Florida HEALTH
Miami-Dade County

2013

Florida Department of Health in Miami-Dade County

REPORTABLE DISEASE HANDBOOK

This handbook is designed for you as a reporting tool

MAIN NUMBER

305-324-2400

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August 2010

Dear Colleagues:

I would like to thank you for working with us in our daily effort to identify, prevent, and respond to public health problems that affect our community. The Florida Department of Health in Miami-Dade County would like to express its genuine appreciation for your support and assistance in our daily communicable disease prevention activities. We certainly value your commitment and contributions to the successful implementation of preventive measures to protect the health of our community.

The Florida Department of Health in Miami-Dade County has compiled an updated information package to inform you of current communicable disease reporting guidelines and modifications of several reporting forms.

There are no changes/updates to the December 2008 list of reportable diseases/conditions. As you know, reporting suspect and confirmed notifiable diseases and conditions and any suspected outbreaks or clusters of disease in the State of Florida is mandated under Florida Statute 381.0031, Rule 64D-3, Florida Administrative Code (F.A.C.). **Please call us immediately to report any cases of diseases marked with a "☎ or !" because such cases may require a timely public health response.** Please fax or send reports to the appropriate program using the enclosed forms next business day after diagnosis. However, please remember that HIV/AIDS reports should be mailed never faxed.

In order to assist you with reporting, we have enclosed the following materials; list of reportable diseases/conditions, list of health department staff with contact phone numbers, a general reporting form, specific disease reporting forms, and brochures on epidemiology services, category A bioterrorism agents, and seasonal influenza.

If you have any questions, please call Epidemiology, Disease Control and Immunization Services at (305) 470-5660 (24/7). Thank you for your assistance in the surveillance and control of communicable diseases and other conditions in Miami-Dade County.

Sincerely,

Reynald Jean, MD, MPH
Acting Director

Lillian Rivera, RN, MSN, PhD, Administrator

REPORTABLE NOTIFIABLE DISEASES/CONDITIONS CONTACT LIST- April 15, 2013

Disease	Phone (O=Office, F=Fax)	Contact Person	Address
AFTER HOURS and WEEKENDS	305-470-5660 (O)	To reach on-call staff	
CONGENITAL ANOMALIES	850-245-4444 x2198 (O)	Jane Correia, Coordinator	Florida Birth Defects Registry
	850-922-8473 (F)		Florida Department of Health
			Bureau of Epidemiology
			4052 Bald Cypress Way, BIN# A12
			Tallahassee, FL 32399
CANCER	305-243-2639 (O)	Mike Thiry, Data Acquisition Manager	Florida Cancer Data System
	1-800-906-3034	http://www.fcds.med.miami.edu	1550 NW 10th Ave, Suite 410
			Miami, Florida 33136
HIV/AIDS	No fax reporting		Florida Department of Health in Miami-Dade County
	305-470-6999	Main Number	AIDS Surveillance Unit
	305-470-5631 (O)	Sam Alghawi, Surveillance	8600 NW 17 Street, Suite 200
	305-470-6984 (O)	Rodolfo Boucugnani, Data Analyst	Miami, Florida 33126
EPIDEMIOLOGY			Florida Department of Health in Miami-Dade County
Immunization	786-845-0550	For Appointments Only	Epidemiology, Disease Control and Immunization
	305-470-5670 (O)	Lydia Sandoval, RN, Program Manager	Services
		Jorge Alonso, RN	8600 NW 17 Street, Suite 200
			Miami, Florida 33126
Hepatitis	305-470-6820 (O)	Marie K. Etienne, RN, Program Manager	
Lead Poisoning	305-470-6872 (O)	Asit Sarkar, PhD, Program Manager	
		Main Number	
Other Communicable	305-470-5660	Reynald Jean, MD, MPH, Acting Director	
Diseases/Conditions		Edhelene "Gigi" Rico, MPH, Survellance	
		Alvaro Mejia-Echeverry, ARNP, MPH, Bioterrorism	
		Juan Suarez, Food and Waterborne Program	
SEXUALLY TRANSMITTED DISEASES	305-575-5423	Main Number	Florida Department of Health in Miami-Dade County
	305-575-5429 (O)	Camille Persaud	STD Surveillance Unit
	305-575-5430 (O)	Yveline Pierre	1350 NW 14 Street, Suite 401
	305-575-3812 (F)		Miami, Florida 33125
TUBERCULOSIS	305-575-5409	Main Number	Florida Department of Health in Miami-Dade County
	305-575-5415 (O)	Oswaldo Curbelo	Tuberculosis Control & Prevention Program
	305-575-5418 (O)	Gina Bispham, RN	1350 NW 14 Street
	305-575-5413 (O)	Frantz Fils-Aime	Miami, Florida 33125
	305-575-5402 (O)	Reynald Jean, MD, MPH, Program Director	
	305-575-3804 (F)		

Florida Administrative Code State Mandated Reportable Diseases/Conditions Practitioner Guide 12/08

Cancer (except non-melanoma skin cancer, and including benign and borderline intracranial and CNS tumors) + (305)243-2639(Tel)

Congenital anomalies (850)245-4444 (Tel) (850)922-5473(Fax)

Epidemiology (305)470-5660 (Tel) (305)470-5533 (Fax)
(Epidemiology, Disease Control & Immunization Services)

! **Any disease outbreak**

! **Any case, cluster of case, or outbreak of a disease or condition hospital, school or other institution, not listed in this Rule that is of urgent public health significance. This includes those indicative of person to person spread, zoonotic spread, the presence of an environmental, food or waterborne sources of exposure and those that result from a deliberated act of terrorism.**

☎ Amebic Encephalitis
! Anthrax
Arsenic●
! Botulism (foodborne, wound, unspecified, other)
Botulism (infant) ●
! Brucellosis
California serogroup virus (neuroinvasive and non-neuroinvasive disease)●
Campylobacteriosis ●
Carbon monoxide poisoning ●
! Cholera
Ciguatera fish poisoning (Ciguatera) ●
Conjunctivitis in neonates ≤ 14 days old ●
Creutzfeldt-Jakob Disease (CJD) ●
Cryptosporidiosis ●
Cyclosporiasis ●
☎ Dengue
! Diphtheria
Eastern equine encephalitis virus disease (non/neuroinvasive) ●
Ehrlichiosis/Anaplasmosis-undetermine or unspecified ●
Encephalitis, other (non-arboviral) ●
Enteric disease due to:
☎ *E. coli*, O157:H7
E. coli , Other (due to other pathogenic E.coli)
Giardiasis ●
! Glanders
! *Haemophilus influenzae* (meningitis and invasive disease)
Hansen's Disease (Leprosy)
☎ Hantavirus infection
☎ Hemolytic Uremic Syndrome
! Influenza due to novel or pandemic strain
☎ Influenza-associated pediatric mortality (in persons < 18 yrs)
Legionellosis ●
Leptospirosis ●
☎ Listeriosis
Lyme Disease ●
Malaria ●
! Measles (Rubeola)
! Melioidosis
☎ Meningitis (bacterial, cryptococcal, mycotic)
! Meningococcal Disease (includes meningitis and meningococcemia)
Mercury Poisoning ●
Mumps ●
☎ Neurotoxic shellfish poisoning
☎ Pertussis
Pesticide-related illness and injury ●
! Plague
Psittacosis (Ornithosis) ●
! Poliomyelitis, paralytic and nonparalytic
Q Fever ●
☎ Rabies (human, animal)
! Rabies (possible exposure)
! Ricin toxicity
Rocky Mountain spotted fever ●
! Rubella (including congenital)
St. Louis encephalitis (SLE) virus disease (neuroinvasive and non-neuroinvasive) ●
Salmonellosis ●
Saxitoxin Poisoning including paralytic shellfish poisoning (PSP) ●
! Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease
Shigellosis ●
! Smallpox
Staphylococcus aureus- community associated mortality
☎ *Staphylococcus aureus* (infection with intermediate or full resistance to vancomycin, VISA, VRSA)
☎ Staphylococcus enterotoxin B
Streptococcal Disease (invasive, Group A) ●
Streptococcus pneumoniae (invasive disease) ●
Tetanus ●
Toxoplasmosis (acute) ●
Trichinellosis (Trichinosis) ●
! Tularemia
☎ Typhoid Fever
! Typhus Fever (disease due to *Rickettsia prowazekii* infection)
Typhus Fever (due to *Rickettsia typhi, R. felis* infection) ●
! Vaccinia Disease
Varicella (Chickenpox) ●
Varicella mortality ●
! Venezuelan equine encephalitis virus disease (non/neuroinvasive)
Vibriosis (Vibrio infections) ●
! Viral hemorrhagic fevers (Ebola, Marburg, Lassa, Machupo)
West Nile virus disease (neuroinvasive and non-neuroinvasive) ●
Western equine encephalitis disease (non/neuroinvasive) ●
! Yellow Fever

Hepatitis (viral) **(305)470-5536(Tel) (305)470-5533(Fax)**

☎ Hepatitis A
Hepatitis B, C, D, E, and G ●
Hepatitis B surface antigen (HBsAg) (positive in a pregnant woman or a child up to 24 months old) ●

HIV/AIDS (305)470-6999(Tel) (No Fax Reporting)

Acquired Immune Deficiency Syndrome (AIDS) +
Human Immunodeficiency Virus (HIV)[all, including neonates born to an infected woman, exposed newborn] +

Lead Poisoning (305)470-6877(Tel) (305)470-5533 (Fax)

STD (305)325-3242/3585(Tel) (305)547-1432(Fax)
(Sexually Transmitted Diseases)
Chancroid ●
Chlamydia ●
Gonorrhea ●
Granuloma Inguinale
Herpes Simplex Virus (HSV) [in neonates and infants up to 60 days old with disseminated infection with involvement of liver,encephalitis and infections limited to skin,eyes and mouth;anogenital in children ≤ 12 years] ●
Human Papillomavirus (HPV) [associated laryngeal papillomas or recurrent respiratory papillomatosis in children ≤ 6 years of age; anogenital in children ≤ 12 yrs] ●
Lymphogranuloma Venereum (LGV)●
Syphilis ●
☎ Syphilis (in pregnant women and neonates)

Tuberculosis (TB) (305)324-2462(Tel) (305)547-5571(Fax)

Section 381.0031(1,2), Florida Statutes provides that "Any practitioner, licensed in Florida to practice medicine, osteopathic medicine, chiropractic, naturopathy, or veterinary medicine, who diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health." The DOH county health departments serve as the Department's representative in this reporting requirement. Furthermore, this Section provides that "Periodically the Department shall issue a list of diseases determined by it to be of public health significance ... and shall furnish a copy of said list to the practitioners...."

! **Report immediately upon Initial suspicion or laboratory test order, 24/7 by phone**
☎ **Report immediately upon diagnosis or test result, 24/7 by phone**
● **Report next business day**
\+ **Other reporting timeframe**

You are an invaluable part of Florida's disease surveillance system: For more information, please call the Florida Department of Health in Miami-Dade County, Epidemiology, Disease Control and Immunization Services at (305) 470-5660 .

PHYSICIAN / HOSPITAL NOTIFIABLE DISEASE/CONDITION REPORT FORM

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control and Immunization Services
8600 N.W. 17th Street, Suite 200, Miami, FL 33126

PATIENT INFORMATION

Patient's Name: _____ (Last name / First name / MI)

SS#: _____ Medical Record#: _____

Date of Birth: _____ Gender: ☐Female ☐Male

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐White ☐Black ☐Asian ☐Alaskan ☐American-Indian ☐Other _____

Patient Address: _____ (Street / City / State / Zip)

Patient ☎: _____ Other ☎: _____

Guardian/Parent Name: _____

Emergency Contact: _____ Phone: _____

Sensitive Occupation: ☐Daycare worker/attendee ☐Unknown ☐Healthcare Worker ☐Other ☐Food Handler

DISEASE/CONDITION INFORMATION

Disease/Condition: _____

Onset Date: _____ Symptoms: _____ Status: ☐Alive ☐Dead

	Yes	No	Unk	Date	
Admitted:	☐	☐	☐	_____	Room #: _____
ER Visit:	☐	☐	☐	_____	
Discharged:	☐	☐	☐	_____	

Comments/ Treatment: _____

Admitting Physician: _____ ☎: _____ Primary Physician: _____ ☎: _____

Has patient been notified of diagnosis / lab result? ☐Yes ☐No ☐Unknown

LABORATORY INFORMATION

Is laboratory result attached? ☐Yes ☐No

Isolate or specimen sent to State Laboratory for confirmation? ☐Yes ☐No ☐N/A ☐Unk

REPORTER INFORMATION

Date: _____ Reporting Agency: _____ Name of Person completing this form: _____ (please print) ☎: _____

REPORT BY PHONE, FAX OR MAIL TO:
Epidemiology, Disease Control and Immunization Services
☎(305) 470-5660, Fax: (305) 470-5533, or Mail to above address

Revised 3/7/13

Note: Report to the specific program as indicated on the Reportable Notifiable Disease/Condition Contact List

Florida HEALTH

Miami-Dade County Epidemiology
Phone: (305) 470-5660
Fax: (305) 470-5533

ANIMAL BITE REPORT
Rabies Control Investigation

Date of Report: _____
Reporting Agency: _____
Person Completing Form: _____
Telephone: _____

I – PERSON BITTEN

IDENTIFICATION

2. Name (Last, First)
3. Sex Male Female
4. Age
5. Telephone
6. Address (No. & Street) (City) (State) (Zip)
7. Name of Parent/Guardian (if victim is a minor)
8. Address (if different)
9. Source of Information (Person or Office) Victim Telephone Other

EXPOSURE

10. Place of attack
11. Time and date of attack
12. Circumstances of attack: K-9 (Police Action) Unknown Unprovoked Playful Provoked Sick/Hurt Other
13. Location and description of wound(s) Hand Arm Face Eyes Head Neck Mouth Foot Torso/Trunk/Chest Abdomen Leg Other: _____

TREATMENT

14. Was wound treated? No Yes Washed Date:
15. Wound treated by: Self Parent Doctor Hospital/ER Other
16. Anti-Rabies Treatment Recommended? (Raccoon, fox, bats or if animal not found PEP recommended) No Yes By Whom:
17. Anti-Rabies Treatment Given: No Yes By Whom: Telephone:
18. Anti Rabies Treatment Given? RIG (Immunoglobulin) Rabbies Vaccine Date Started: _____
19. Victim Hospitalized: Yes No

MISC

Notes/Comment:

Patient DOB:

MDPD – ANIMAL CONTROL NOTIFIED

No
Yes By Whom: Victim Hospital MD Other

II – ANIMAL / OWNER

IDENTIFICATION

20. Animal Owner (Custodian) Telephone:
21. Address (No. & Street) (City) (State) (Zip)
22. Type of animal: Dog Cat Fox Raccoon Bat Other Specify Owned Stray Male Female Wild Est. Age:
23. Description: (Breed, Color, Etc.)
24. License Number: Date: From:
25. Behavior Unknown Normal Abnormal
26. Prior Bites? Yes No
27. Vaccinated against rabies? Yes No Unknown VET . Vaccination Date: Rabies Tag No.. 1 Year Vaccine 3 Year Vaccine

QUAR.

