Florida HEALTH
Miami-Dade County

2018

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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January 2018

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 have been changes/updates made to the 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, MSN, AGPCNP-BC
Director

Florida Department of Health
in Miami-Dade County • Epidemiology, Disease Control and Immunization Services
8600N.W. 17th Street, Suite 200
Miami, Florida 33126
PHONE: 305/470-5660 • FAX: 305/470-5533
Miamidade.floridahealth.gov

Lillian Rivera, RN, MSN, PhD, Administrator

REPORTABLE NOTIFIABLE DISEASES/CONDITIONS CONTACT LIST- January 1, 2018

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	1350 NW 14 Street, Suite 301
	305-470-6984 (O)	Rodolfo Boucugnani, Data Analyst	Miami, Florida 33125
EPIDEMIOLOGY			Florida Department of Health in Miami - Dade
Immunization	786-845-0550	For Appointments Only	County
	305-470-5670 (O)	Lydia Sandoval, RN, Program Manager	Epidemiology, Disease Control and Immunization
		Jorge Alonso, RN	Services
			8175 NW 12 Street, Suite 304
			Miami, Florida 33126
Hepatitis	305-470-6820 (O)	Marie K. Etienne, RN, Program Manager	
Lead Poisoning	305-499-2065 (O)	Keren Joseph	
Other Communicable Diseases/Conditions	305-470-5660	Main Number	
	305-470-5533 (F)	Reynald Jean, MD, MPH, MSN, AGPCNP-BC Director	
		Edhelene “Gigi” Rico, MPH, Surveillance	
		Alvaro Mejia-Echeverry, ARNP, MPH, Bioterrorism	
		Juan Suarez, Food and Waterborne Program	
SEXUALLY TRANSMITTED DISEASES	305-575-5430 (O)	Josephine Gilbert	Florida Department of Health in Miami-Dade County
			STD Surveillance Unit
	305-575-3812 (F)	Secured Fax	1350 NW 14 Street, Suite 401
	305-575-5423	Main Number	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, Program Director	
	305-575-3804 (F)		

Reportable Diseases/Conditions in Florida

Practitioner List (Laboratory Requirements Differ)

Per Rule 64D-3.029, Florida Administrative Code, promulgated October 20, 2016 Florida Department of Health in Miami-Dade County

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 or visit our website.

Epidemiology, Disease Control and Immunization Services (EDC-IS)
Phone Number: 305-470-5660
Website: http://miamidade.floridahealth.gov/

Birth Defects (850)245-4401 (Tel) (850)922-8473 (Fax)

- \+ Congenital anomalies
- \+ Neonatal abstinence syndrome (NAS)

Cancer (305) 243-2639 (Tel)

- \+ Cancer, excluding non-melanoma skin cancer and including benign and borderline intracranial and CNS tumors

Hepatitis (Viral) (305)470-5536(Tel) (305)470-5533 (Fax)

- ☎ Hepatitis A
- • Hepatitis B, C, D, E, and G
- • Hepatitis B surface antigen in pregnant women and children <2 years old

HIV/AIDS (305)470-6953(Tel) (No Fax Reporting)

- \+ Acquired immune deficiency syndrome (AIDS)
- \+ Human immunodeficiency virus (HIV) infection
- • HIV-exposed infants <18 months old born to an HIV-infected woman

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

- • Lead poisoning (blood lead level ≥5 µg/dL)

STD (305)575-5430 (Tel) (305)575-3812(Fax)

- • Chancroid
- • Chlamydia
- • Conjunctivitis in neonates <14 days old
- • Gonorrhea
- • Granuloma inguinale
- • Herpes simplex virus (HSV) in infants <60 days old with disseminated infection and liver involvement; encephalitis; and infections limited to skin, eyes, and mouth; anogenital HSV in children <12 years old
- • Human papillomavirus (HPV)-associated laryngeal papillomas or recurrent respiratory papillomatosis in children <6 years old; anogenital papillomas in children ≤12 years old
- • Lymphogranuloma venereum (LGV)
- • Syphilis
- ☎ Syphilis in pregnant women and neonates

Tuberculosis (305)575-5415 (Tel) (305)547-3804 (Fax)

- • Tuberculosis

Epidemiology (305)470-6660 (Tel) (305)470-5533 (Fax)

- ! Outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g., hospital, school, other institution) not listed that is of urgent public health significance
- ☎ Amebic encephalitis
- ! Anthrax
- • Arsenic poisoning
- ! Arboviral diseases not otherwise listed
- • Babesiosis
- ! Botulism, foodborne, wound, and unspecified
- • Botulism, infant
- ! Brucellosis
- • California serogroup virus disease
- • Campylobacteriosis
- • Carbon monoxide poisoning
- • Chikungunya fever
- ☎ Chikungunya fever, locally acquired
- ! Cholera (*Vibrio cholerae* type O1)
- • Ciguatera fish poisoning
- • Creutzfeldt-Jakob disease (CJD)
- • Cryptosporidiosis
- • Cyclosporiasis
- ! Dengue fever
- ! Diphtheria
- • Eastern equine encephalitis
- • Ehrlichiosis/anaplasmosis
- • *Escherichia coli* infection, Shiga toxin-producing
- • Giardiasis, acute
- ! Glanders
- ! *Haemophilus influenzae* invasive disease in children <5 years old
- • Hansen's disease (leprosy)
- ☎ Hantavirus infection
- ☎ Hemolytic uremic syndrome (HUS)
- ☎ Herpes B virus, possible exposure
- ! Influenza A, novel or pandemic strains
- ☎ Influenza-associated pediatric mortality in children <18 years old
- • Legionellosis
- • Leptospirosis
- ☎ Listeriosis
- • Lyme disease
- • Malaria
- ! Measles (rubeola)
- ! Melioidosis
- • Meningitis, bacterial or mycotic
- ! Meningococcal disease
- • Mercury poisoning
- • Mumps
- ☎ Neurotoxic shellfish poisoning
- ☎ Paratyphoid fever (*Salmonella* serotypes Paratyphi A, Paratyphi B, and Paratyphi C)
- ☎ Pertussis
- • Pesticide-related illness and injury, acute
- ! Plague
- ! Poliomyelitis
- • Psittacosis (ornithosis)
- • Q Fever
- ☎ Rabies, animal or human
- ! Rabies, possible exposure
- ! Ricin toxin poisoning
- • Rocky Mountain spotted fever and other spotted fever rickettsioses
- ! Rubella
- • St. Louis encephalitis
- • Salmonellosis
- • Saxitoxin poisoning (paralytic shellfish poisoning)
- ! Severe acute respiratory disease syndrome associated with coronavirus infection
- • Shigellosis
- ! Smallpox
- ☎ Staphylococcal enterotoxin B poisoning
- ☎ *Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)
- • *Streptococcus pneumoniae* invasive disease in children <6 years old
- • Tetanus
- • Trichinellosis (trichinosis)
- ! Tularemia
- ☎ Typhoid fever (*Salmonella* serotype Typhi)
- ! Typhus fever, epidemic
- ! Vaccinia disease
- • Varicella (chickenpox)
- ! Venezuelan equine encephalitis
- • Vibriosis (infections of *Vibrio* species and closely related organisms, excluding *Vibrio cholerae* type O1)
- ! Viral hemorrhagic fevers
- • West Nile virus disease
- ! Yellow fever
- ! Zika fever

! Report immediately 24/7 by phone upon initial suspicion or laboratory test order
☎ Report immediately 24/7 by phone
• Report next business day
\+ Other reporting timeframe

Coming soon: "What's Reportable?" app for iOS and Android

*Subsection 381.0031(2), Florida Statutes, provides that "Any practitioner licensed in this state to practice medicine, osteopathic medicine, chiropractic medicine, naturopathy, or veterinary medicine; any hospital licensed under part I of chapter 395; or any laboratory licensed under chapter 483 that diagnoses or suspects the existence of a disease of public health significance shall immediately report the fact to the Department of Health." Florida's county health departments serve as the Department's representative in this reporting requirement. Furthermore, subsection 381.0031(4), Florida Statutes, provides that "The Department shall periodically issue a list of infectious or noninfectious diseases determined by it to be a threat to public health and therefore of significance to public health and shall furnish a copy of the list to the practitioners…"

Practitioner Disease Report Form-Epidemiology, Disease Control and Immunzation Services (EDC-IS)
Florida Department of Health in Miami-Dade County

Per Rule 64D-3.029, Florida Administrative Code, promulgated October 20, 2016 (laboratory reporting requirements differ).

To report a disease/condition, ☑check a box below and note notification timeframe.
Call 305-470-5660 (24/7) or submit this form to confidential fax # 305-470-5533

Contact information for the following programs: **HIV/AIDS** Ph: 305-470-6953 ◆ **STD** Ph: 305-575-5430 ◆ **Tuberculosis** Ph: 305-575-5415

A. PATIENT INFORMATION

Last name: **First name:** **Middle:** **Birth date:**

Parent name: **Home address:** **City:** **State:** **Zip:**

Home phone: **Other phone:** **Email:**

Gender: ○ Male ○ Female, pregnant? ☐ Yes ☐ No ○ Unknown **Ethnicity:** ○ Hispanic ○ Non-Hispanic ○ Unknown

Race: ○ American Indian/Alaska native ○ Asian/Pacific islander ○ Black ○ Other ○ Unknown

B. MEDICAL INFORMATION

MRN: **Date onset:** **Date admitted:** **Date discharged:**

Hospitalized: ○ Yes ○ No ○ Unknown **Died:** ○ Yes, date: ○ No ○ Unknown **Insurance:**

Treated: ○ Yes ○ No ○ Unknown **Specific treatment:**

Laboratory testing: ○ Yes (attach result) ○ No ○ Unknown

C. PROVIDER INFORMATION

Facility: **Physician:** **Phone:** **Fax:**

Address: **City:** **State:** **Zip:**

Person completing this form: **Phone:** **Email:**

D. NOTIFIABLE DISEASES / CONDITIONS LIST- check one ☑

! Report Immediately 24/7 by phone upon initial suspicion or laboratory test order / ☎ Report immediately 24/7 by phone / • Report next business day

