Zip:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Phone: ( )</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Fax: ( )</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Testing Laboratory:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Street:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>State/Zip:</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Phone: ( )</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Fax: ( )</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
<tr>
<td>Symptoms (describe if any):</td>
<td></td>
<td>Testing Initiated By:</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Employee Information</th>
<th>Company Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company Name:</td>
<td>Phone: ( )</td>
</tr>
<tr>
<td>( )</td>
<td>Fax: ( )</td>
</tr>
<tr>
<td>Exposure Site Street Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td></td>
</tr>
<tr>
<td>County:</td>
<td>State:</td>
</tr>
<tr>
<td>Zip Code:</td>
<td></td>
</tr>
<tr>
<td>Type of Business (i.e. demolition, radiator repair, painting):</td>
<td></td>
</tr>
<tr>
<td>Job Title (at the time of this blood lead testing):</td>
<td></td>
</tr>
<tr>
<td>Employment Hire Date: (mm/dd/yyyy)</td>
<td>Employment Termination Date: (mm/dd/yyyy)</td>
</tr>
<tr>
<td>If non-occupational activities resulted in exposure, please describe (e.g., hobby- pistol marksmanship):</td>
<td></td>
</tr>
</tbody>
</table>

Form # F09-11624 Revised 01/06/2012
Childhood Blood Lead Level Report

Confidential Medical Record

Send to:
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)

From:
Provider Name:
City/State/ZIP:
Phone Number: (   )
Fax Number: (   )

<table>
<thead>
<tr>
<th>Child Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>M.I.</td>
</tr>
<tr>
<td>Date Birth:</td>
</tr>
<tr>
<td>_____ / _____ / _____</td>
</tr>
<tr>
<td>Gender:</td>
</tr>
<tr>
<td>☐ Male</td>
</tr>
<tr>
<td>☐ Female</td>
</tr>
<tr>
<td>Age in Months:</td>
</tr>
<tr>
<td>Medicaid# / CHIP ID#:</td>
</tr>
<tr>
<td>Current Address:</td>
</tr>
<tr>
<td>Apartment #:</td>
</tr>
<tr>
<td>City:</td>
</tr>
<tr>
<td>State:</td>
</tr>
<tr>
<td>Zip:</td>
</tr>
<tr>
<td>Ethnicity: (check one)</td>
</tr>
<tr>
<td>☐ Hispanic</td>
</tr>
<tr>
<td>☐ Non-Hispanic</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
<tr>
<td>Child Race: (check one)</td>
</tr>
<tr>
<td>☐ White</td>
</tr>
<tr>
<td>☐ Black</td>
</tr>
<tr>
<td>☐ Asian or Pacific Islander</td>
</tr>
<tr>
<td>☐ Multi-Racial</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blood Lead Level Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Lead Test Level: _________ micrograms per deciliter (mcg/dL)</td>
</tr>
<tr>
<td>Blood Draw Date: _____ / _____ / _____</td>
</tr>
<tr>
<td>Type of Blood Sample: (check one)</td>
</tr>
<tr>
<td>☐ Capillary</td>
</tr>
<tr>
<td>☐ Venous</td>
</tr>
<tr>
<td>☐ Unknown</td>
</tr>
<tr>
<td>Testing Laboratory:</td>
</tr>
<tr>
<td>Laboratory Phone: (   )</td>
</tr>
<tr>
<td>If Using LeadCare System, Place Label Here</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Attending Physician Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Last Name:</td>
</tr>
<tr>
<td>First Name:</td>
</tr>
<tr>
<td>Location (City):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>For TX CLPPPP Use Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person Receiving Report:</td>
</tr>
<tr>
<td>Date Received: _____ / _____ / _____</td>
</tr>
</tbody>
</table>
# PATIENT INFORMATION