28. Unable to locate animal Animal Confined From Date: To Date:
29. If at owner's Home, has Quarantine Agreement been signed? Yes No

ANTIBIOTICS GIVEN:

Yes
No
If Yes, which antibiotic? _____

TETANUS GIVEN:

Yes
No
If No, was it offered? Yes No

III – DISPOSITION OF ANIMAL

REVIEW

30. Cause of Death Illness Injury Euthanasia Date:
31. Quarantine released: Date: By:
32. Veterinarian Did Did not see animal
33. Head examination is Requested Not warranted
34. Remarks:

LABORATORY

DATE BY TELEPHONE
35. Head Sent to Lab _____ _____ _____
36. Results POSITIVE NEGATIVE UNSATISFACTORY
37. Victim notified by Person Phone Mail Date: By:
38. Case closed Date: By:

DH 4042, 02 / 2013 (Replaces previous editions)

Complete and fax to (305) 284-0919

Childhood Lead Poisoning Prevention Program

Any questions, please call (305) 470-6877

Patient Name: _____ (Last), _____ (First) **Sex:** ___ **Date of Birth:** _____

Race: (please check)
- ☐ White
- ☐ African American/Black
- ☐ Asian
- ☐ Native Hawaiian/Pacific Islander
- ☐ Am. Indian/Alaska Native
- ☐ Other (specify _____)

Language: (please check)
- ☐ Spanish
- ☐ English
- ☐ Creole
- ☐ Other _____

Ethnicity: (please check)
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ Haitian
- ☐ Other _____

Country of Birth: _____ **Entry Date to US:** _____

Type of insurance: (please check) ☐ Public (i.e. Medicaid) ☐ Private ☐ Other:_____

Parent/Guardian Name: _____ (Last), _____ (First)

Relationship to child: _____ **Phone Number:** _____

Home Address: _____

City: _____ **State:** _____ **Zip Code:**_____

Blood Lead Result: _____µg/dL

Sample Date: ____/____/____

Analyzed Date: ____/____/____

Lab Report Date: ____/____/____

Hemoglobin Test Result: _____ **Date**: _____

PLEASE ATTACH COPY OF LAB TEST RESULT

Sample Type: (check one)
- ☐ Capillary
- ☐ Venous

Screened Site: (check one)
- ☐ Clinic
- ☐ CLPPP Clinic
- ☐ Private Physician
- ☐ Other Fixed Site

Laboratory sent to: (check one)
- ☐ Lab Corp
- ☐ Quest/ Nichols Lab
- ☐ Jackson Memorial Hosp. Lab
- ☐ State Lab

Physician Name: _____

Physician Office: _____

Provider Address: _____

City: _____ **State:** _____ **Zip:**_____

Provider Phone #: _____ **Fax #:** _____

Test Reason: (check one)
- ☐ Medicaid EPSDT
- ☐ Follow-up
- ☐ Routine Screen
- ☐ Confirmatory
- ☐ Symptoms

Childhood Lead Poisoning Screening in Florida: Quick Reference for Medical Professional

Provide a blood lead test to:

- ☐ **Children living in high-risk zip codes at ages 1 and 2.** A high-risk area is defined as a census blockgroup with 2:27% pre-1950 housing or 2:74% pre-1970 housing. Consult Florida Department of Health geographic information maps for high-risk areas and associated zip codes (http://www.doh.state.fl.us/environment/community/Lead/CountyMap.html).
- ☐ **Older children, up to 6, in high risk areas who did not receive a blood lead test by age 2.**
- ☐ **Children under age 6 that answer "yes" to one of the questions on the Florida Department of Health's Lead Risk Assessment Questionnaire** (opposite page).
- ☐ **Medicaid eligible children at 12 and 24 months of age, and between the ages of 36 months and 72 months of age if they have not been previously screened for lead poisoning.**
  (Blood lead screening for Medicaid eligible children is a federal requirement).
- ☐ **All refugee and immigrant children from 6 months to 16 years old upon entry to the United States.*** Repeat blood lead testing of all refugee children 6 months to 6 years of age 3 to 6 months after children are placed in permanent residences. Older children should also receive a follow-up test if warranted by poor nutritional status and the presence of risk factors.
- ☐ **Children adopted from outside the U.S.***
- ☐ **Children in foster care.**

Follow-up testing:

- **Children found to have an initial capillary blood lead level of ≥10 micrograms per deciliter (μg/dL) require a confirmation test. A venous sample is preferred.**
- **Children with elevated blood lead levels in the following categories should receive associated medical follow-up:**

Blood Lead Level	Follow-up venous	Recommended actions
10-14 μg/dL	Within 3 months	Notify parents/guardians and obtain environmental history; provide health education & nutritional guidance. Report to local county health department.
15-19 μg/dL	Within 2 months	Same as above; screen siblings and household members under age 6.
20-44 μg/dL	Within 1 month	Same as above; conduct medical evaluation and history.
45-69 μg/dL	Within 48 hours	Same as above; assess for lead poisoning symptoms; consider Succimer treatment.
≥70 μg/dL	Admit to hospital; repeat testing 1-3 weeks after discharge	Hospitalize and initiate chelation therapy.

Physicians: Lead may still be used in paint, gasoline or other products in many countries. Screening these children is a precaution.

Childhood Lead Poisoning Case Management Guidelines

Case management of children with elevated blood lead levels involves coordinating, providing and overseeing services required to reduce blood lead levels to below 10 µg/dL. This quick reference is for case management coordinators at county health departments (CHD) and the team of individuals (physicians, nurses, nutritionists, environmental inspectors, and others) responsible for providing follow-up services and care for lead poisoned children.

Priority should be placed on responding to children with the highest blood lead level and to children less than two years of age with any elevated blood lead level. Lead levels in children less than two years of age are more likely to increase and their growing bodies are more sensitive to the effects of lead.

Confirmed Test Results	Follow-up Testing Schedule	Case Management Guidelines	Case Mgt Time Frame
Class 1 10-14 µg/dL	**Within 3 months**	**Notify the caregiver:** Contact by phone, and send a notification letter to the family / caregiver. **Report the case: Physicians** report case to CHD. **CHDs** report case in Merlin (the state system for reportable diseases), and enter follow-up and case tracking information on lead data screens. **Assess family needs and obtain an environmental history:** Interview the family by phone or at residence to assess the child's environmental risk factors, eating habits, behaviors, and health, housing and social service needs. **Develop a care plan:** Collaborate with the family, physicians and other providers to develop an appropriate care plan based on the needs assessment. Include all necessary referrals in the care plan. **Provide health education:** Educate the family about sources of lead, exposure pathways, and methods of prevention including proper nutrition and lead safe work practices. **Assess for developmental delay.** **Refer the family to developmental programs and community resources:** Make referrals to the local Children's Medical Services office and to developmental programs, health, and housing and/or social services when appropriate. **Test siblings and household contacts under six years of age for lead poisoning.** **Consider an Environmental Health Investigation**: when a child has a confirmed blood lead level ≥10µg/dL *AND* The child has a blood lead test taken more than three months from the date of confirmation with a result greater than or equal to the test result at confirmation. Include primary/secondary residence and/or child care facility as part of investigation. Report findings in Merlin.	**Within 20 Business Days**
Class 2 15-19 µg/dL	**Within 2 Months**	**Follow Class 1 Guidelines AND** **Conduct an Environmental Health Investigation:** Conduct an investigation when a child has a confirmed blood lead level in the range of 15-19 µg/dL followed by a blood lead test taken more than three months apart with a result in the same range. Include primary/secondary residence and/or child care facility as part of investigation. Report findings in Merlin.	**Within 10 Business Days**
Class 3 20-44 µg/dL	**Within 1 Month**	**Follow Class 1 and 2 Guidelines AND** **Physician: Conduct medical exam:** Conduct a physical examination. Assess for anemia and recommend multi-vitamins with iron or iron treatment as indicated. **Conduct an Environmental Health Investigation**: Include primary/secondary residence and/or child care facility as part of investigation. Report findings in Merlin.	**Within 5 Business Days**
Class 4 45-69 µg/dL	**Urgent Treatment** Repeat within 48 hours	**Follow Class 1, 2, and 3 Guidelines AND** **Physician: Provide a complete neurological exam.** **Physician: Consider chelation treatment.** Consider treatment options such as oral chelation therapy (succimer). Intravenous inpatient treatment chelation may be necessary to stimulate release of lead from bone. See post-chelation guidelines below.	**Within 2 Business Days**
Class 5 ≥70 µg/dL High Priority	**Medical Emergency!** Admit to Hospital	**Follow Class 1, 2, and 3 Guidelines AND** **Physician: Hospitalize and initiate chelation therapy.** Chelation therapy should not be postponed while awaiting results of a repeat test for Class V. **Post-Chelation Guidelines**: **Repeat venous lead test in 1-3 weeks after hospital discharge.** **Repeat venous lead test every two weeks for 6-8 weeks.** **Monitor lead level closely for 4-6 months after chelation**. If the lead level "rebounds" to pre-treatment levels, consider repeat chelation therapy. Minimum of two-week intervals is needed between chelation courses.	**Within 2 Business Days**

Lead Poisoning Risk Assessment Questionnaire

INSTRUCTIONS: Parents/caretakers of children less than six years of age who are not part of the targeted populations listed on page 6 of the Childhood Lead Poisoning Screening and Case Management Guide should complete this questionnaire at each annual check-up.

A "yes" or "don't know" response to any question indicates the child is at risk for lead poisoning and should receive a blood lead test and appropriate follow-up.

Question	Yes, No, or Don't Know
1. Does your child live in or regularly visit (once a week or more) any house or building built before 1978?	
2. Does your child live in or regularly visit any house or building that has recently undergone renovation?	
3. Does your child frequently come into contact with an adult whose job or hobby involves exposure to lead? **Examples:** *Occupations*: building renovation, battery factory or recycling, auto or radiator repair; highway bridge sandblasting or painting, welding metal structures, or wire cable cutting *Hobbies*: refinishing furniture; home renovation; casting bullets; auto battery or radiator repair, making stained glass, ceramics, toy soldiers, dive weights, or fishing weights	
4. Does your child have contact with cosmetics, kohl, candies, spices, jewelry, ceramic dishware and/or home (or folk) remedies not made in the United States; and/or leaded crystal, imported ceramic, or pewter dishes?	
5. Does your child play in loose soil, near a busy road or near any industrial sites such as a battery recycling plant, junk yard or lead smelter?	
6. Have you ever seen your child eat dirt or put his/her mouth on painted surfaces, paint chips, toys, jewelry or vinyl mini blinds?	
7. Has your child recently visited or lived in another country for an extended period of time?	

Hepatitis A Report Form

Please complete this form and fax back to (305) 470-5533 by 4:00 PM today. It is very important to include in your returned fax the results of the patient's hepatitis panel which are liver enzyme levels and HAV IgM. Date: _____

Part I: Demographics

Patient name: _____
(Last) (First)

Birthdate: _____ **Occupation**: _____

Address: _____ **Phone:** _____
(Street / Apt. #) (home)

_____ _____
(City) (State) (Zip Code) (work)

Sex: ____ Male
____ Female

Race: ____ American Indian/Alaskan Native
____ Asian or Pacific Islander
____ Black
____ White

Ethnicity: ____ Hispanic
____ Non-Hispanic

Part II: Clinical Information

Please Mark **Symptoms:**

Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk
Jaundice				Dark Urine				Abd. pain			
Nausea				Light stools				Fatigue			
Vomiting				Fever				Other			

Date of onset: ____/____/____ First symptom: _____

Was the patient a child or employee in a nursery, day care, preschool or elementary school? ….. [Yes] [No] [Unk]

Did the patient recently receive the Hep A vaccine? If yes, when and where…… [Yes] [No] [Unk]

Is the patient employed as a food handler? …… [Yes] [No] [Unk]

If yes, where? _____

Was the patient hospitalized? ..... [Yes] [No] [Unk]

If yes, name of hospital? _____

Was this patient a contact to a confirmed case of Hepatitis A? ..... [Yes] [No] [Unk]

Were the patient's close contacts offered immune globulin? ..... [Yes] [No] [Unk]

Date of diagnosis: ____/____/____

If you have any additional questions or concerns, please call Marie K. Etienne, R.N., M.P.H., Hepatitis Program Coordinator at (305) 470-6820.

Name of person completing form: _____ ☎: _____ Date: _____

Comments: _____

Florida Department of Health
Miami-Dade County
Epidemiology, Disease Control, and Immunizations Services
8600 NW 17th Street, Suite 200 Miami, Florida 33126
PHONE: 305/470-5660 • FAX 305/470-5533

www.FloridasHealth.com
TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh

HEPATITIS B REPORT FORM (*Page 1*)

Please complete this form and fax back to (305) 470-5533 by 4:00 PM today. It is very important to include in your returned fax results of the patient's hepatitis panel which are liver enzyme levels and IgM anti- HBc.

Part I: Demographics

Date: _____

Patient name: _____ **Occupation**: _____
(Last) (First) (M.I.)

Birthdate: _____ **Phone:** _____
(home)

Address: _____ _____
(Street / Apt. #) (work)

_____
(City) (State) (Zip Code)

Sex: ____ Male
____ Female

Race: ____ American Indian/Alaskan Native
____ Asian or Pacific Islander
____ Black
____ White

Ethnicity: ____ Hispanic
____ Non-Hispanic

If patient is a male disregard next page

Part II: Clinical Information

Was patient hospitalized for hepatitis? [Yes] [No] [Unk] If yes, name of hospital: _____
Admitted: _____ Discharged: _____

Was this patient a contact to a confirmed case of Hepatitis B? …….. [Yes] [No] [Unk]

Were the patient's household and sexual contacts tested for hepatitis B? …… [Yes] [No] [Unk]

Was this patient diagnosed with acute or chronic hepatitis B? …….. ……. ___Acute ___Chronic

Date of diagnosis: ___/___/___ Did the patient have symptoms? …….. [Yes] [No] [Unk]

If yes,

Date of onset: ___/___/___ First symptom: …… _____

Please Mark Symptoms:

Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk
Jaundice				Dark Urine				Abd. pain			
Nausea				Light stools				Fatigue			
Vomiting				Fever				Other			

HEPATITIS B REPORT FORM (*Page 2*)

Perinatal Hepatitis B Screening

Is patient currently pregnant or has been pregnant in the past 12 months?