- ☐☎Amebic encephalitis
- ☐ ! Anthrax
- ☐ • Arsenic poisoning
- ☐ ! Arbovrial diseases not otherwise listed
- ☐ • Babesiosis
- ☐ ! Botulism, foodnorne, wound, and unspecified
- ☐ • Botulism, infant
- ☐ ! Brucellosis
- ☐ • California serogroup virus disease
- ☐ • Campylobacteriosis
- ☐ •Carbon monoxide poisoning
- ☐ • Chikungunya fever
- ☐☎Chikungunya fever, locally acquired
- ☐ ! Cholera (*Vibrio cholera* type 01)
- ☐ • Ciguatera fish poisoning
- ☐ • Creutzfeldt-Jakob disease (CJD)
- ☐ • Cryptosporidiosis
- ☐ • Cyclosporiasis
- ☐ ! Dengue fever
- ☐ ! Diphtheria
- ☐ • Eastern equine encephalitis
- ☐ • Ehrlichiosis/anaplasmosis
- ☐ • Escherichia coli infection, Shiga toxin-producing
- ☐ • Giardiasis, acute
- ☐ ! Glanders
- ☐ ! Haemophilus influenza invasive disease in children <5 years old
- ☐ • Hansen's disease (leprosy)
- ☐☎Hantavirus infection
- ☐☎Hemolytic uremic syndrome (HUS)
- ☐☎Hepatitis A
- ☐ • Hepatitis B, C, D, E, and G
- ☐ • Hepatitis B surface antigen in pregnant women and children <2 years old
- ☐☎Herpes B virus, possible exposure
- ☐ ! Influenza A, novel or pandemic strains
- ☐☎Influenza-associated pediatric mortality in children <18 years old
- ☐ • Lead poisoning (blood lead level ≥5µg/dL)
- ☐ • Legionellosis
- ☐ • Leptospirosis
- ☐☎Listeriosis
- ☐ • Lyme disease
- ☐ • Malaria
- ☐ ! Measles (rubeola)
- ☐ ! Melioidosis
- ☐ • Meningitis, bacterial or mycotic
- ☐ ! Meningococcal disease
- ☐ • Mercury poisoning
- ☐ • Mumps
- ☐☎Neurotoxic shellfish poisoning
- ☐☎Paratyphoid fever (*Salmonella* serotypes Paratyphi A, Paratyphi B, and Paratyphi C)
- ☐☎Pertussis
- ☐ • Pesticide-related illness and injury, acute
- ☐ ! Plague
- ☐ ! Poliomyelitis
- ☐ • Psittacosis (ornithosis)
- ☐ • Q fever
- ☐☎Rabies, animal or human
- ☐ ! Rabies, possible exposure
- ☐ ! Ricin toxin poisoning
- ☐ • Rocky Mountain spotted fever and other spotted fever rickettsiosis
- ☐ ! Rubella
- ☐ • St. Louis encephalitis
- ☐ • Salmonellosis
- ☐ • Saxitoxin poisoning (paralytic shellfish poisoning)
- ☐ ! Severe acute respiratory disease syndrome associated with coronavirus infection
- ☐ • Shigellosis
- ☐ ! Smallpox
- ☐☎Staphylococcal enterotoxin B poisoning
- ☐☎*Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)
- ☐ • *Streptococcus pneumoniae* invasive disease in children <6 years old
- ☐ • Tetanus
- ☐ • Trichinellosis (trichinosis)
- ☐ ! Tularemia
- ☐☎Typhoid fever (*Salmonella* serotype Typhi)
- ☐ ! Typhus fever, epidemic
- ☐ ! Vaccinia disease
- ☐ • Varicella (chickenpox)
- ☐ ! Venezuelan equine encephalitis
- ☐ • Vibriosis (infections of Vibrio species and closely related organisms, excluding Vibrio cholera type O1
- ☐ ! Viral hemorrhagic fevers
- ☐ • West Nile virus
- ☐ ! Yellow fever
- ☐ ! Zika fever
- ☐ ! Outbreaks of any disease, any case, cluster of cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting (e.g. hospital, school, other institution) not listed that is of urgent public health significance.

Comments:

Revised: January 2018

Animal Bite Report Form

Epidemiology, Disease Control and Immunization Services (EDC-IS)
PH: 305-470-5660 • Fax: 305-470-5533

The Florida Administrative Code Chapter 64D-3 requires that animal bites to humans by a potentially rabid animal be reported to the health department next business day of the event.