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
<th>Date of Birth:</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
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<tbody>
<tr>
<td></td>
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<table>
<thead>
<tr>
<th>Sex:</th>
<th>Male</th>
<th>Female</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Marital Status:</th>
<th>S</th>
<th>M</th>
<th>W</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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</table>

<table>
<thead>
<tr>
<th>Is this patient pregnant?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
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<table>
<thead>
<tr>
<th>Weeks:</th>
<th>Emergency Contact Number:</th>
<th>Work Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Race (check all that apply):</th>
<th>American Indian or Alaskan Native</th>
<th>Black or African American</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Asian</th>
<th>White</th>
<th>Native Hawaiian or Pacific Islander</th>
<th>Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnic Origin:</th>
<th>Hispanic or Latino</th>
<th>Not Hispanic or Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td>☐</td>
</tr>
</tbody>
</table>

# CLINICAL INFORMATION

<table>
<thead>
<tr>
<th>Exam Reason:</th>
<th>DIS Partner Referral</th>
<th>Referred by Partner</th>
<th>Screening Jail/Prison</th>
<th>DIS Suspect Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Prenatal</th>
<th>Delivery</th>
<th>Volunteer</th>
<th>Referred by Another Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</table>

<table>
<thead>
<tr>
<th>Other:</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Information (check all that apply):</th>
<th>Asymptomatic</th>
<th>Symptomatic</th>
<th>Rash</th>
<th>Chancre (sore/lesion)</th>
<th>Condyloma lata</th>
<th>Alopecia</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td></td>
<td>☐</td>
<td>☐</td>
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<table>
<thead>
<tr>
<th>Exam Date:</th>
<th>Lab Result Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Site / Specimen (check all that apply):</th>
<th>Cervix</th>
<th>Pharynx</th>
<th>Rectum</th>
<th>Urethra</th>
<th>Urine</th>
<th>Vagina</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Site / Specimen (check all that apply):</th>
<th>Cervix</th>
<th>Pharynx</th>
<th>Rectum</th>
<th>Urethra</th>
<th>Urine</th>
<th>Vagina</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab Result(s): (Please fax lab results with report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Results: ____________  Lab Results: ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lab Result(s): (Please fax lab results with report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lab Results: ____________  Lab Results: ______________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code 200 (not 490)</th>
<th>Genital</th>
<th>Ophthalmia</th>
<th>Code 490</th>
<th>Associated with</th>
<th>200</th>
<th>300</th>
</tr>
</thead>
<tbody>
<tr>
<td>☒</td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Code 300 (not 490)</th>
<th>Genital</th>
<th>Rectal</th>
<th>Pharyngea</th>
<th>Ophthalmia</th>
<th>Other</th>
<th>Code 100</th>
<th>Code 600</th>
</tr>
</thead>
<tbody>
<tr>
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<table>
<thead>
<tr>
<th>Code 700:</th>
<th>710*</th>
<th>720*</th>
<th>730</th>
<th>745</th>
<th>750</th>
<th>790</th>
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<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Neurological Involvement:</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code 900</th>
<th>950</th>
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</thead>
<tbody>
<tr>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>

The Health Department requires additional information on 900 patients.

For all 900 Reporting, please call (512)-972-5144.

Notes:

<table>
<thead>
<tr>
<th>Date of Treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment: (check all that apply)</td>
</tr>
<tr>
<td>☐ Ceftriaxone - 250 mg IM</td>
</tr>
<tr>
<td>☐ Bicillin 2.4MU</td>
</tr>
</tbody>
</table>

# FACILITY INFORMATION

<table>
<thead>
<tr>
<th>Physician or Facility Name</th>
<th>Contact Person</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
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