Yes ☐ **How many weeks?** _____ **Estimated Date of delivery** _____

No ☐ **Postpartum ☐** **Unknown ☐**

Part III: Delivery Hospital Information Request

If Yes or Postpartum, please complete Part III

Child's Name: _____ **D.O.B:** _____

Child's Pediatrician: _____ Time of Birth: _____

Child's Address: _____ Hospital: _____

_____

(City) (State) (Zip Code)

Mother Information:

Name: _____ **D.O.B:** _____

Address: _____ Telephone: _____

_____ Other Telephone: _____

Father's Information:

Name: _____ **D.O.B:** _____

Address: _____ Telephone: _____

_____ Other Telephone: _____

Name of person completing form: Phone number:

_____ _____

HBIG: Given ☐ Not Given ☐

Date: _____ Time: _____ Manufacturer: _____ Dosage: _____

Brand Name: _____ Lot #: _____

Hepatitis B Vaccine: Given ☐ Not Given ☐

Date: _____ Time: _____ Manufacturer: _____ Dosage: _____

Brand Name: _____ Lot #: _____

Please make sure the child's mother is aware of the additional Hep B vaccines for the child to complete his/her Hep B vaccine series.

Comments: _____

Hepatitis C Report Form

Please complete this form and fax back to (305) 470-5533 along with the results of the patient's hepatitis panel, including Liver Enzyme levels and Hep C confirmatory test *(PCR if available)*

Part I: Demographics

Date: _____

Patient name:

_____
(Last) (First) (M.I.)

Birthdate: _____ **Occupation**: _____

Address: _____ **Phone:** _____
(Street / Apt. #) (home)

_____ _____
(City) (State) (Zip Code) (work)

Sex: ____ Male ____ Female

Race: ____ American Indian/Alaskan Native ____ Asian or Pacific Islander ____ Black ____ White

Ethnicity: ____ Hispanic ____ Non-Hispanic

Clinical Information

Was patient **hospitalized for hepatitis**? …….. [Yes] [No] [Unk]
If yes, name of **hospital**: _____ Date of Admission: _____ Discharge: _____
Was this patient diagnosed clinically with **acute** or **chronic** hepatitis C? …… ___ Acute ___ Chronic

Date of diagnosis: ——/——/—— **Symptoms**? [Yes] [No] [Unk] If **yes, date of onset:** ——/——/——

Has the patient had hepatitis B? …… [Yes] [No] [Unk]
If no, has the patient received the **hepatitis B vaccine**? ..... [Yes] [No] [Unk]
Dates? _____ All three doses? …… [Yes] [No] [Unk]
Has the patient had hepatitis A? ..... [Yes] [No] [Unk]
Has the patient received the **hepatitis A vaccine**? …… [Yes] [No] [Unk]
Dates? _____ Both doses? …… [Yes] [No] [Unk]

Please Mark Symptoms:

Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk	Symptom:	Yes	No	Unk
Jaundice				Dark Urine				Abd. pain			
Nausea				Light stools				Fatigue			
Vomiting				Fever				Other			

Hospital _____ ☎: _____ 🖷: _____

Name of person completing form: _____ ☎: _____
Comments: _____

Florida Adult HIV/AIDS Confidential Case Report

(Patients ≥ 13 years of age at time of diagnosis)

I. HEALTH DEPT USE ONLY

Date Received at Health Department	Did this report initiate a new case investigation?	State Number
___ ___/ ___ ___/ ___ ___ ___ ___	❑ Yes ❑ No ❑ Unknown	

Document Source	Surveillance Method	Report Medium
A_____-_____-_____-____	A F P R	❑ Field Visit ❑ Mailed ❑ Faxed ❑ Phone ❑ Electronic Transfer ❑ CD/Disk

Report Status	Reporting Health Department- City
New Update	

II. PATIENT IDENTIFIER INFORMATION-*data not transmitted to CDC*

Patient Name Last Name First Name Middle Name	Social Security Number

Address ❑ Residential ❑ Bad Address ❑ Correctional Facility ❑ Foster Home ❑ Homeless ❑ Postal ❑ Shelter ❑ Temporary	Current Street Address

City	State	Zip Code	County	Phone ( )

City/County Patient Number

III. DEMOGRAPHIC INFORMATION-*complete **ALL** fields*

Diagnostic Status ❑ HIV ❑ AIDS	Sex assigned at Birth ❑ Male ❑ Female	Date of Birth __ __/__ __/__ __ __ __

Country of Birth ❑ US ❑ Other (specify):	Status ❑ Alive ❑ Dead

Date of Death ___ ___/___ ___/___ ___ ___ ___	State/Territory of Death _____

Current Gender Identity ❑ Male ❑ Female ❑ Transgender Male-to-Female (MTF) ❑ Transgender Female-to-Male (FTM) ❑ Unknown ❑ Additional gender identity (specify) _____

Ethnicity (select one): ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unknown

Race: (select all that apply) Black/AA Asian Native American or Alaskan White Hawaiian/PI Unknown

Residence at Diagnosis: Same as Current Street Address:

City: County: State/Country: Zip:

IV. FACILITY OF DIAGNOSIS

Facility Name:

Address:

City:

State/Country: Zip:

Facility Type (check one)
❑ Physician, HMO ❑ Hospital, Inpatient ❑ Other

Facility Code:

Facility Setting (check one)
❑ Public ❑ Private ❑ Federal ❑ Other

Provider Name (Last, First, MI)

Provider Ph. No. ( )

Med. Rec. No:

Person Completing Form (Last, First, MI)

Phone No. ( )

Date form completed _____/_____/_____

V. PATIENT HISTORY- *complete **ALL** fields*

Preceding the first positive HIV antibody test or AIDS diagnosis, this patient had (Respond to **ALL** Categories)

	Yes	No	Unk
Sex with male	❑	❑	❑
Sex with female	❑	❑	❑
Injected non-prescription drugs	❑	❑	❑
Received clotting factor for hemophilia/coagulation disorder	❑	❑	❑
Specify disorder: ❑ Factor VIII (Hemophilia A) ❑ Factor IX (Hemophilia B) ❑ Other (specify):			
HETEROSEXUAL relations with any of the following:			
Intravenous/Injection Drug User	❑	❑	❑
Bisexual male (**applies to females only**)	❑	❑	❑
Person with hemophilia/coagulation disorder	❑	❑	❑
Transfusion recipient with documented HIV infection	❑	❑	❑
Transplant recipient with documented HIV infection	❑	❑	❑
Person with AIDS or documented HIV infection, risk unspecified	❑	❑	❑
Received transfusion of blood/blood components (other than clotting factor) First Date:____/____/____ Last Date:____/____/____	❑	❑	❑
Received organ transplant, tissue or artificial insemination	❑	❑	❑
Worked in healthcare or clinical laboratory	❑	❑	❑
(specify occupation): _____			
Other documented risk	❑	❑	❑

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VI. LABORATORY DATA

HIV Antibody Tests at Diagnosis (Indicate first test-mm/dd/yyyy)			**HIV Detection Tests**: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 NAT		
HIV-1/2 EIA			HIV-1 Qual PCR RNA		
HIV -1/2 Ag/Ab			HIV-1 P24 Antigen		
HIV-1/2 Differentiating			HIV-1 Qual PCR DNA		
(e.g., Multispot)			Other		
HIV-1 Western Blot/IFA			Other		
Other			Other		
Other			Other		

Viral Load Test: (**most recent** test- mm/dd/yyyy)			**Immunologic Lab Test:** (test date-mm/dd/yyyy)	
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status	Collection Date
HIV-1 NASBA			CD4 Count:_____ cells/ul (_____%)	
HIV-1 RT-PCR			**First<200 or <14% of total lymphocytes**	
HIV-1 bDNA			CD4 Count:_____ cells/ul (_____%)	
Other				

Physician Diagnosis:

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ❑ Yes ❑ No ❑ Unknown

If yes, enter date of diagnosis (mm/dd/yyyy) _____

VII. CLINICAL STATUS

Clinical Record Reviewed? ❑ **Yes** ❑ **No**	**Initial Dx Date mm/dd/yyyy**	**Def.**	**Pres.**		**Initial DxDate mm/dd/yyyy**	**Def.**	**Pres.**
Candidiasis, bronchi, trachea, or lungs	____/____/_____	❑		Lymphoma, Burkitt's (or equivalent term)	____/____/_____	❑	
Candidiasis, esophageal	____/____/_____	❑	❑	Lymphoma, immunoblastic (or equivalent terms)	____/____/_____	❑	
Carcinoma, invasive cervical	____/____/_____	❑		Lymphoma, primary in brain	____/____/_____	❑	
Coccidioidomycosis, disseminated or extrapulmonary	____/____/_____	❑		Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	____/____/_____	❑	❑
Cryptococcosis, extrapulmonary	____/____/_____	❑		M. tuberculosis, pulmonary *	____/____/_____	❑	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	____/____/_____	❑		M. tuberculosis, disseminated, or extrapulmonary *	____/____/_____	❑	❑
Cytomegalovirus disease (other than in liver, spleen, or nodes)	____/____/_____	❑		Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	____/____/_____	❑	❑
Cytomegalovirus retinitis (loss of vision)	____/____/_____	❑	❑	Pneumocystis carinii pneumonia	____/____/_____	❑	❑
HIV encephalopathy	____/____/_____	❑		Pneumonia, recurrent, in 12 mo. period	____/____/_____	❑	❑
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	____/____/_____	❑		Progressive multifocal leukoencephalopathy	____/____/_____	❑	
Histoplasmosis, disseminated, or extrapulmonary	____/____/_____	❑		Salmonella septicemia, recurrent	____/____/_____	❑	
Isosporiasis, chronic intestinal (>1 mo. duration)	____/____/_____	❑		Toxoplasmosis of brain	____/____/_____	❑	❑
Kaposi's sarcoma	____/____/_____	❑	❑	Wasting syndrome due to HIV	____/____/_____	❑	

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT Case Number_____

VIII. TREATMENT/SERVICES REFERRALS

Patient informed of his/her infection?	❑ Yes ❑ No ❑ Unknown
This patient's partners will be notified about their HIV exposure and counseled by: ❑ 1-Health Dept ❑ 2-Physician/Provider ❑ 3-Patient ❑ 9-Unknown	
WOMEN ONLY	
Is patient receiving or been referred for obstetrical or gynecological services?	❑ Yes ❑ No ❑ Unknown
Is patient currently pregnant?	❑ Yes ❑ No ❑ Unknown
If YES, EDC (due date) / /	
Has patient delivered a live-born infant?	❑ Yes ❑ No ❑ Unknown

CHILD OF PATIENT (record most recent birth in these boxes; record additional or multiple births in the Comments section)

Hospital:	City:	State:	Zip:
Child's Name (Last, First, MI)	Child's State No:	Date of Birth __ __/__ __/__ __ __ __	

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IX. LOCAL FIELDS

PRISM #	**NIR STATUS: NIR_____OP_____ NIR OP DATE _____**
DOC #	**NIR_CL_____ NIR CL DATE:_____**
Link with eHARS stateno(s):	**NIR_RE_____ NIR RE DATE:_____**
OTHER RISKS: A___ B/C____ D____ F____ M____ V____ J____	**INITIALS (3)_____ SOURCE CODE A_____**
HEPATITIS: A____ B____ C____ Other____ Unknown____	

X. COMMENTS:

XI. INCIDENCE and RESISTANCE

HIV TESTING AND ANTIRETROVIRAL USE HISTORY (record all dates as MM/DD/YYYY)

Main source of testing and treatment history information (select one) ❑ Patient Interview ❑ Medical Record Review ❑ Provider Report ❑ Other _____	Date patient reported information __ __ / __ __ / __ __ __ __
Ever had a previous positive HIV test? ❑ Yes ❑ No ❑ Refused ❑ Unknown If **YES**, date of First Positive HV test __ __/__ __/__ __ __ __ If **YES,** in what **STATE** was the **First Positive** HIV test performed? _____	
Ever had a negative HIV test? ❑ Yes ❑ No ❑ Unknown ❑ Refused If **YES,** date of Last Negative test __ __/ __ __/__ __ __ __	
Number of ***negative*** HIV tests within 24 months before first positive #_____ ❑ Refused ❑ Unknown If **YES**, in what **STATE** was the **Last Negative** HIV test performed? _____	
Ever taken any antiretrovirals (ARVs)? ❑ Yes ❑ No ❑ Unknown ❑ Refused First date of ARV/HIV medication ___ ___/___ ___/___ ___ ___ ___ Last date of ARV/HIV medication ___ ___/___ ___/ ___ ___ ___ ___ __ Patient is currently taking any ARV Code of ARV medication(s) _____ _____ _____ _____	

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General Guidance on Section XI – HIV/AIDS Incidence

Yes	evidence that the event occurred
No	evidence that the event did NOT occur
Unknown	1) evidence that patient said, "Don't know" 2) provider documented "Unknown" or 3) insufficient evidence
Refused	Patient refused, provider documented "Refused," or the facility did not allow for medical record review
Blank	Patient or provider was not asked or source was not investigated

For all dates, only enter information that you have evidence of. For example, if only month & year are known enter 05/__/2000 or if only the year is known enter __/__/2000.

Patient Information
Please select the source of Testing and Treatment History (TTH) information by checking the appropriate source box. If you use a source not listed, please specify that source on the "Other" line provided. **Only one source may be used per form.** Record the Date patient reported information as follows:

- For Medical Record Review: Date when most recent TTH data provided. Do NOT use the date of review unless no other date is available.
- For Provider Report: Date when TTH information was obtained from patient. If date is unknown, enter date when report was received at health department.
- For Other: Use the date the TTH information was originally collected.

Previous Positive Testing History
All of the questions in this section reference the patient's first positive HIV test ever. **Only complete this section when there is evidence regarding a positive test before the one which initiated the case report.** List the month (mm), day (dd), and year (yyyy) of the patient's first positive test. If date is unknown, leave date field blank. Indicate the state where the first positive HIV test was performed.

Previous Negative Testing History
Indicate whether the patient has ever had a negative HIV test prior to receiving their first positive result. List the month (mm), day (dd), and year (yyyy) of the patient's last negative test. If date is unknown, leave date field blank. Indicate the total number of negative tests the patient had during the twenty-four months prior to receiving their first positive result. Indicate the state where the last negative HIV test was performed.