Date of Report: _____

Reporting Agency: _____

Person completing Form: _____

Telephone: _____

A. Person Bitten (Victim)

Name (Last, First):	DOB:	Age:	Sex: ☐Male ☐Female, pregnant? ○No ○Yes
Race: ☐American Indian/Alaskan Native ☐Asian/Pacific Islander ☐White ☐Black ☐Other ☐Unknown			Ethnicity: ☐Hispanic ☐non-Hispanic ☐UNK
Address:	City:	State:	Zip:
Telephone:	Other telephone/email:		
Parent/Guardian name (if victim is minor):	Insurance: ☐No ☐Yes, name: ☐UNK Medicaid: ☐No ☐Yes		
Victim relationship to animal: ☐No relation ☐Occupational ☐Owner ☐UNK			
Place of attack:	Time and date of attack:		
Circumstances of attack: ☐Playful ☐Provoked ☐Sick/Hurt ☐K-9 (Police Action) ☐Unknown ☐Other:			
Type of exposure: ☐Bite ☐ Scratch ☐Saliva to mucus membrane or open cuts ☐handling/contact ☐Other:			
Wound(s) location: ☐Eyes ☐Face ☐Head ☐Mouth ☐Neck ☐Arm ☐Hand ☐Abdomen ☐Leg ☐Torso/Trunk/Chest ☐Other:			

Wound care Information

Patient washed wound? ☐No ☐Yes, how long after exposure: _____

Physician:

saw patient on (date): _____
washed/flushed wound? ☐ No ☐Yes
gave tetanus prophylaxis? ☐ No ☐Yes
gave antibiotics? ☐ No ☐Yes
sutured wound? ☐ No ☐Yes
provided other treatment? _____

ER visit? ☐ No ☐Yes Hospitalized? ☐ No ☐Yes

Anti-Rabies Post-Exposure Prophylaxis (PEP)

Note: raccoon, fox, bats or if animal not found PEP is recommended

Recommended? ☐No ☐Yes

If yes, by whom: _____

Initiated? ☐No ☐Yes, date: _____

If yes, which one? ○ RIG (Immunoglobulin)
○ Rabies Vaccine

Comments/Notes:

B. Animal Information

Type of animal: ☐Dog ☐Cat ☐Other:	Description (breed, color, etc.):		
Animal was: ☐Owned ☐Stray ☐Wild ☐ UNK	Behavior: ☐Normal ☐Abnormal ☐UNK		
Animal owner name (custodian):	Telephone:		
Address:	City:	State:	Zip:
Animal ever vaccinated against rabies? ☐No ☐Yes ☐UNK	If yes, vaccinated by: ☐Owner ☐Vet ☐UNK		

Health Department use only:

- *Case #*_____
- *Incident reported to animal services control?* ☐No ☐Yes, *date:* _____
- Animal vaccinated?
  - ☐ No
  - ☐ Yes, type of vaccine: ☐1st vaccine ☐1-year ☐3-year ☐UNK ☐other: _____ Recent vaccination date:

Complete and fax to (305) 470-5533

Childhood Lead Poisoning Prevention Reporting Form

Any questions, please call (305) 470-6877

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

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

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

Sample Date: ____/____/____

Analyzed Date: ____/____/____

Lab Report Date: ____/____/____

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

Laboratory sent to: (check one)
- ☐ Lab Corp Tampa
- ☐ Quest Diagnostics
- ☐ _____

PLEASE ATTACH COPY OF LAB TEST RESULT

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 Professionals

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 (JJg/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 testing	Recommended actions
10-14vg/dL	Within 3 months	Notify parents/guardians and obtain environmental history; provide health education & nutritional guidance. Report to local county health department.
15-19vg/dL	Within 2 months	Same as above; screen siblings and household members under age 6.
20-44vg/dL	Within 1 month	Same as above; conduct medical evaluation and history.
45-69 vg/dL	Within 48 hours	Same as above; assess for lead poisoning symptoms; consider Succimer treatment.
70 vg/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 in Miami-Dade County • Epidemiology, Disease Control and Immunization Services
8600N.W. 17th Street, Suite 200
Miami, Florida 33126
PHONE: 305/470-5660 • FAX: 305/470-5533
Miamidade.floridahealth.gov

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: _____
_____

Patient Identification (record all dates as mm/dd/yyyy)

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (ex: Alias, Married)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street		Address Date __ __/__ __/__ __ __ __
*Phone ( ) _____	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type		* Number

Social Security

U.S. Department of Health & Human Services

Adult HIV Confidential Case Report Form

(Patients ≥13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Centers for Disease Control and Prevention

Form approved OMB no. 0920-0573 Exp. 06/30/2019

Health Department Use Only (record all dates as mm/dd/yyyy)

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID _____	State Number _____
Reporting Health Dept - City/County		City/County Number
Document Source _____	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown	
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field Visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic Transfer ☐ 6-CD/Disk	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ( ) _____
*Street Address			
City	County	State/Country	* ZIP Code
Facility Type	*Inpatient*: ☐ Hospital ☐ Other, specify _____	*Outpatient*: ☐ Private Physician's Office ☐ Adult HIV Clinic ☐ Other, specify _____	*Screening, Diagnostic, Referral Agency*: ☐ CTS ☐ STD Clinic ☐ Other, specify _____	*Other Facility*: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____
Date Form Completed __ __/__ __/__ __ __ __	*Person Completing Form		*Phone ( ) _____

Patient Demographics (record all dates as mm/dd/yyyy)

Sex assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US Dependency (please specify) _____
Date of Birth __ __/__ __/__ __ __ __	Alias Date of Birth __ __/__ __/__ __ __ __
Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __/__ __/__ __ __ __	State of Death _____
Current Gender Identity	☐ Male ☐ Female ☐ Transgender Male-to-Female (MTF) ☐ Transgender Female-to-Male (FTM) ☐ Unknown ☐ Additional gender identity (specify) _____
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity _____
Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race _____

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Type (Check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at AIDS diagnosis ☐ Check if SAME as Current Address			
*Street Address			Address Date __ __/__ __/__ __ __ __
City	County	State/Country	*ZIP Code

STATE/LOCAL USE ONLY

*Provider Name (Last, First, M.I.)