Updated December 1, 2016
<table>
<thead>
<tr>
<th>Test Name</th>
<th>Results (Titer if applicable)</th>
<th>Date of Specimen Collection</th>
<th>Date of Lab Analysis</th>
<th>Patient’s Name (Last, First, MI):</th>
<th>Patient’s Address (Including, City, County &amp; Zip)</th>
<th>DOB</th>
<th>Sex</th>
<th>Race</th>
<th>Hisp Y/N</th>
<th>Physician/Facility’s Name, Address, City, Zip &amp; Phone No.</th>
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NOTIFICATION OF LABORATORY TEST FINDINGS INDICATING PRESENCE OF CHLAMYDIA TRACHOMATIS, GONORRHEA, SYPHILIS, CHANCROID, HIV INFECTIONS OR SUPRESSED CD4 COUNTS

____________________________  ____________________  
Laboratory Supervisor              Date

Updated 12/15/2016
# Austin Public Health Department
## Tuberculosis Elimination Division
### Report of Case and Patient Services

**Appointment Date**: [ ] / [ ] / [ ]

**Appointment Time**: [ ] : [ ] AM  [ ] PM

**CT to Case#**

**CI**  [ ]
**NCM**  [ ]

**Medicaid#**

**ID#**

**Social Security Number**

**Date of Birth (mm/dd/yy)**

**First Name**

**Last Name**

**Middle Name**

**Suffix**

**Address**

**Phone Number**

**Facility/Care Provider Name**

**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 Testing
- [ ] Employment/Admin
- [ ] 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?**

- [ ] 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
- [ ] Native Hawaiian or Pacific Islander
- [ ] White

**Resident of Correctional Facility at Time of Dx**

- [ ] Yes
- [ ] No
- [ ] Unknown

**Resident of Long Term Care Facility at Time of Dx**

- [ ] Yes
- [ ] No
- [ ] Unknown

**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

**Notice of Arrival of Alien with TB Class**

- [ ] A
- [ ] B2
- [ ] B1
- [ ] B3

**TB CARD?**

- [ ] Yes
- [ ] No

**If YES, Death Date**

**Was TB cause of death?**

- [ ] Yes
- [ ] No
- [ ] Unk

**Country of Origin?**

- [ ] Yes
- [ ] No

**Homeless within the last year:**

- [ ] Yes
- [ ] No
- [ ] Unknown

**Primary Occupation (within last yr.)**

- [ ] Migrant/Seasonal Worker
- [ ] Health Care Worker
- [ ] Correctional Employee
- [ ] Other Occupation

- [ ] Unknown
- [ ] Not Seeking Employment

- [ ] Student
- [ ] Child
- [ ] Retiree
- [ ] Disabled

- [ ] Homemaker
- [ ] Institutionalized

- [ ] Home
- [ ] Work
- [ ] Cell

- [ ] CI
- [ ] NCM

- [ ] Yes
- [ ] No

- [ ] Yes
- [ ] No
- [ ] Unknown

- [ ] Yes
- [ ] No
- [ ] Unknown

- [ ] Yes
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- [ ] Yes
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- [ ] Yes
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- [ ] Unknown

- [ ] Yes
- [ ] No
- [ ] Unknown

- [ ] Yes
- [ ] No
- [ ] Unknown
### Documented History of Positive TST?
- Yes
- No

### Prior LTBI Treatment?
- Yes
- No

### DOPT:
- Yes, totally observed
- No, self-administered
- Both

### DOPT Site:
- Clinic or medical facility
- Field
- Both

### Frequency:
- Daily
- Twice Weekly
- Three X’s Weekly

### Start Date

### Weight

### Height

### 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

### HIV TEST RESULTS
- Date HIV Test
- Test Type
- Test Place
- Results CD4 Count
- Date CD4 Count
- Test Place

### TST:
- Date
- Diameter mm
- Result
- Percent

### IGRA:
- Date
- Test Type
- Test Place
- Result
- Percent

### 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
- Other

### Tuberculin Skin Test
- Date
- Diameter mm
- Result

### Other (specify)

### Travel History
- Date
- Number of months
- Number of months recommended

### Closures
- Provider Decision
- Close Episode?
- # months on Rx
- # months recommended

### General Comments:

---

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Other</th>
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### Physician Signature