XIV. Antiretroviral Medications
Indicate whether the patient has ever taken any HIV or antiretroviral medications (ARVs). If yes, indicate date the patient first began taking HIV or ARV medications. List the date the patient stopped taking ARV medications. List the names of the medications taken using the abbreviation list below. Check the box if the client is currently taking HIV or ARV meds.

Medicine Codes

22= Agenerase (amprenavir)
30= Aptivus (tipranavir, TPV)
32= Atripla (efavirenz/ emtricitabine/ tenofovir DF)
24= Combivir (lamivudine/ zidovudine)
06= Crixivan (indinavir sulfate)
11= Emtriva (emtricitabine, FTC)
03= Epivir (lamivudine, 3TC)
28= Epzicom (3TC/ABC)
25= Fortovase (saquinavir)
10= Fueon (enfuvirtide, T-20)
19= Hepsera (adefovir)
02= Hivid (zalcitabine, ddC)
23= Hydroxyurea
18= Invirase (saquinavir mesylate)
34= Intelence (etravirine)
36= Isentress (raltegravir)
16= Kaletra (lopinavir/ ritonavir)
31= Lexiva (fosamprenavir, 908)
07= Norvir (ritonavir)
33= Prezista (darunavir, DRV)
09= Rescriptor (delavirdine mesylate)
26= Retrovir (zidovudine, ZDV, AZT)
15= Reyataz (atazanavir sulfate)
08= Saquinavir (Fortavase, Invirase)
35= Selzentry (maraviroc)
21= Sustiva (efavirenz)
13= Trizivir (abacavir sulfate/ lamivudine/ zidovudine)
27= Truvada (FTC/TDF)
01= Videx (didanosine, ddI)
14= Videx EC (didanosine, I)
17= Viracept (nelfinavir mesylate)
05= Viramune (nevirapine)
12= Viread (tenofovir)
04= Zerit (stavudine, d4T)
20= Ziagen (abacavir sulfate)
88= Other
99= Unspecified

Pediatric HIV/AIDS Confidential Case Report

(Patients < 13 years of age at time of diagnosis)

I. HEALTH DEPT USE ONLY

Date Received at Health Department ___ ___/ ___ ___/ ___ ___ ___ ___	Did this report initiate a new case investigation? ❑ Yes ❑ No ❑ Unknown	State Number
Document Source A____-____-____-____-___	**Surveillance Method** A F P R	**Report Medium** ❑ Field Visit ❑ Mailed ❑ Faxed ❑ Phone ❑ Electronic Transfer ❑ CD/Disk
Report Status New Update	**Reporting Health Dept. City**	

II. PATIENT IDENTIFIER INFORMATION-*data not transmitted to CDC*

Patient Name Last Name First Name Middle Name		Social Security Number
Address	City	County
State Zip	Phone ( )	City/County Patient Number

III. DEMOGRAPHIC INFORMATION-*complete **ALL** fields*

Diagnostic Status ❑ Perinatal HIV Exposure ❑ Pediatric HIV ❑ Pediatric AIDS ❑ Pediatric Seroreverter		
Sex assigned at Birth ❑ Male ❑ Female	**Date of Birth** __ __/__ __/__ __ __ __	**Status** ❑Alive ❑Dead
Country of Birth ❑ US ❑ Other (specify):		
Date of Death ___ ___/___ ___/___ ___ ___ ___	**State/Territory of Death** _____	
Ethnicity (select one): ❑ Hispanic/Latino ❑ Not Hispanic/Latino ❑ Unknown		
Race: (select all that apply) ❑ Black/AA ❑ Asian ❑ Native American or Alaskan ❑ White ❑ Hawaiian/PI ❑ Unknown		
Residence at Diagnosis: ❑ Same as Current Street Address: City: County: State/Country: Zip:		

IV. FACILITY OF DIAGNOSIS

Facility Name:

Address:

City:

State/Country: Zip:

Facility Type (check one)
❑ Physician, HMO ❑ Hospital, Inpatient
❑ Other

Facility Code:

Facility Setting (check one)
❑ Public ❑ Private ❑ Federal ❑ Other

Provider Name (Last, First, MI)

Provider Ph. No. ( )

Med. Rec. No:

Person Completing Form (Last, First, MI)

Phone No. ( )

Date form completed _____/_____/_____

V. PATIENT HISTORY- *complete **ALL** fields*

Preceding the first positive HIV antibody test or AIDS diagnosis, the child's biological mother had (Respond to **ALL** Categories)

	Yes	No	Unk
Perinatally acquired HIV infection	❑	❑	❑
Injected non-prescription drugs	❑	❑	❑
HETEROSEXUAL relations with any of the following:			
Intravenous/Injection Drug User……	❑	❑	❑
Bisexual male ……	❑	❑	❑
Transfusion recipient with documented HIV infection……	❑	❑	❑
Transplant recipient with documented HIV infection……	❑	❑	❑
Person with AIDS or documented HIV infection, risk unspecified……	❑	❑	❑
Received transfusion of blood/blood components (other than clotting factor) First Date:____/____/____ Last Date:____/____/____	❑	❑	❑
Received transplant of tissue/organs or artificial insemination	❑	❑	❑

Preceding the first positive HIV antibody test or AIDS diagnosis, the child had

Injected non-prescription drugs	❑	❑	❑
Received clotting factor for hemophilia/coagulation disorder Specify Clotting Date received (mm/dd/yyyy)	❑	❑	❑
Received transfusion of blood/blood components (other than clotting factor) First Date:____/____/____ Last Date:____/____/____			
Received transplant of tissue/organs	❑	❑	❑
Is transplant or artificial insemination being investigated or considered	❑	❑	
Sexual contact with male	❑	❑	❑
Is pediatric sexual contact being investigated or considered as primary mode of exposure	❑	❑	❑
Sexual contact with female	❑	❑	❑
Is pediatric sexual contact being investigated or considered as primary mode of exposure	❑	❑	❑
Other documented risk	❑	❑	❑
Is other exposure being investigated or considered as primary mode of exposure	❑	❑	❑

Child's biological mother's HIV infection status:

❑ Refused HIV testing	❑ Known to be uninfected after this child's birth	❑ HIV+, time of diagnosis unknown
❑ Known HIV+ before pregnancy	❑ Known HIV+ at time of delivery	❑ Known HIV+ after the child's birth
❑ Known HIV+ during pregnancy	❑ Known HIV+ sometime before birth	❑HIV status unknown

Date of mother's first positive HIV confirmatory test (mm/dd/yyyy)

Was the biological mother counseled about HIV testing during this pregnancy, labor or delivery? (circle one) Yes No Unknown

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IX. TREATMENT/SERVICES REFERRALS

This child received or is receiving:		Date Started (mm/dd/yy)
Neonatal zidovudine (ZDV, AZT) for HIV prevention	☐ Yes ☐ No ☐ Unknown	
Other neonatal anti-retroviral medication for HIV prevention	☐ Yes ☐ No ☐ Unknown	
If **Yes**, specify the medications:		
Anti-retroviral therapy for HIV treatment	☐ Yes ☐ No ☐ Unknown	
PCP prophylaxis	☐ Yes ☐ No ☐ Unknown	
Was the child breastfed?	☐ Yes ☐ No ☐ Unknown	

This child's primary caretaker is: ☐ Biological parents ☐ Foster/adoptive parent, relative ☐ Social service agency ☐ Unknown ☐ Other relative ☐ Foster/adoptive parent, unrelated ☐ Other (if **Other,** please specify):

VI. LABORATORY DATA

HIV Antibody Tests at Diagnosis (Indicate first test - mm/dd/yyyy)			**HIV Detection Tests**: (Record earliest test-mm/dd/yyyy)		
	Positive	Negative		Positive	Negative
HIV-1 EIA			HIV-1 P24 Antigen		
HIV-1/2 EIA			HIV-1RNA PCR (Qual)		
HIV -1/2 Ag/Ab			HIV-1 Culture		
HIV-1/2 Differentiating (e.g., Multispot)			HIV-1 Proviral DNA (Qual)		
			HIV-2 Culture		
HIV-1 Western Blot/IFA			Other		
Other			Other		

Viral Load Test: (**most recent** test- mm/dd/yyyy)			**Immunologic Lab Test:** (test date-mm/dd/yyyy)	
Type Name	Copies / ML	Collection Date	At or closest to current diagnostic status	Collection Date
HIV-1 RNA NASBA			CD4 Count:_____ cells/ul (_____%)	
HIV-1 RNA RT-PCR			**First<200 or <14% of total lymphocytes**	
HIV-1 RNA bDNA			CD4 Count:_____ cells/ul (_____%)	
HIV-1 RNA Other				

Was patient confirmed by a physician as:
HIV- infected ☐ Yes ☐ No ☐ Unknown — If **Yes**, enter date of diagnosis (mm/dd/yyyy)
Not HIV- infected ☐ Yes ☐ No ☐ Unknown — If **Yes**, enter date of diagnosis (mm/dd/yyyy)

VII. CLINICAL STATUS

Clinical Record Reviewed? ☐ **Yes** ☐ **No**	Initial Dx Date mm/dd/yy	Def.	Pres.		Initial DxDate mm/dd/yy	Def.	Pres.
Bacterial infection, multiple or recurrent (including Salmonella septicemia)	___/___/____	☐		Kaposi's sarcoma	___/___/____	☐	☐
Candidiasis, bronchi, trachea, or lungs	___/___/____	☐		Lymphoid interstitial pneumonia and/or pulmonary	___/___/____	☐	☐
Candidiasis, esophageal	___/___/____	☐	☐	Lymphoma, Burkitt's (or equivalent)	___/___/____	☐	
Coccidioidomycosis, disseminated or extrapulmonary	___/___/____	☐		Lymphoma, immunoblastic (or equivalent)	___/___/____	☐	
Cryptococcosis, extrapulmonary	___/___/____	☐		Lymphoma, primary in brain	___/___/____	☐	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	___/___/____	☐		Mycobacterium avium complex or M. kansasii, disseminated, or extrapulmonary	___/___/____	☐	☐
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at > 1 mo of age	___/___/____	☐		M. tuberculosis, disseminated, or extrapulmonary *	___/___/____	☐	☐
Cytomegalovirus retinitis (with loss of vision)	___/___/____	☐	☐	Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	___/___/____	☐	☐
HIV encephalopathy	___/___/____	☐		Pneumocystis carinii pneumonia	___/___/____	☐	☐
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis onset>1 mo of age	___/___/____	☐		Progressive multifocal leukoencephalopathy	___/___/____	☐	
Histoplasmosis, disseminated, or extrapulmonary	___/___/____	☐		Toxoplasmosis of brain, onset at >1 mo of age	___/___/____	☐	☐
Isosporiasis, chronic intestinal (>1 mo. duration)	___/___/____	☐		Wasting syndrome due to HIV	___/___/____	☐	

Has the child been diagnosed with pulmonary tuberculosis? ☐ Yes ☐ No ☐ Unknown

If **Yes,** initial diagnosis and date ☐ TB pre- 1993 ☐ Definitive ☐ Presumptive ☐ Unknown (mm/dd/yyyy)

RVCT Case Number

DH 2140, Rev 03/12

VIII. BIRTH HISTORY (for PERINATAL cases only)

Birth history available for this child: ☐ Yes ☐ No ☐ Unknown If **No** or **Unknown**, do not complete this section.

Residence at Birth: ☐ Same Address as patient address Address:

City: County: State/Country: Zip:

Hospital at Birth: Facility Name: Phone No: ( ) -

Address: City: County: State/Country: Zip:

Birth weight enter lbs/oz OR grams		
_____ (lbs)	Birth Type ☐ Single ☐ Twin ☐ > 2 ☐ Unknown	
_____ (oz)	Birth Delivery ☐ Vaginal ☐ Elective Caesarean ☐ Non-elective Caesarean ☐ Caesarean, Unk type ☐ Unk	
_____ (g)	Birth Defects ☐ Yes ☐ No ☐ Unknown	If **Yes,** specify types and enter codes, if known:
	Specify:	Specify:
	Code:	Code:

Neonatal Status: ☐ Full term ☐ Premature No. of weeks (gestational age) (99-Unknown)

Prenatal Care- Month of pregnancy when prenatal care began: (99-Unknown) (00=None)

Prenatal Care- Total number of prenatal care visits (99-Unknown) (00=None)

Did mother receive zidovudine (ZDV, AZT) during pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown

If **Yes**, week of pregnancy when zidovudine (ZDV, AZT) began: Week _____ (99=Unknown)

Did mother receive zidovudine (ZDV, AZT) during labor/delivery? ☐ Yes ☐ No ☐ Refused ☐ Unknown

Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? ☐ Yes ☐ No ☐Unknown

Did mother receive any other antiretroviral medication during pregnancy? ☐ Yes ☐ No ☐ Unknown

If **Yes**, specify:

Did mother receive any other antiretroviral medication during labor/delivery? ☐ Yes ☐ No ☐ Unknown

If Yes, specify:

Maternal Date of Birth Maternal Soundex

Maternal State Patient Number

Birthplace of Biological Mother

☐ U.S. ☐ U.S. Minor Outlying Area: (specify)

☐ Unknown ☐ Other: (specify)

X. LOCAL FIELDS

PRISM #

Link with eHARS stateno(s):

EPF____ EPF DATE_____

OTHER RISKS: A____ B/C____ D____ F____ M____ V____ J____

SOURCE CODE A_____

HEPATITIS: A____ B____ C____ Other____ Unknown_____

NIR STATUS: NIR_OP_____ NIR OP DATE_____

NIR_ CL_____ NIR CL DATE_____

NIR_RE_____ NIR RE DATE_____ Initials (3)_____

XI. COMMENTS

DH 2140, REV. 03/12

April 2013

TO: ALL CONCERNED

FROM: Reynald Jean, MD, MPH
Acting Chief Physician, Florida Department of Health in Miami-Dade County

SUBJECT: **2013 Updated Immunization Recommendations**

In January each year, updated schedules are published that include current recommendations for use vaccines licensed by the Food and Drug Administration and approved by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) and the American Academy of Family Physicians.

- Updated recommendations for use of **tetanus, diphtheria, and acellular pertussis vaccine (Tdap) in pregnant women**. ACIP recommends that providers of prenatal care administer a dose of Tdap during each pregnancy, *irrespective of the patient's prior history of receiving Tdap*, preferably during the third or late second trimester (after 20 weeks' gestation). If not administered during pregnancy, Tdap should be administered immediately postpartum.