_____ *Phone ( ) _____

Hospital/Facility

_____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (Check all that apply to facility below) ☐ HIV ☐ AIDS ☐ Check if SAME as Facility Providing Information

Facility Name	***Phone** ( ) _____
***Street Address**	

City	**County**	**State/Country**	***ZIP Code**

Facility Type

Inpatient: ☐ Hospital ☐ Other, specify _____

Outpatient: ☐ Private Physician's Office ☐ Adult HIV Clinic ☐ Other, specify _____

Screening, Diagnostic, Referral Agency: ☐ CTS ☐ STD Clinic ☐ Other, specify _____

Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Provider Name**	***Provider Phone** ( ) _____	**Specialty**

Patient History (respond to all questions) (record all dates as mm/dd/yyyy) ☐ Pediatric risk (please enter in Comments)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:	
Sex with male	☐ Yes ☐ No ☐ Unknown
Sex with female	☐ Yes ☐ No ☐ Unknown
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/ coagulation disorder — Specify clotting factor: Date received (mm/dd/yyyy):__ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received __ __ /__ __ /__ __ __ __ Last date received __ __ /__ __ /__ __ __ __	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting: _____	☐ Yes ☐ No ☐ Unknown
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Laboratory Data (record additional tests and tests not specified below in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Non-differentiating)

TEST 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

TEST 2: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB
Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

HIV Immunoassays (Differentiating)

☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT*: HIV-1 Ag
☐ Reactive ☐ Nonreactive ☐ Not Reported
Collection Date: __ __ /__ __ /__ __ __ __

HIV-Ab
☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
*Select one result for HIV-1 Ag *and* one result for HIV Ab

HIV Detection Tests (Qualitative)

TEST: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis

TEST 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

First CD4 result <200 cells/µL or <14%: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Other CD4 result: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm: __ __ /__ __ /__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? ☐ Yes ☐ No ☐ Unknown
If YES, provide date of diagnosis: __ __ /__ __ /__ __ __ __

Date of last documented negative HIV test (before HIV diagnosis date): __ __ /__ __ /__ __ __ __ Specify type of test: _____

Clinical (record all dates as mm/dd/yyyy)

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary†	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary†	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoma, Burkitt's (or equivalent)		Pneumonia, recurrent, in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, immunoblastic (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, primary in brain		Salmonella septicemia, recurrent	
Cytomegalovirus retinitis (with loss of vision)		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary		Toxoplasmosis of brain, onset at >1 mo. of age	
HIV encephalopathy				Wasting syndrome due to HIV	

†If TB selected above, indicate RVCT Case Number:

Treatment/Services Referrals (record all dates as mm/dd/yyyy)

Has this patient been informed of his/her HIV 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

For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services: ☐ Yes ☐ No ☐ Unknown

Is this patient currently pregnant?
☐ Yes ☐ No ☐ Unknown

Has this patient delivered live-born infants?
☐ Yes ☐ No ☐ Unknown

For Children of Patient (record most recent birth in these boxes; record additional or multiple births in Comments)

*Child's Name

Child's Last Name Soundex

Child's Date of Birth __ __/__ __/__ __ __ __

*Child's Coded ID

Child's State Number

Facility Name of Birth (if child was born at home, enter "home birth")

*Phone ( ) _____

Facility Type

Inpatient:
☐ Hospital
☐ Other, specify _____

Outpatient:
☐ Other, specify _____

Other Facility: ☐ Emergency Room ☐ Corrections ☐ Unknown
☐ Other, specify _____

*ZIP Code

*Street Address

City

County

State/Country

HIV Antiretroviral Use History (record all dates as mm/dd/yyyy)

Main source of antiretroviral (ARV) use information (select one):
☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E ☐ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever taken any ARVs? ☐ Yes ☐ No ☐ Unknown

If yes, reason for ARV use (select all that apply):

☐ HIV Tx	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
☐ PrEP	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
☐ PEP	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
☐ PMTCT	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
☐ HBV Tx	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __
☐ Other_____			
	ARV medications: _____	Date began: __ __/__ __/__ __ __ __	Date of last use: __ __/__ __/__ __ __ __

HIV Testing History (record all dates as mm/dd/yyyy)

Main source of testing history information (select one):
☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E ☐ Other

Date patient reported information __ __/__ __/__ __ __ __

Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Unknown

Date of first positive HIV test __ __/__ __/__ __ __ __

Ever had a negative HIV test? ☐ Yes ☐ No ☐ Unknown

Date of last negative HIV test *(If date is from a lab test with test type, enter in Lab Data section)* __ __/__ __/__ __ __ __

Number of negative HIV tests within 24 months before first positive test # _____ ☐ Unknown