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### Country
- US
- Mexico
- Other

### State/Name
- US
- Mexico
- Other

### Death Date

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<th>Date</th>
<th>Time</th>
<th>Other</th>
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### Close Episode?
- Yes
- No

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### Reason:
- Other

---

### TNF Therapy

---

### Obesity

---

### Immunosuppression

---

### Long-term facility for elderly/resident

---

### Political Risk
- Immigration Status at First Entry to the US
- Other

---

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### Provider Decision:
- pregnant
- Non-TB

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### Patient Choosing to Stop
- Deceased
- Other

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### Healthcare Facility:
- Health Care Facility/resident
- Other

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### Other Risk
- Low Income
- Inner-city resident
- Foreign born
- Binational (US-Mexico)
- Immigrant Visa
- Student Visa
- Tourist Visa
- Family/Fiance Visa
- Asylee or Parolee
- Employment Visa
- Refugee Visa
- Unk
- Other

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### Risk of TB Infection
- 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

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### Risk of Tuberculosis:
- Spotted with abnormal chest x-ray
- Lymphoma
- Cancer of head
- Cancer of neck
- Drug abuse within past year:
- Injecting
- Unknown if injecting
- Non-injecting
- HIV seropositive
- Tuberculin skin test conversion
- Fibrotic lesions (on chest x-ray) consistent with old, healed TB
- Chronic renal failure
- Organ Transplant

---

### General Comments:

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<th>Date</th>
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### TUBERCULIN SKIN TEST Documented History of Positive TST?
- Yes
- No

### Prior LTBI Treatment?
- Yes
- No

### FOR TREATMENT OF LTBI ONLY
- CT Scan
- Radiograph
- Other Chest imaging

### DOPT:
- Yes, totally observed
- No, self-administered
- Both

### DOPT Site:
- Clinic or medical facility
- Field
- Both

### Frequency:
- Daily
- Twice Weekly
- Three X’s Weekly

### Weight

### Height

### Date

### Medication Change Date

### Prescribed for (months):

### Maximum refills authorized:

### Dosage

### Unit

### Duration in weeks

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### Physician Signature

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### Final Decision:
- Pregnant
- Non - TB

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### Patient Choosing to Stop
- Deceased
- Other

---

### Healthcare Facility:
- Health Care Facility/resident
- Other

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### Other Risk
- Low Income
- Inner-city resident
- Foreign born
- Binational (US-Mexico)
- Immigrant Visa
- Student Visa
- Tourist Visa
- Family/Fiance Visa
- Asylee or Parolee
- Employment Visa
- Refugee Visa
- Unk
- Other
### Directly Observed Therapy (DOT) Doses

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

### DOT Site

- Clinic or medical facility
- DOT/Field
- Both

### DOT Frequency

- Daily
- Twice Weekly
- Three X's Weekly

### DOT Site Administered

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

### DOT Frequency

- Daily
- Twice Weekly
- Three X's Weekly

### DOT Frequency

- Daily
- Twice Weekly
- Three X's Weekly

---

### Treatment for Active TB Disease

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<th>Date Regimen Stop</th>
<th>Weight</th>
<th>Height</th>
<th>Prescribed for (months): Maximum refills authorized</th>
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<tr>
<th>Dosage</th>
<th>Unit</th>
<th>Duration (in weeks)</th>
<th>Reason Therapy Extending &gt; 12 months</th>
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- Collect next sputum on
- Other Lab Studies
- Return to MD clinic on
- Return to Nurse 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
- Cause: Country / State/Name: Deceased
- Moved out of state/country
- Other

### General Comments:

- Informed Consent: Yes / No
- Died: / / /
- Date referred to Austin: / / /
- Date referred to Austin: / / /

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Nurse Signature Date

Physician Signature Date

Nurse Signature

Physician Signature