- New ACIP recommendations for adolescents and adults (e.g., parents, siblings, grandparents, child-care providers, and health-care personnel) who have or anticipate having **close contact with an infant aged <12 months**. They should receive a single dose of **Tdap** to protect against pertussis if they have not previously received Tdap. Ideally, these adolescents and adults should receive Tdap at least 2 weeks before beginning close contact with the infant.

- Children who started their immunizations after seven years of age should receive a total of three doses of adult tetanus-diphtheria vaccine (Td). **Tdap** should be used to replace one dose of the Td, which will meet 7th grade school requirement.

- **Meningococcal conjugate vaccine (MCV4)** vaccine minimum ages and intervals were updated to reflect licensure of the Hib-MenCY vaccine.

- Recommendations for us of **Hepatitis A vaccine (HepA)** for any person aged 2 years and older who has not already received the HepA vaccine series. Two doses of the HepA vaccine separated by 6 to 18 months may be administered if immunity against Hepatitis A is desired.

- The **13-valent pneumococcal conjugate vaccine (PCV13)** is recommended for adults aged 19 years and older with immunocompromising conditions. Those not previously vaccinated with PCV13 or pneumococcal polysaccharide (PPSV23) should receive a single dose of PCV13, followed by a dose of PPSV23 at least 8 weeks later. Those previously vaccinated with PPSV23 should be vaccinated with PCV13 one year or more after PPSV23 vaccination.

ACIP statements with details regarding special situations and recommendations for individual vaccines, including recommendations for children and adults with high-risk conditions, are available at www.cdc.gov/vaccines/pubs/ACIP-list.htm.

Florida Department of Health
Miami-Dade County
Epidemiology, Disease Control, and Immunizations Services
8600 NW 17th Street, Suite 200 Miami, Florida 33126
PHONE: 305/470-5660 • FAX 305/470-5533

www.FloridasHealth.com
TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh

Vaccine Information

Vaccines are offered for the following diseases:

- Diphtheria
- Haemophilus Influenza Type B (HIB)
- Hepatitis A and B
- Herpes Zoster (Shingles)
- Human Papillomavirus (HPV)
- *Japanese Encephalitis
- Measles
- Meningitis
- Mumps
- Pertussis (Whooping Cough)
- Pneumococcal 13, 23
- Polio
- Rabies (Pre-exposure prophylaxis only)
- Rotavirus
- Rubella (German measles)
- Seasonal Influenza (Flu)
- Tetanus
- *Typhoid Fever
- Varicella (Chickenpox)
- Yellow Fever

All vaccines (with the exception of travel vaccines) for children through 18 years of age are **FREE OF CHARGE**

Adult & Immigration Vaccines Available

In addition, prophylaxis for those traveling to Malaria endemic countries is offered.

Call (786) 845-0550 to make an appointment.

Immunization Clinics

West Perrine Center
18255 Homestead Avenue
Miami, Florida 33157
Mon..-Fri. (8 am - 4 pm)

Little Haiti Health Center
300 NE 80th Terrace
Miami, Florida 33138
Mon., Wed., & Fri.. (8 am – 4 pm)

Health District Center
1350 NW 14th Street
Miami, Florida 33125
Mon.-Fri. (8 am - 3:30 pm)

North Miami Clinic
14101 NW 8th Avenue
North Miami, Florida 33168
Tues. & Thurs. (8 am – 4 pm)

Immunization is one of the best forms of protection

Vaccine Selection for the 2013-2014 Influenza Season

It is recommended that vaccines for use in the 2013-14 influenza season (northern hemisphere winter) contain the following:

- an A/California/7/2009 (H1N1)pdm09-like virus[a];
- an A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011[b]*;
- a B/Massachusetts/2/2012-like virus.

It is recommended that quadrivalent vaccines containing two influenza B viruses contain the above three viruses and a B/Brisbane/60/2008-like virus[c].

[a] A/Christchurch/16/2010 is an A/California/7/2009-like virus;
[b] A/Texas/50/2012 is an A(H3N2) virus antigenically like the cell-propagated prototype virus A/Victoria/361/2011;
[c] B/Brisbane/33/2008 is a B/Brisbane/60/2008-like virus.

* It is recommended that A/Texas/50/2012 is used as the A(H3N2) vaccine component because of antigenic changes in earlier A/Victoria/361/2011-like vaccine viruses (such as IVR-165) resulting from adaptation to propagation in eggs.

TABLE 1. Influenza Vaccines — United States, 2013–14 influenza season*

Vaccine	Trade name	Manufacturer	Presentation	Mercury content (mcg Hg/0.5 mL)	Age indications	Route
Inactivated Influenza Vaccine, Trivalent††† (IIV3), Standard Dose	Afluria®	CSL Limited	0.5 mL single-dose prefilled syringe	0.0	≥9 yrs.***	IM†
			5.0 mL multidose vial	24.5		
	Fluarix®	GlaxoSmithKline	0.5 mL single-dose prefilled syringe	0.0	≥3 yrs.	IM†
	Flucelvax®§§§	Novartis Vaccines	0.5 mL single-dose prefilled syringe	0.0	≥18 yrs.	IM†
	FluLaval®	ID Biomedical Corporation of Quebec (distributed by GlaxoSmithKline)	5.0 mL multidose vial	<25.0	≥18 yrs	IM†
	Fluvirin®	Novartis Vaccines	0.5 mL single-dose prefilled syringe	≤1	≥4 yrs.	IM†
			5.0 mL multidose vial	25.0		
	Fluzone®	Sanofi Pasteur	0.25 mL single-dose prefilled syringe	0.0	6 through 35 mo.	IM†
			0.5 mL single-dose prefilled syringe	0.0	≥36 mo.	IM†
			0.5 mL single-dose vial	0.0	≥36 mo.	IM†
			5.0 mL multidose vial	25.0	≥6 mo.	IM†
	Fluzone® Intradermal§	Sanofi Pasteur	0.1 mL prefilled microinjection system	0.0	18 through 64 yrs.	ID
Inactivated Influenza Vaccine, Trivalent††† (IIV3), High Dose	Fluzone® High-Dose**	Sanofi Pasteur	0.5 mL single-dose prefilled syringe	0.0	≥65 yrs.	IM†
Inactivated Influenza Vaccine, Quadrivalent††† (IIV4), Standard Dose	Fluarix® Quadrivalent	GlaxoSmithKline	0.5 mL single-dose prefilled syringe	0.0	≥3 yrs.	IM†
Recombinant Influenza Vaccine, Trivalent††† (RIV3)	FluBlok®	Protein Sciences	0.5 mL single-dose vial	0.0	18 through 49 yrs.	IM†
Live-attenuated Influenza Vaccine, Quadrivalent††† (LAIV4)	FluMist® Quadrivalent††	MedImmune	0.2 mL prefilled intranasal sprayer	0.0 (per 0.2 mL)	2 through 49 yrs.§§	IN

Influenza-Associated Pediatric Deaths Case Report Form

Form approved
OMB No. 0920-0007

STATE USE ONLY – DO NOT SEND INFORMATION *IN THIS SECTION* TO CDC

Last Name: _____ First Name: _____ County: _____

Address: City: State, Zip:

Patient Demographics

1. State:	2. County:	3. State ID:	4. CDC ID:
5. Age: _____ O Days O Months O Years	6. Date of birth: _____/_____/_____ MM DD YYYY	7.Sex: O Male O Female O Unkown	8. Ethnicity: O Hispanic or Latino O Not Hispanic or Latino O Unknown

9. Race: ☐ White ☐ Black ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ American Indian or Alaska Native ☐ Unknown

Death Information

10. Date of illness onset: _____/_____/_____ MM DD YYYY	11. Date of death: _____/_____/_____ MM DD YYYY	12. Was an autopsy performed? O Yes O No O Unknown

13 a. Did cardiac/respiratory arrest occur outside the hospital? O Yes O No O Unknown

13 b. Location of death: O Outside the Hospital (e.g. home or in transit to hospital) O Emergency Dept (ED) O Inpatient ward O ICU O Other (specify): _____

13 c. If the death occurred in the hospital, what was the date of admission? _____/_____/_____ MM DD YYYY

CDC Laboratory Specimens

14 a. Were pathology specimens sent to CDC's Infectious Diseases Pathology Branch? O Yes O No O Unknown
Please provide the lab ID No. if known_____

14 b. Were influenza isolates or original clinical material sent to CDC's Influenza Division? O Yes O No O Unknown
Please provide the lab ID No. if known_____

14 c. Were *Staph aureus* isolates sent to CDC's Division of Healthcare Quality Promotion? O Yes O No O Unknown
Please provide the lab ID No. if known_____

Influenza-Associated Pediatric Deaths Case Report Form

Influenza Testing (check all that were used)

Test Type	Result	Specimen Collection Date
15. ☐ Commercial rapid diagnostic test	O Influenza A O Influenza B O Negative O Influenza A/B (Not Distinguished) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Viral culture	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Fluorescent antibody (IFA or DFA)	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Enzyme immunoassay (EIA)	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ RT-PCR	O Influenza A (Subtyping Not Done) O Influenza B O Negative O Influenza A (Unable To Subtype) O Influenza A (H1) O Influenza A (H3) O 2009 Influenza A (H1N1) O Influenza virus co-infection (specify)_____	_____/ _____/ _____
☐ Immunohistochemistry (IHC)	O Influenza A O Influenza B O Negative O Influenza virus co-infection (specify)_____	_____/ _____/ _____

Culture confirmation of bacterial pathogens from STERILE (Invasive) SITES

16 a. Was a specimen collected for bacterial culture from a normally sterile site (e.g., blood, cerebrospinal fluid [CSF], tissue, or pleural fluid O Yes O No O Unknown

16 b. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
☐ Blood	Date __/__/__	O Positive O Negative O Unknown
☐ Pleural fluid	Date __/__/__	O Positive O Negative O Unknown
☐ CSF	Date __/__/__	O Positive O Negative O Unknown
☐ Other _____	Date __/__/__	O Positive O Negative O Unknown
☐ Unknown		

16 c. If positive, please check the organism cultured.

☐ *Streptococcus pneumoniae*

☐ Group A streptococcus

☐ Other bacteria: _____
(If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)

☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**

☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**

☐ *Staphylococcus aureus,* **sensitivity not done**

☐ *Haemophilus influenzae* not-type b

☐ *Haemophilus influenzae* type b

☐ *Pseudomonas aeruginosa*

Culture confirmation of bacterial pathogens from NON-STERILE SITES

16 d. Were other **respiratory** specimens collected for bacterial culture (e.g., sputum, ET tube aspirate)? O Yes O No O Unknown

16 e. If yes, please indicate the site from which the specimen was obtained and the result. *If more than one specimen type is positive and more than one organism is identified please indicate the organism cultured from each specimen type in the comments section.*

Specimen Type	Collection Date	Result
☐ Sputum	Date __/__/__	O Positive O Negative O Unknown
☐ ET tube	Date __/__/__	O Positive O Negative O Unknown
☐ Other _____	Date __/__/__	O Positive O Negative O Unknown
☐ Unknown		

16 f. If positive, please check the organism cultured.

☐ *Streptococcus pneumoniae*	☐ *Staphylococcus aureus,* methicillin **sensitive (MSSA)**	☐ *Haemophilus influenzae* not-type b
☐ Group A streptococcus	☐ *Staphylococcus aureus,* methicillin **resistant (MRSA)**	☐ *Haemophilus influenzae* type b
☐ Other bacteria: _____ *(If reporting another viral co-infection please do so in section 19 Clinical Diagnosis and Complications)*	☐ *Staphylococcus aureus,* **sensitivity not done**	☐ *Pseudomonas aeruginosa*

Pathology confirmation of bacterial pathogens

16 g. Was a specimen (e.g., fixed lung tissue) collected from an autopsy for testing of bacterial pathogens by a local or state pathologist? *(If pathology results are available from CDC it is not necessary to input those results here, however please make sure to complete section 14 "CDC Laboratory Specimens")* O Yes O No O Unknown

If yes please indicate the results of these tests in the comments section at the end of the form.

Medical Care

17. Was the patient placed on mechanical ventilation? O Yes O No O Unknown

Influenza-Associated Pediatric Deaths Case Report Form

Clinical Diagnoses and Complications

18 a. Did complications occur during the acute illness? O Yes O No O Unknown

18 b. **If yes,** check all complications that occurred during the acute illness:

☐ Pneumonia (Chest X-Ray confirmed) ☐ Acute Respiratory Disease Syndrome (ARDS) ☐ Croup ☐ Seizures

☐ Bronchiolitis ☐ Encephalopathy/encephalitis ☐ Reye syndrome ☐ Shock

☐ Sepsis ☐ Hemorrhagic pneumonia/pneumonitis ☐ Cardiomyopathy/myocarditis

☐ Another viral co-infection: _____ ☐ Other: _____

19 a. Did the child have any medical conditions that existed before the start of the acute illness? O Yes O No O Unknown

19 b. **If yes,** check all medical conditions that existed before the start of the acute illness:

☐ Moderate to severe developmental delay ☐ Hemoglobinopathy (e.g. sickle cell disease) ☐ Asthma/ reactive airway disease

☐ Diabetes mellitus ☐ History of febrile seizures ☐ Seizure disorder ☐ Cystic fibrosis

☐ Cardiac disease/congenital heart disease (specify) _____ ☐ Renal disease (specify) _____ ☐ Skin or soft tissue infection (SSTI)

☐ Chromosomal Abnormality/Genetic Syndrome (specify) _____ ☐ Mitochondrial Disorder (specify) _____

☐ Chronic pulmonary disease (specify) _____ ☐ Immunosuppressive condition (specify) _____

☐ Cancer (diagnosis and/or treatment began in previous 12 months) (specify)_____ ☐ Endocrine disorder (specify) _____ ☐ Obesity ☐ Cerebral Palsy ☐ Prematurity (specify gestational age) ____ weeks

☐ Neuromuscular disorder (e.g. muscular dystrophy) (specify) _____ ☐ Other Neurological disorder (specify) _____

☐ Pregnant (specify gestational age) _____ weeks ☐ Other (specify) _____

Medication and Therapy History

20 a. Was the patient receiving any of the following therapies ***prior*** to illness onset?
(if yes, check all that apply)

☐ Yes ☐ No ☐ Unknown

☐Antiviral Prophylaxis ☐ Chronic aspirin therapy ☐ Chemotherapy or radiation therapy ☐ Steroids by mouth or injection

☐ other immunosuppressive therapy:_____

20 b. Did the patient receive any of the following ***after*** illness onset? **(if yes, check all that apply)**

☐ Yes ☐ No ☐ Unknown ☐ Antibiotic therapy specify_____ ☐ Antiviral therapy specify_____