Comments

☐ Check OOS State: _____

*Local/Optional Fields

PRISM #

DOC #

Link with e-HARS stateno(s):

Other Risks: A ___ B/C ___ D ___ F ___ M ___ V ___ J ___

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) _____ Source Code A _____

If pregnant, list EDD (due date) ___/___/___

Patient Identification (record all dates as mm/dd/yyyy)

*First Name	*Middle Name	*Last Name	Last Name Soundex
Alternate Name Type (ex: Birth, Call Me)	*First Name	*Middle Name	*Last Name
Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Address, Street		Address Date __ __/__ __/__ __ __ __
*Phone ( ) _____	City	County	State/Country	*ZIP Code
*Medical Record Number	*Other ID Type SOCIAL SECURITY	*Number	

U.S. Department of Health & Human Services

Pediatric HIV Confidential Case Report Form

(Patients <13 Years of Age at Time of Diagnosis) * Information NOT transmitted to CDC

Centers for Disease Control and Prevention

Form approved OMB no. 0920-0573 Exp. 06/30/2019

Health Department Use Only (record all dates as mm/dd/yyyy)

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID _____	State Number _____
Reporting Health Dept - City/County	City/County Number	
Document Source _____	Surveillance Method ☐ Active ☐ Passive ☐ Follow up ☐ Reabstraction ☐ Unknown	
Did this report initiate a new case investigation? ☐ Yes ☐ No ☐ Unknown	Report Medium ☐ 1-Field Visit ☐ 2-Mailed ☐ 3-Faxed ☐ 4-Phone ☐ 5-Electronic Transfer ☐ 6-CD/Disk	

Facility Providing Information (record all dates as mm/dd/yyyy)

Facility Name			*Phone ( ) _____
*Street Address			
City	County	State/Country	*ZIP Code
Facility Type	*Inpatient:* ☐ Hospital ☐ Other, specify _____	*Outpatient:* ☐ Private Physician's Office ☐ Pediatric Clinic ☐ Pediatric HIV Clinic ☐ Other, specify _____	*Other Facility:* ☐ Emergency Room ☐ Laboratory ☐ Unknown ☐ Other, specify _____
Date Form Completed __ __/__ __/__ __ __ __	*Person Completing Form		*Phone ( ) _____

Patient Demographics (record all dates as mm/dd/yyyy)

Diagnostic Status at Report ☐ 3-Perinatal HIV Exposure ☐ 4-Pediatric HIV ☐ 5-Pediatric AIDS ☐ 6-Pediatric Seroreverter	Sex assigned at Birth ☐ Male ☐ Female ☐ Unknown	Country of Birth ☐ US ☐ Other/US Dependency (please specify) _____
Date of Birth __ __/__ __/__ __ __ __	Alias Date of Birth __ __/__ __/__ __ __ __	
Vital Status ☐ 1-Alive ☐ 2-Dead	Date of Death __ __/__ __/__ __ __ __	State of Death _____
Date of Last Medical Evaluation __ __/__ __/__ __ __ __	Date of Initial Evaluation for HIV __ __/__ __/__ __ __ __	
Ethnicity ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown	Expanded Ethnicity _____	
Race (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Unknown	Expanded Race _____	

Residence at Diagnosis (add additional addresses in Comments) (record all dates as mm/dd/yyyy)

Address Type (Check all that apply to address below)	☐ Residence at HIV diagnosis	☐ Residence at AIDS diagnosis	☐ Residence at Perinatal Exposure	☐ Residence at Pediatric Seroreverter	☐ Check if SAME as Current Address
* Street Address					Address Date __ __/__ __/__ __ __ __
City	County	State/Country			*ZIP Code

STATE/LOCAL USE ONLY

*Provider Name (Last, First, M.I.)

_____ *Phone ( ) _____

Hospital/Facility _____

Facility of Diagnosis (add additional facilities in Comments)

Diagnosis Type (Check all that apply to facility below) ☐ HIV ☐ AIDS ☐ Perinatal Exposure ☐ Check if SAME as Facility Providing Information

Facility Name			***Phone** ( ) _____
***Street Address**			
City	**County**	**State/Country**	***ZIP Code**

Facility Type
Inpatient: ☐ Hospital ☐ Other, specify _____
Outpatient: ☐ Private Physician's Office ☐ Pediatric Clinic ☐ Pediatric HIV Clinic ☐ Other, specify _____
Other Facility: ☐ Emergency Room ☐ Laboratory ☐ Unknown ☐ Other, specify _____

***Provider Name**	***Provider Phone** ( ) _____	**Specialty**

Patient History (respond to all questions) (record all dates as mm/dd/yyyy)

Child's biological mother's HIV infection status (select one): ☐ Refused HIV testing ☐ Known to be uninfected after this child's birth ☐ Known HIV+ before pregnancy ☐ Known HIV+ during pregnancy ☐ Known HIV+ sometime before birth ☐ Known HIV+ at delivery ☐ Known HIV+ after child's birth ☐ HIV+, time of diagnosis unknown ☐ HIV status unknown