Influenza-Associated Pediatric Deaths Case Report Form

Influenza Vaccine History

21. Did the patient receive any **seasonal** influenza vaccine during the current season (before illness) O Yes O No O Unknown

22. **If YES*,** please specify the **seasonal** influenza vaccine received before illness onset:
- ☐ Trivalent inactivated influenza vaccine (TIV) *[injected]*
- ☐ Live-attenuated influenza vaccine (LAIV) *[nasal spray]*
- ☐ Unknown

23. **If YES for seasonal vaccine***, how many doses did the patient receive and what was the timing of each dose? (Enter vaccination dates if available)

O 1 dose **ONLY**	☐ <14 days prior to illness onset ☐ ≥14 days prior to illness onset	Date dose given:_____/ _____/ _____ MM DD YYYY	
O 2 doses	☐ 2nd dose given <14 days prior to onset ☐ 2nd dose given ≥14 days prior to onset	Date of 1st dose: _____/ _____/_____ MM DD YYYY	Date of 2nd dose: _____/ _____/ _____ MM DD YYYY

24 . Did the patient receive any **seasonal** influenza vaccine in previous seasons?	O Yes	O No	O Unknown
24 a. **If YES to question 24**, and patient was between **6 months and ≤ 8 years of age** at the time of death, was the 2009-2010 influenza season the first time the patient received **seasonal** influenza vaccine?	O Yes	O No	O Unknown
24b. **If YES to question 24a,** did the patient receive 2 doses of **seasonal** influenza vaccine during the 2009-2010 influenza season?	O Yes	O No	O Unknown
25. If the patient was between **6 months and ≤8 years of age** at the time of death, did they receive at least one dose of **2009 influenza A (H1N1)** vaccine during the previous season?	O Yes	O No	O Unknown

Submitted By: _____ Date: _____/ _____/ _____
Phone No.: (_____)___-_____ MM DD YYYY
E-mail Address: _____

CONFIDENTIAL SEXUALLY TRANSMITTED DISEASE REPORTING FORM
MIAMI - DADE COUNTY HEALTH DEPARTMENT
STD SURVEILLANCE

1350 NW 14th Street Suite 401 ■ Miami, FL 33125 ■ Phone:(305)575-5430 ■ Secure Fax: (305)575-3812
Attention: Camille Persaud, Surveillance Manager

Date of Report: MM	DD	YY	**Reporting Facility Name:**	
			Person Reporting:	**Phone: ( ) -**

PATIENT'S:				**TEST**				**TREATMENT**		Pregnancy EDD or LMP	Physician Phone
Name - Address - Phone MR Number - SS#	SEX	DOB	RACE*	DATE	TYPE	RESULT	LAB	TYPE & DOSE	DATE		

** If patient is Hispanic, please indicate White Hispanic (WH), or Black Hispanic (BH)*

Please report any reactive syphilis serology in pregnant women and/or newborns immediately 24/7 by phone or fax and all other early cases of syphilis by the next business day. All other STDs (excluding HIV / AIDS) must be reported by the next business day from the receipt of results . For reporting requirements please refer to the Florida Statute 381.0031, Rule 64D-3, F.A.C.

DO NOT USE THIS FORM TO REPORT LAB RESULTS OR DIAGNOSIS OF HIV / AIDS, CONTACT HIV / AIDS SURVEILLANCE STAFF AT (305) 470-6999

DO NOT FAX HIV / AIDS RESULTS ON THIS FORM

Updated: January 2013

Dear Physician:

The Florida Department of Health in Miami-Dade County wants to build a partnership with you to decrease the prevalence of Tuberculosis (TB) in Miami-Dade County. We are asking for your help in diagnosing and reporting all cases of active TB to us.

Some important point to remember:

- Help is available at all times to manage any case of TB in Miami-Dade County. Please feel free to call our Helpline at (305) 324-2400 or the Florida TB Physician's Network 1-800 4 TB info.

- All cases of Active Tuberculosis (confirmed or suspect) must be reported to the Health Department (see attachment of TB case/suspect form). Our fax number is (305) 575-3804. If you have any questions about reporting of a case of TB, please contact our Surveillance Section at (305) 575-5415.

TB Screening of School-aged children:

1. All school children do NOT need to be tested. TB skin test or IGRAs is NOT ROUTINELY recommended for individuals who are at low-risk for TB infection and progression to TB Disease. Please refer to our Pocket-Card for guidelines about Targeted Skin Testing.

2. In addition to the question on this form, the following questions need to be asked in order to determine if a child is at risk for TB infection:
   a) Is the child a frequent visitor to TB endemic areas?
   b) Are frequent visitors to the child's home from a TB endemic country?
   c) Are the child's caregiver(s) or other relatives recent immigrants/refugees from a TB endemic country?

3. The Mantoux Tuberculin Test (PPD) or IGRAs (Quantiferon or T-Spot) are the methods recommended for testing.

4. Please discard any history of BCG vaccination in interpreting a PPD reading. A positive PPD or a positive IGRA is a positive result regardless of any history of BCG Vaccination.

5. Results of the TB assessment including the Mantoux Tuberculin Test or IGRA results are not necessary for school entry and should not be placed on the school entry Health Exam Form (DH 3040). This form (including instruction sheet form) is available at the Florida Department of Health in Miami-Dade County. Please see attachment.

6. Physician should determine if the patient has underlying medical conditions, especially HIV infection and Diabetes regardless of age. These conditions may increase the risk for progression to TB disease in patients with Latent TB infection.

1. Finally if you choose to treat your patient for Latent TB Infection, please make sure your patients COMPLETES the full nine (9) month course of INH treatment or the twelve (12) week course of INH and Rifapentine (INH-RFT) treatment. Many patients are appropriately screened for LTBI and started on treatment but are lost to follow-up once they have their clearance letter. Therefore, they are at high risk to develop the disease.

TB Screening of Immuno-suppressed individuals:

The Florida Department of Health in Miami-Dade County would like to remind all practitioners to screen patients for risk factors for Tuberculosis and test them with the Mantoux test or IGRA before initiating immunosuppressive therapies TNF alpha antagonists infliximab (Remicade ®), etanercept (Enbrel ®) and adalimumab (Humira).

We greatly appreciate your collaboration in the fight against TB and will be available for any questions or guidance at any time.

Sincerely,

Reynald Jean, MD, MPH
Director, TB Program

Emma Simmonds, MD
TB Physician

Florida Department of Health in Miami-Dade County
Tuberculosis Control & Prevention Program
TEL (305) 575-5415 FAX (305) 575-3804 Surveillance

TB CASE/SUSPECT REPORT FORM

1 Reporting Entity

Reporting Date _____ Suspect ☐ New Case ☐ Reactivation ☐ Transfer Entity Name _____

Entity Phone Number _____ Entity Fax Numbe _____ Reported by (Last Name, First Name) _____

2 Patient Demographics & Current Address

Last Name _____ First Name _____ Mi ____ Date of Birth _____ Social Security number _____

Current Address (Number & Street Name) _____ Apt. Numbe ____

City _____ State ____ Zip Code ____

Home Phone Number _____

Gender: ☐ Male ☐ Female **Marital Status:** ☐ Single ☐ Married

Race: ☐ Amer. Ind. or Alaskan Native ☐ Asian or Pacific Isl. ☐ Black ☐ White

Ethnicity: ☐ Hispanic ☐ Not Hispanic

If not US, Date arrived in USA _____ Florida Resident: ☐ Yes ☐ No

Language Spoken if NOT English: _____

If Yes, Date Arrived in Florida _____ Country of Origin _____

Homeless within past year: ☐ Yes ☐ No Status at Diagnosis of TB: ☐ Alive ☐ Dead

3 Previous Address: *(Fill only if less than 6 months in Current Address)*

Previous Address (Number & Street Name) _____ Apt. Number ____ City _____ State ____ Zip Code ____

4 Occupation *(Check all that apply within the past 24 months.)*

☐ Health Care Worker ☐ Correctiona Employee ☐ Migratory Agricultural Worker ☐ Unknown ☐

☐ Student ☐ School Staff ☐ Restaurant Worker ☐

☐ Not Employed within the past 24 months. ☐ Other Occupation (specify _____

5 Work Place

Institution Name _____ Suite Number _____

Number & Street Name _____ Work Phone Number _____

City _____ State ____ Zip Code ____

6 Past Medical (TB) History

Yes ☐ No ☐ ____ If Yes, When (Year) **Where:** Country, State or County _____ **BCG:** ☐ Yes ☐ No If Yes, Month & Year of BCG _____

Med Taken: ☐ 1 Drug ☐ 2 or more Drugs **Previous PPD:** ☐ Positive ☐ Negative

Duration of Rx. _____ Specify (drug Name) _____ If + Size in mm. _____ PPD Date (MM/YYYY) _____

7 Current Supervision/ Meds./ PPD & X-ray

Meds. Supervision:

Physician's / Institution's Name _____

Phone Number _____ Fax Numbe _____

Admission Date _____ Discharge Date _____

Chest X-ray Date _____ Results: ☐ Normal ☐ Abnormal ☐ Cavitary

Chest X-ray Comments. _____

Current TB Meds.

	INH	RIF	PZA	EMB
Dosage/mg:				

TB Medications Start Date _____

Other Medications & Dosage _____

Current Non TB Medications _____ **Patient's weight:** _____ In Lbs

Current PPD: _____ Implant Date _____ Reading Date _____ Result in mm:

IGRA: ☐ Pos ☐ Neg ☐ Indeteminate **Date:** _____

8 Bacteriology

Specimen: ☐ Sputum ☐ Other Tissue/Fluid

Smear: ☐ Pos ☐ Neg. Result Date _____

Culture: ☐ Pos ☐ Neg. Result Date _____ (Diagnosis Date)

Date: _____ Culture ID _____

Lab Name: _____

Lab Phone Number _____ Lab Fax Number _____

9 Site(s) of Disease

☐ Pulmonary ☐ Lymphatic Unknown ☐ Lymphai Cervical ☐ Lymphatic Intrathoracic ☐ Lymphatic Other

☐ Pleural ☐ Bone & or Joint ☐ Genitourinary ☐ Miliary ☐ Meningeal

☐ Peritoneal ☐ Other Specify) _____

10 HIV Status

Date _____

☐ Positive ☐ Negative ☐ Indeterminate ☐ Refused ☐ Not Offered

☐ Test Done Results Unknown **If Positive, Based on :** ☐ Medical Documentation ☐ Patient History

TB-S04 Send report to: DOH/TB Program 1350 NW. 14th. Street, Miami, FL 33125 Fax: (305) 575-3804

Rev 05/22/2013

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Florida Department of Health in Miami-Dade County
Tuberculosis Control & Prevention Program
TEL (305) 575-5415 FAX (305) 575-3804 Surveillance

TB CASE/SUSPECT REPORT FORM

Last Name _____ First Name _____ Mi ___ Date of Birth _____ Social Security Number _____

11 Symptoms

☐ Asymptomatic ☐ Wt. Lost _____ Amount Lbs. Over _____ Months

☐ Cough ☐ Fatigue ☐ Hemoptysis ☐ Fever ☐ Anorexia ☐ Fistula

☐ Night Sweat ☐ Shortness of breath ☐ Other _____

12 Alcohol / Drug Use

☐ Pleuris Intra-Venous drug use ☐ Yes ☐ No Date Last Use _____

Non Injection drug Use within past year: ☐ Yes ☐ No Date Last Use _____

Excess Alcohol Use within past year: ☐ Yes ☐ No Date Last Use _____

13 Contact to TB Case

Ever Exposed to a TB Case? ☐ Yes ☐ No How long? Month _____ Last Name _____ First Name _____

Did any family member die with TB? ☐ Yes ☐ No Relationship _____ Date of last Contact _____

14 Other Medical Conditions

Previously Diagnosed with Liver Disease: ☐ Yes ☐ No

If **"Yes"**, What & When? _____ Date _____

☐ Gastrectomy ☐ Diabetes Mellitus ☐ Renal Failure _____

☐ Organ Transplant ☐ Pregnant Expected time of Delivery Date _____

☐ Epilepsy Last Episode date _____

☐ Allergies Name _____

☐ Immunosuppressive Medications ☐ Silicosis (Occupation al Lung Disease) ☐ Epilepsy Bypass

☐ Other, Specify _____

15 Correctional Facility

(A) Was the client incarcerated during their infectious period: ☐ Yes ☐ No

If '**Yes**', Where ?: ☐ Federal Prison ☐ Local Jails ☐ Other Correctional Facility

☐ State Prison ☐ Juvenile Correctional Facility

Correctional Facility Name _____

Correctional Facility Phone Number _____ Correctional Facility Fax Number _____

16 Long Term Care Facility

(A) Resident of Long Term Care Facility at time of Diagnosis: ☐ Yes ☐ No

(B) Resident of Long Term Care Facility within the last 2 Years: ☐ Yes ☐ No

If 'Yes' **to** A **or** B: ☐ Nursing Home ☐ Hospital ☐ Residential ☐ Mental Health ☐ Alcohol/Drug Treatment ☐ Other Long Term Care Facility

Long Term Care Facility Name _____

Long Term Care Facility Phone Number _____ Long Term Care Facility Fax Number _____

17 Emergency Contacts

Last Name _____ First Name _____ Relationship _____ Phone Number _____ Other Information _____

Last Name _____ First Name _____ Relationship _____ Phone Number _____ Other Information _____

18 Comments

_____

_____

_____

_____

FOR DOH USE ONLY

TB IMS Case Number: Current Year _____

Within City Limit: ☐ Yes ☐ No

Diagnosis for Case Register _____

Date Submitted to Tallahassee _____ County Case Number _____

Report Received by:

Last Name _____ First Name _____

Interview Date _____

Interviewer's Name _____

Interviewer's Signature _____

TB-S04 **Send report to: DOH/TB Program 1350 NW. 14th. Street, Miami, FL 33125 Fax: (305) 575-3804**

Rev 05/22/2013
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Florida Department of Health in Miami-Dade County
Tuberculosis Control & Prevention Program
TEL (305) 575-5415 FAX (305) 575-3804 Surveillance

Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request

Patient Name:_____ **Submitted By**:_____
Phone_____ Pager_____
D.O.B:_____ MR# _____ **Facility**_____
Fax_____

If Pulmonary: Dates of three consecutive negative smears

1_____ 2 _____ 3 _____

Discharge to: ☐ Home ☐ Shelter ☐ SNF ☐ Jail/Prison ☐ Other_____
Discharge address and phone:_____
_____
Date Patient to be discharged _____ **F/U Appt. Date** _____

Physician agreeing to assume TB care _____ Phone # _____
Health Care Facility_____
Address _____

DischargeTB medication regimen:
(indicate total daily dose)

Rifamate (INH+RIF)*_____ pills/day
Rifater (INH+RIF+PZA)_____ pills/day
INH _____mg
Rifampin _____mg
Ethambutol _____mg
Pyrazinamide _____mg
Other _____mg
Side Effects _____

Medication complication (specify):
_____
_____

# of days of medication supply _____
(Must be sufficient to supply patient until follow up provider appointment)

Does the patient have risks that indicate Directly Observed Therapy (DOT)?
Mental Impairment ☐ Homeless ☐ HIV ☐ Hx of any non-compliant behavior ☐ Substance ☐
Contact TB Control if uncertain about risk.