Date of mother's first positive HIV confirmatory test: __ __ /__ __ /__ __ __ __	Was the biological mother counseled about HIV testing during this pregnancy, labor, or delivery? ☐ Yes ☐ No ☐ Unknown

After 1977 and before the earliest known diagnosis of HIV infection, this child's biological mother had:	
Perinatally acquired HIV infection	☐ Yes ☐ No ☐ Unknown
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Biological Mother had HETEROSEXUAL relations with any of the following:	
HETEROSEXUAL contact with intravenous/injection drug user	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with bisexual male	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with hemophilia/coagulation disorder with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transfusion recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with transplant recipient with documented HIV infection	☐ Yes ☐ No ☐ Unknown
HETEROSEXUAL contact with person with documented HIV infection, risk not specified	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received ___ ___ / ___ ___ / ___ ___ ___ ___ Last date received ___ ___ / ___ ___ / ___ ___ ___ ___	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Before the diagnosis of HIV infection, this child had:	
Injected non-prescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/ coagulation disorder Specify clotting factor: Date received: ___ ___ / ___ ___ / ___ ___ ___ ___	☐ Yes ☐ No ☐ Unknown
Received transfusion of blood/blood components (other than clotting factor) (document reason in Comments) First date received ___ ___ / ___ ___ / ___ ___ ___ ___ Last date received ___ ___ / ___ ___ / ___ ___ ___ ___	☐ Yes ☐ No ☐ Unknown
Received transplant of tissue/organs	☐ Yes ☐ No ☐ Unknown
Sexual contact with male	☐ Yes ☐ No ☐ Unknown
Sexual contact with female	☐ Yes ☐ No ☐ Unknown
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

Laboratory Data (record additional tests and tests not specified in Comments) (record all dates as mm/dd/yyyy)

HIV Immunoassays (Non-differentiating)

TEST 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

TEST 2: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB

Test Brand Name/Manufacturer:_____

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

HIV Immunoassays (Differentiating)

☐ HIV-1/2 Type-differentiating (Differentiates between HIV-1 Ab and HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab-differentiating (Differentiates between HIV Ag and HIV Ab)
Test Brand Name/Manufacturer:_____

RESULT: ☐ Ag reactive ☐ Ab reactive ☐ Both (Ag and Ab reactive) ☐ Neither (negative) ☐ Invalid/Indeterminate
Collection Date: __ __ /__ __ /__ __ __ __ ☐ Rapid Test (*check if rapid*)

☐ HIV-1/2 Ag/Ab and Type-differentiating (Differentiates among HIV-1 Ag, HIV-1 Ab, HIV-2 Ab)
Test Brand Name/Manufacturer:_____

RESULT*: HIV-1 Ag
☐ Reactive ☐ Nonreactive ☐ Not Reported
Collection Date: __ __ /__ __ /__ __ __ __

HIV-Ab
☐ HIV-1 Reactive ☐ HIV-2 Reactive ☐ Both Reactive, Undifferentiated ☐ Both Nonreactive
*Select one result for HIV-1 Ag *and* one result for HIV Ab

HIV Detection Tests (Qualitative)

TEST: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

RESULT: ☐ Positive/Reactive ☐ Negative/Nonreactive ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Quantitative viral load) Note: Include earliest test at or after diagnosis

TEST 1: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Quantitative viral load) ☐ HIV-2 RNA/DNA NAAT (Quantitative viral load)

RESULT: ☐ Detectable ☐ Undetectable **Copies/mL:** _____ **Log:** _____ **Collection Date:** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

First CD4 result <200 cells/µL or <14%: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Other CD4 result: CD4 count: _____cells/µL **CD4 percentage:** ____% **Collection Date:** __ __ /__ __ /__ __ __ __

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm: __ __ /__ __ /__ __ __ __
Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, viral load, or qualitative NAAT [RNA or DNA]

If laboratory tests were not documented, is patient confirmed by a physician as:
HIV-Infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis:** __ __ /__ __ /__ __ __ __
Not HIV-Infected ☐ Yes ☐ No ☐ Unknown **Date of diagnosis:** __ __ /__ __ /__ __ __ __

Clinical (record all dates as mm/dd/yyyy)

Diagnosis	Dx Date	Diagnosis	Dx Date	Diagnosis	Dx Date
Bacterial infection, multiple or recurrent (including Salmonella septicemia)		HIV encephalopathy		Mycobacterium avium complex or M. kansasii, disseminated or extrapulmonary	
Candidiasis, bronchi, trachea, or lungs		Herpes simplex: chronic ulcers (>1 mo. duration), bronchitis, pneumonitis, or esophagitis		M. tuberculosis, pulmonary†	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary†	
Carcinoma, invasive cervical		Isosporiasis, chronic intestinal (>1 mo. duration)		Mycobacterium, of other/unidentified species, disseminated or extrapulmonary	
Coccidioidomycosis, disseminated or extrapulmonary		Kaposi's sarcoma		Pneumocystis pneumonia	
Cryptococcosis, extrapulmonary		Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia		Pneumonia, recurrent in 12 mo. period	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		Lymphoma, Burkitt's (or equivalent)		Progressive multifocal leukoencephalopathy	
Cytomegalovirus disease (other than in liver, spleen, or nodes)		Lymphoma, immunoblastic (or equivalent)		Toxoplasmosis of brain, onset at >1 mo. of age	
Cytomegalovirus retinitis (with loss of vision)		Lymphoma, primary in brain		Wasting syndrome due to HIV	