Contact Information/Household composition:
Number of people in household?
Are there children age 5 years and younger? ☐ Yes ☐ No
Are there individuals immunocompromised? ☐ Yes ☐ No

Tuberculosis Control use only:

Program Review – Problems Notes_____
_____
Action taken before discharge _____
_____

Reviewed by _____ Date reviewed _____
Approved by _____ Date approved _____

Discharge Approved
☐ **Yes** ☐ **No**
Date_____

The Confidential Tuberculosis Suspect Case Report (TB-S04) form must be on file at Tuberculosis Control or submitted with this form

Revised 04/13

TB-S05 Date Submitted _____ Faxed By:_____

Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request (TB-S05) Instructions

Discharge of a Suspect or Confirmed Tuberculosis Patient

Patients suspected or confirmed with tuberculosis may not be discharged or transferred from a health facility (e.g. hospital) without prior approval of the DOH-Miami-Dade County Tuberculosis Control and Prevention Program.

To facilitate a timely and appropriate discharge, the provider should submit a written discharge plan to the TB Program 1 to 2 days prior to the anticipated discharge. TB Control will review the discharge plan for approval or denial.

County Health Department Response Plan:

Weekly discharge (Non Holiday 8:00 am - 5:00 pm): The written discharge plan should be submitted preferably by FAX or mail.

Tuberculosis Control and Prevention Program staff will review the discharge plan and notify the provider **within 24 hours** of approval or inform the provider of any additional information/action required or needed for approval prior to discharge.

If a home evaluation is required to determine if the environment is suitable for discharge, health department staff will make a visit.

Holiday and weekend Discharge: All arrangements for discharge should be made in advance when weekend discharge is anticipated. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone our Helpline at (305) 324-2400 and ask to contact the on-call TB physician. A response will usually occur within one hour. The process outlined above will be followed. If the discharge cannot be approved, the patient must be held until the next business day until appropriate arrangements can be made (*to fulfill State requirements for communicable diseases reporting, the TB Suspect/Case Report (TB-S04) must be completed and submitted prior to or concurrently with the Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request) (TB-S05).*

(NOTE: This form is used for discharge care planning only. Call the Tuberculosis Control and Prevention Program prior to faxing documents to ensure timely processing.)

TB RISK ASSESSMENT FOR SCHOOL ADMISSIONS

Date: _____

Name: _____ DOB: _____

Address: _____

Screen ALL for risk for TB but offer TB skin test ONLY to those who are in following high-risk categories.

A. Clients with the following risk factors are considered positive if the PPD is ≥ 5mm

- *Close contact to active TB case*
- *HIV positive or at high risk for HIV infection*
- *Organ transplant or chronic prednisone use (more than 15 mg/day for over one month)*

B. Clients with the following risk factors are considered positive if the PPD is ≥ 10mm

- *Recent immigrant (< 5 years) frequent visitor to TB endemic areas*
- *Frequent contact with adults at high-risk for disease, HIV+, homeless, incarcerated, illicit drug user*
- *Residents/Employees of high risk congregate settings (jails, nursing homes, hospitals)*
- *HIV+ or have other medical conditions that increase the risk to progress from infection to disease, e.g., chronic renal failure, diabetes, hematologic or any other malignancy, weight loss > 10% of ideal body weight, on immunosuppressive medications*

C. Active TB Disease Risk:

___Does the child exhibit signs/symptoms of tuberculosis (e.g. cough for three weeks or longer, weight loss, loss of appetite?

___If symptoms are present, work-up or refer for TB disease evaluation

Recommendations

___ No risk factors were found, no PPD is indicated and client can attend school

___ Risk factors found ___ **PPD** test done on _____ **IGRAs** ___QFT ___ T-Spot

___Negative _____mm ___ Positive _____mm ___Negative ___ Positive

If PPD is positive, or if there are signs and symptoms or active TB, a CXR is indicated prior to attending school

CXR done on _____ ___ CXR Negative for active TB

Provider's Name_____

Florida Department of Health
Miami-Dade County
Tuberculosis Control & Prevention Program
1350 NW 14th Street, Miami, Florida 33125-1609
PHONE: 305/575-5409 • FAX 305/575-3804

www.FloridasHealth.com
TWITTER:HealthyFLA
FACEBOOK:FLDepartmentofHealth
YOUTUBE: fldoh

About Us

Epidemiology, Disease Control and Immunization Services works diligently to protect and promote the health of Miami-Dade County residents and visitors from communicable disease and vaccine preventable disease. This is accomplished through the operation of public health surveillance, field investigations, health assessments, emergency preparedness activities, epidemiologic studies, administering immunization, and providing various informational and educational materials.

Mission

To protect, promote & improve the health of all people in Florida through integrated state, county , & community efforts.

Vision

To be the Healthiest State in the Nation

Florida HEALTH Miami-Dade County

Epidemiology

Disease Control & Immunization Services

EDC-IS Office

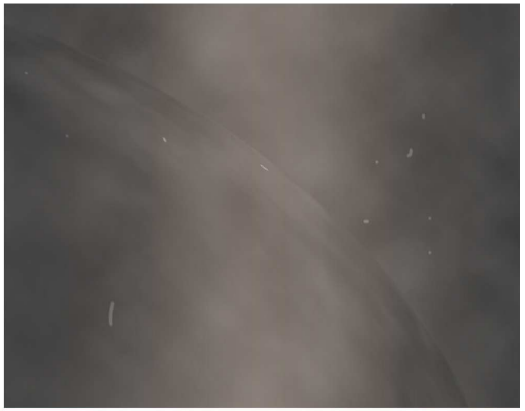
8600 NW 17th Street, Suite 200

Miami, FL 33126

(P) 305.470.5660

(F) 305.470.5533

www.dadehealth.org



Florida Department of Health in Miami-Dade County

General Surveillance

General Surveillance is the core unit of Epidemiology, Disease Control and Immunization Services (EDC-IS). This program conducts public health investigations and implements response activities in the event of a communicable disease outbreak. The program has the primary responsibilities, in compliance with the Florida Dept. of Health Admin. Code Chapter 64D-3, to conduct surveillance on notifiable diseases and outbreaks; educate and train staff, health care providers, and the community on communicable diseases; and investigate significant alerts from daily syndromic surveillance, and public school absentee reports. General Surveillance is also responsible for investigating and reporting animal bites.

Hepatitis

This program provides viral hepatitis education, screening, vaccination and referral to clients in the community. Supported by the Immunization Services, the Hepatitis Prevention Program core activities revolve around surveillance and clinic services. Several stakeholders collaborate with the program to provide access to care and treatment to clients with positive test results and to individuals at high risk in jails, homeless shelters and drug rehab centers.

Applied Epidemiology & Research

The Applied Epidemiology and Research Unit primarily provides assistance to investigations in the areas of research project design, data management and analysis, and information technology. The Unit also provides assistance to other programs within the health department, as well as the general public. In addition, the Unit produces reports and performs data analysis related to: Syndromic Surveillance, Injury Surveillance, Health Education, Maternal and Child Health, and special research studies.

Immunizations Services

The Immunization Program provides immunizations and offers vaccine-related education and information services. The program provides vaccines free of charge for children up to 18 years of age, and at-cost for adults. This program contributes to the elimination of vaccine preventable diseases in residents and visitors in Miami-Dade County.

BioTerrorism

The Bio-T/H1N1 Program supports General Surveillance activities and is in charge of investigating outbreaks of bio-terrorism/H1N1-related diseases as well as the creation and update of standard operating procedures (SOP) and response plans for the investigation of diseases of this nature.

The Bio-T Unit leads the Epidemiology Response Team (EpiRT) and is also involved in diverse response activities and initiatives such as Bio-Watch, USPS Anthrax Response Plan, Unexplained Death, etc.

Administration

Administrative staff is responsible for ensuring the smooth and effective EDC-IS operation activities that include: data entry, human resources issues, purchasing, travel preparation, immigration support services, leave and attendance, budget monitoring, maintenance, cell phone verifications, recruitment-related issues, etc.

Healthy Homes & Lead Poisoning Prevention Program

This program is responsible for raising awareness of environmental health risks in home, increasing primary prevention activities and lead screening among at-risk children. In addition, the program conducts surveillance of lead poisoning cases reported in Miami-Dade County and refers those with elevated Blood Lead Levels (BLL) to providers.

Category A Agents

- ❑ Anthrax (*Bacillus anthracis)*
- ❑ Botulism *(Clostridium botulinum* toxin*)*
- ❑ Plague (*Yersinia pestis*)
- ❑ Smallpox (*Variola major*)
- ❑ Tularemia (*Francisella tularensis*)
- ❑ Viral hemorrhagic fevers (*filoviruses* – e.g. *Ebola, Marburg; arenaviruses*- e.g. *Lassa, Machupo*; bunyaviruses; and flaviviruses)

Category A agents characteristics *(CDC)*

1) Can be easily disseminated, and some are transmitted from person to person
2) Result in high mortality rates and have the potential for major public health impact
3) Might cause public panic and social disruption
4) Require special action for public health preparedness

Reporting Protocols & Resources

(ACP/ASIM)

If you suspect bioterrorism,
contact your local health department immediately!
Do not wait for confirmation.

Suspicious case ⇒ record data and order tests ⇒ report to local health dept. ⇒ alert clinical lab ⇒ arrange for consultations ⇒ discuss findings with all involved parties.

ACP ASIM Guide to Bioterrorism Identification

Epidemiological Clues of a Bioterroristic Attack

1. Unusual temporal or geographic clustering of illness
2. Unusual age distribution of common disease (e.g., an illness that appears to be chickenpox in adults but is really smallpox).
3. Large epidemic, with greater case loads than expected, especially in a discrete population.
4. More severe disease than expected.
5. Unusual route of exposure.
6. A disease that is outside its normal transmission season, or is impossible to transmit naturally in the absence of its normal vector.
7. Multiple simultaneous epidemics of different diseases.
8. A disease outbreak with health consequences to humans and animals.
9. Unusual strains or variants of organisms or antimicrobial resistance patterns.

None of these clues alone are pathognomonic of bioterrorist attack, but several taken together provide support for further investigation

Sentinel Clues for Category A Biological Agents

These agents are easily disseminated, may be transmitted from person to person, and can cause high mortality.

Pneumonia or Influenza-like Syndromes

- ❖ Chest pain, dry cough, possible nausea and abdominal pain, followed by sepsis, shock, widened mediastinum, hemorrhagic pleural effusions, and respiratory failure. A Gram-positive bacillus may be isolated. *Consider inhalation anthrax.*
- ❖ Gram-negative bacillus pneumonia associated with muco-purulent sputum, chest pain, and hemoptysis, particularly in an otherwise normal host. *Consider pneumonic plague.*
- ❖ A Gram-negative coccobacillus broncho-pneumonia associated with pleuritis and hilar lymphadenopathy, particularly in an otherwise normal host. *Consider tularemia.*

Cutaneous Ulcer or Ulceroglandular Syndromes

- ❖ A painless ulcer covered by a black eschar, surrounded by extensive non-pitting edema that is out of proportion to the size of the ulcer. Fever and regional lymphadenopathy may be present. *Consider cutaneous anthrax.*

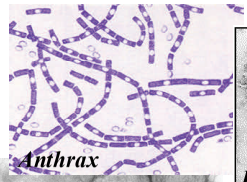
Fever and Rash Syndromes

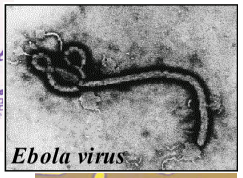
- ❖ An abrupt, influenza-like illness with fever, dizziness, myalgias, headache, nausea, abdominal pain, diarrhea and prostration. Evidence of "leaky capillary syndrome" with edema or signs of bleeding ranging from conjunctival hemorrhage, mild hypotension, flushing, petechiae, and ecchymoses to shock and generalized mucous membrane hemorrhage and evidence of pulmonary, hematopoietic, renal and neurological dysfunction. *Consider viral hemorrhagic fevers.*
- ❖ A febrile illness with myalgias followed in two to three days by a generalized macular or papular-vesicular-pustular eruption, with greatest concentration of lesions on the face and distal extremities, including the palms. On any one part of the body (face, arms, chest) all lesions are the same stage of development (all papules, vesicles, pustules, or scabs). *Consider smallpox.*

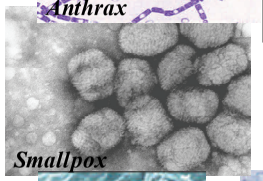
Paralytic Syndromes

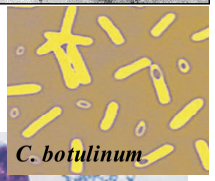
- ❖ A paralytic illness characterized by symmetric, descending flaccid paralysis of motor and autonomic nerves, usually beginning with the cranial nerves. *Consider botulism.*

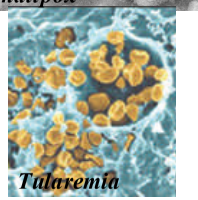
Bioterrorism Guide: Category A Agents

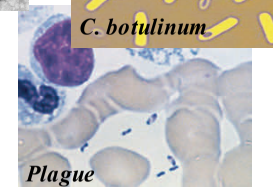












Florida Department of Health in Miami-Dade County
8600 N.W. 17th Street
Miami, Florida. 33126

Telephone: (305) 470-5660 (24/7)
Fax: (305) 470-5533

Florida HEALTH
Miami-Dade County

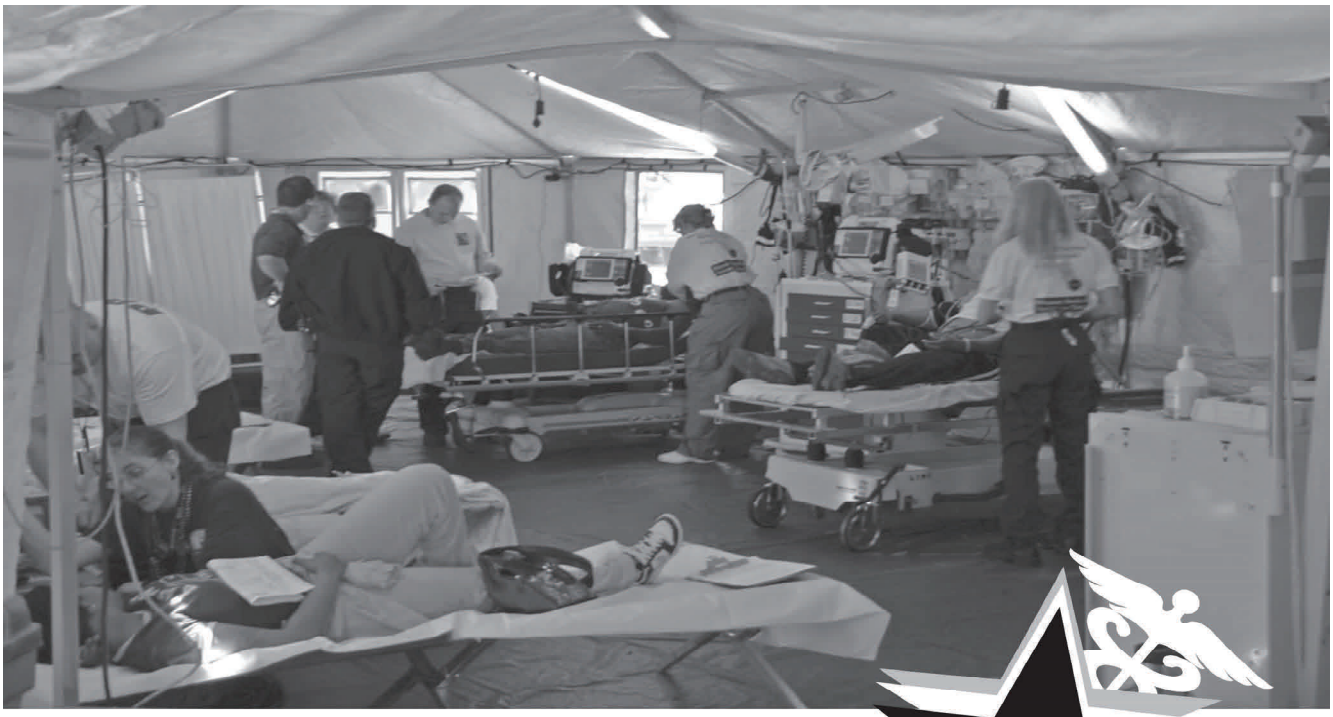
CATEGORY "A" AGENTS OF BIOTERRORISM

DISEASE INCUBATION PERIOD (BSL)	MICROBIOLOGY	CLINICAL SYNDROME	DIFFERENTIAL DIAGNOSIS	ISOLATION PRECAUTIONS/ MODE OF TRANSMISSION	SAMPLE/ DIAGNOSTICS	RECOMMENDED THERAPY (Alternatives may be available)	POST-EXPOSURE PROPHYLAXIS
ANTHRAX *Inhalational/GI:* 1-7 days (up to 60 days). *Cutaneous:* 1-12 days (BSL 2)	*Bacillus anthracis*: Spore-forming, encapsulated, Gram-positive bacillus that grows aerobically in long chains. Non-motile, non-hemolytic, catalase-positive. *Spores are actual infective agent.*	**Inahlational**: non-specific "flu-like" illness with fever, nausea, emesis, cough, +/- chest discomfort, without coryza or rhinorrhea → abrupt onset of respiratory distress. CXR: mediastinal widening. **Cutaneous**: pruritic, painless papule→ vesicle→ulcer→edematous black eschar. +/- massive edema, regional adenopathy, fevers, evolving over 3-7 days. **GI:** abdominal distress, nausea, emesis, fever, dysphagia, diarrhea, GI ulcers, regional edema & lymphadenitis	**Inhalational Anthrax, Tularemia and Pneumonic Plague:** Bacterial and mycoplasmic pneumonias, SARS, mediastinitis, coccidiomycosis, Q fever, psittacosis, influenza, Legionella, staphylococcal or streptococcal diseases, tuberculosis, and cat-scratch fever **Cutaneous Anthrax:** Human Orf, early boils, arachnid bites, vaccinia **Septicemic Plague:** Meningococcemia, Gram-negative streptococcal, pneumococcal or staphylococcal sepsis and SARS	Standard / Contact with animal tissue, hides, hair, wool, or bone meal.. Cutaneous infections require contact with damaged skin. GI infections may arise from ingestion of *B. anthracis* spores. Person-to-person transmission rare.	Nasal swab, blood culture, pleural fluid, BAL, sputum, serum, skin lesion, mediastinal lymph node biopsy or aspirate/ Culture, RT-PCR, serologic testing, Direct Fluorescence Antibody (DFA) assay, Gamma-phage lysis, Time-resolve Fluorescence (TRF) Assay, Immunohistochemistry (IHC) & ELISA	**Inhalational & GI**: *Adults*: *Cipro 400 mg IV BID* **AND** 1-2 antibiotics with in vitro activity: (e.g. Rifampin, vanco, penicillin, ampicillin, chloramphenicol, etc), changing to oral therapy when stable. *60 total days of treatment* *Children*: Same as above with appropriate dose adjustments. **Cutaneous:** *Cipro 500 mg PO BID x 60 days*	**Inhalational**: *Adults*: Cell-free vaccine at 0, 2 & 4 weeks if 18-59 years old **WITH** *Cipro 500 mg PO BID* **OR** (if susceptible) *Amox 500mg PO TID x 60 days* *Children*: Same as above with appropriate dose adjustments.
PLAGUE 1-6 days (BSL 2/3)	*Yersinia pestis:* small, non-motile, non-spore forming Gram-negative bacillus, with bipolar staining- "safety-pin" ovoid appearance	**Septicemic**: Sepsis, DIC, purpura, ecchymoses, acral gangrene, GI symptoms, hypotension, acute renal failure and other signs of shock. **Pneumonic**: Cough, fever, dyspnea, hemoptysis, +/- shock, & organ failure, +/- cervical bubo, GI symptoms. Advanced disease with purpuric skin lesions & necrotic digits. Chest x-ray with pulmonary infiltrates or consolidation		Droplet if pneumonic and drainage/secretions if bubonic, until 3 days of successful treatment/ Inhalation of respiratory droplets or contact with infected animals	Throat swab, blood /sputum culture, sputum smears, serum, bubo aspirate, CSF, lesion scraping, LN aspirate Culture, 4-fold change in antibody titer, DFA, RT-PCR, antigen detection, PHA, serology, TRFIA	*Adults*: *Streptomycin 1g BID* **OR** *Gentamicin 1mg/kg TID* **OR** *Tetracycline 0.5g QID* **OR** *Chloramphenicol* 12.5mg/kg QID x 7-10 days* *Children*: Same as above with appropriate dose adjustments. **required for plague meningitis*	*Adults*: *Tetracycline 1g* **OR** *Doxy 100 mg PO BID* **OR** *Cloramphenicol 30mg/kg PO QID x 7 days* *Children*: Same as above with appropriate dose adjustments.
TULAREMIA 1-14 days (BSL 2/3)	*Francisella tularensis:* Small, Gram-negative non-spore forming, aerobic, non-motile Coccobacillus requiring cysteine for growth	**Inhalational**: Acute fever with pharyngitis, pleuropneumonitis, bronchiolitis +/- hilar lymphadenopathy, and variable progression to respiratory failure. CXR: peribronchial infiltrates progressing to multilobar bronchopneumonia, pleural effusion, and hilar adenopathy		Standard/ No person-to-person transmission, but can be acquired environmentally	Throat swab, blood culture, serum, respiratory secretions, ulcer exudate/ DFA, Culture, ELISA assay for serum antibodies (in 2nd week), RT-PCR, antigen detection	*Adults*: *Streptomycin 1 g BID IM* **OR** *Gentamicin 5 mg/kg QD IM or IV x 10-14 days* *Children*: Same as above with appropriate dose adjustments	*Adults:* *Doxy 100 mg* **OR** *Cipro 500 mg BID PO x 14 days.* *Children*: Same as above with appropriate dose adjustments.
BOTULISM 6 hr-10 days (BSL 2)	Toxins (A-G) of *Clostridium botulinum:* spore forming, obligate anaerobe, Gram-positive bacillus	Acute onset of afebrile, symmetric, descending flaccid paralysis that begins in bulbar muscles. Findings include dilated pupils, dry mucous membranes with difficulties in swallowing and speaking; but no loss of consciousness.	Polio, tick paralysis, chemical intoxication, Guillain-Barre, myasthenia gravis	Standard/ Ingestion or inhalation of *C. botulinum* toxins or colonization of GI tract by ingested spores.	Nasal swab, wound tissue smear, serum, stool, gastric aspirate, vomitus/ Mouse bioassay, culture, antigen detection ELISA for A, B, E toxin, PCR	Supportive care and polyvalant (equine type AB or ABE) *botulinum* antitoxin (ASAP) - contains antibodies against toxin types A, B, E. One 10mL vial by slow IV infusion.	Close observation. At the first signs of illness, administer antitoxin.
SMALLPOX 7-19 days (BSL 4)	*Variola*: large, 300 nm, DNA virus with a dumbbell shaped core, and complex membrane system	Systemic toxicity: Prodrome of high fever, headache, back ache, prostration, chills, vomiting, abdominal pain, followed by synchronous, deep-seated rash beginning on face & extremities, progressive: papular → vesicular → pustular.	Atypical varicella or measles, influenza, secondary syphilis, molluscum contagiosum, meningococcemia, monkeypox, vaccinia, and scabies	Standard, contact and airborne/ Commonly spread through respiratory droplets or skin inoculation	Fluid of skin lesion, scab, Serum during febrile illness Cell culture, RT-PCR, negative stain electron microscopy, antigen detection, serology	Supportive care: Treat secondary bacterial infection Cidofovir effective in vitro; animal studies ongoing	Vaccination of close contacts and those living in the immediate vicinity within 4 days of exposure
Viral Hemorrhagic Fever (VHF) 4-21 days (varies with virus) (BSL 4 except Dengue; 3)	*Filoviridae, Arenaviridae, Bunyaviridae, Flaviviridae*: RNA viruses	Acute influenza-like illness → signs of increased vascular permeability: edema, hypotension, petechiae, conjunctival hemorrhage → generalized mucous membrane bleeding, shock, multiorgan failure	Leptospirosis, Meningococcemia, typhus, malaria, rickettsial disease, thrombocytopenic purpura, hemolytic uremic syndrome	Standard, contact and airborne/ Person-to-person transmission rare, usually vector-borne.	Nasal swab, serum, CSF/ Rapid antigen capture ELISA, acute sera antibody, RT-PCR, viral culture	Supportive care: Ribavirin (IND) for possible Arena or Bunyavirus. Ribavirin 30 mg/kg IV (max 2 g) load, then 16 mg/kg IV (max 1 g/ dose) QID x 4 days, then 8 mg/kg IVT ID x 6 days (max 500mg/dose)	Medical surveillance for symptoms. If fever ≥ 101 ° F, start Ribavirin 500mg PO QID x 10 days for possible Bunyavirus or Arenavirus

Version 4.0 May 2010
Adapted from IDSA, ACP, CDC resources, and JAMA consensus statements

VOLUNTEER

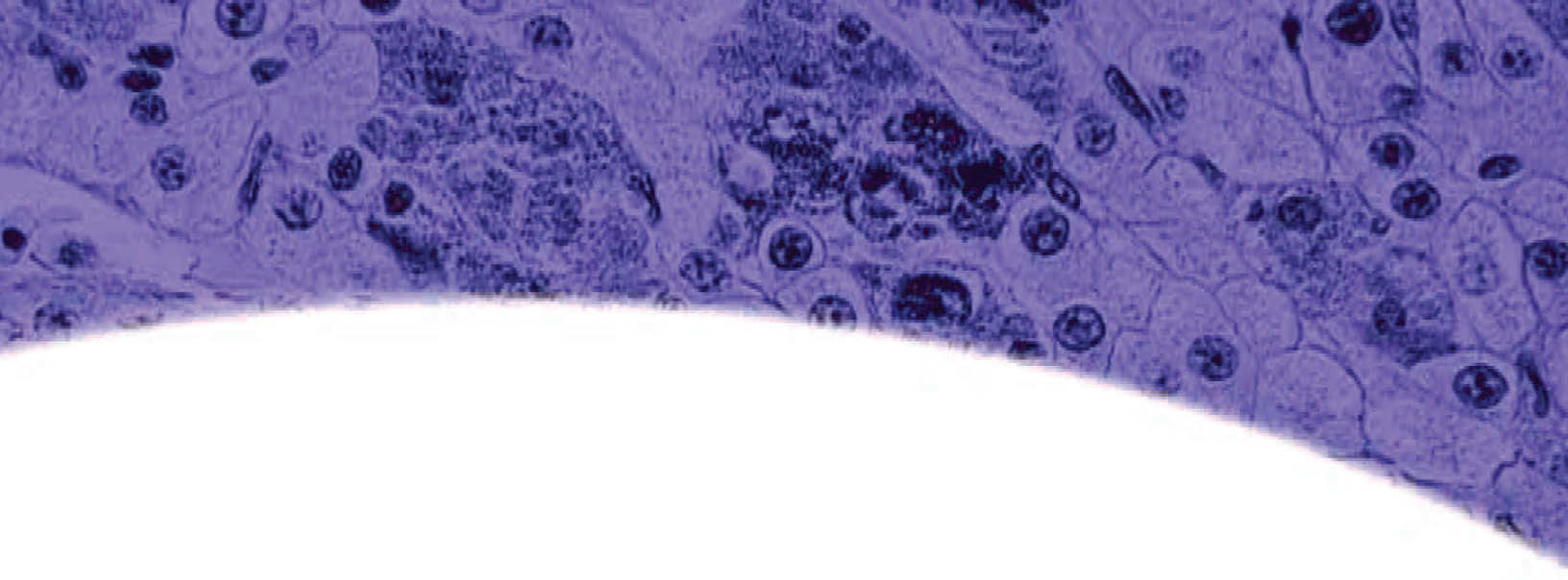
Medical Reserve Corps (MRC)
Medical Disaster Relief Team



medical
reserve
corps

MIAMI-DADE

www.miamidademrc.org



"Working together to protect the health of our community."

Florida HEALTH
Miami-Dade County

Florida Department of Health in Miami-Dade County

Epidemiology, Disease Control & Immunization Services

8600 NW 17th Street, Suite 200

Miami, Florida 33126

Main Number 305-324-2400

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