†If TB selected above, indicate RVCT Case Number:

Birth History (for Perinatal Cases only)

Residence at Birth

Birth History Available ☐ Yes ☐ No ☐ Unknown | ☐ Check if SAME as Current Address

*** Street Address** | **City**

County | **State/Country** | ***ZIP Code**

Facility of Birth

☐ Check if SAME as Facility Providing Information

Facility Name of Birth (if child was born at home, enter "home birth") | ***Phone** ( ) _____ | ***ZIP Code**

Facility Type *Inpatient:* ☐ Hospital ☐ Other, specify _____ *Outpatient:* ☐ Other, specify _____ *Other Facility*: ☐ Emergency Room ☐ Corrections ☐ Unknown ☐ Other, specify _____

***Street Address** | **City** | **County** | **State/Country**

Birth History

Birth Weight _____ lbs _____ oz _____ grams | **Type** ☐ 1-Single ☐ 2-Twin ☐ 3->2 ☐ 9-Unknown | **Delivery** ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Non-Elective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown

Birth Defects ☐ Yes ☐ No ☐ Unknown | **If yes, please specify:**

Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ Unknown | **Neonatal Gestational Age in Weeks:** _____ (99–Unknown)

Gestational Month Prenatal Care Began _____ (00-None, 99-Unknown) | **Prenatal Care – Total number of prenatal care visits:** _____ (00-None, 99-Unknown)

Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ Unknown | **If yes, please specify all:**

Maternal Information

Maternal DOB | **Maternal Last Name Soundex** | **Maternal Stateno** | **Maternal Country of Birth**

***Other Maternal ID – List Type** | **Number**

Services Referrals (record all dates as mm/dd/yyyy)

This child received or is receiving:

Neonatal ARVs for HIV prevention: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

If Yes, please specify: 1) 2) 3) 4) 5)

Anti-retroviral therapy for HIV treatment: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

PCP Prophylaxis: ☐ Yes ☐ No ☐ Unknown **Date began:** __ __ /__ __ /__ __ __ __ **Date of last use:** __ __ /__ __ /__ __ __ __

Was this child breastfed? ☐ Yes ☐ No ☐ Unknown

This child's primary caretaker is: ☐ 1- Biological Parent ☐ 2- Other Relative ☐ 3- Foster/Adoptive parent, relative ☐ 4- Foster/Adoptive parent, unrelated ☐ 7- Social Service Agency ☐ 8- Other (please specify in comments) ☐ 9- Unknown

Comments

*Local/Optional Fields

Initials (3) _____ Source Code A _____

PRISM # NIR Status: NIR OP __ NIR OP Date ___/___/___

Link with e-HARS stateno(s): NIR CL __ NIR CL Date ___/___/___

Hepatitis: A ___ B ___ C ___ Other ___ UNKnown ___ NIR RE ___ NIR RE Date ___ / ___ / ___

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV. Information in CDC's National HIV Surveillance System that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

2017 Updated Immunization Recommendations

The **2017 Immunization Schedules** are now available online. Every year, the Advisory Committee on Immunization Practices (ACIP) develops recommendations for routine use of vaccines in children. When approved by the CDC Director, they become official CDC/HHS policy

Recommended Immunization Schedule for Children and Adolescents Aged 18 Years or Younger, UNITED STATES, 2017

Diphtheria and tetanus toxoids and acellular pertussis vaccine

- The diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP) footnote was revised to more clearly present recommendations following an inadvertently early administered fourth dose of DTaP.

- The tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap) footnote for vaccination of pregnant adolescents between gestational weeks 27–36 has been updated to reflect a preference for vaccination earlier during this period. Currently available data suggest that vaccinating earlier in the 27 through 36 week time period will maximize passive antibody transfer to the infant.

Hepatitis B vaccine

The Hepatitis B vaccine (HepB) footnote was revised to reflect that the birth dose of HepB should be administered within 24 hours of birth.

Haemophilus influenzae type B vaccine

Within the *Haemophilus influenzae* type b vaccine (Hib) footnote, Comvax was removed from the routine vaccination portion of footnote. This vaccine has been removed from the market, and all available doses have expired. Additionally, Hiberix has been added to the list of vaccines that may be used for the primary vaccination series.

Human papillomavirus vaccine

- A blue bar was added to the schedule for human papillomavirus vaccine (HPV) for children aged 9–10 years, indicating that persons in this age group may be vaccinated (even in the absence of a high-risk condition).The footnote for HPV vaccine has been updated to include the new 2-dose schedule for persons initiating the HPV vaccination series before age 15 years. Additionally, bivalent HPV vaccine has been removed from the schedule. This vaccine has been removed from the U.S. market, and all available vaccine doses have expired

Influenza vaccine

- Live attenuated influenza vaccine (LAIV) has been removed from the influenza row of the schedule.
- The influenza vaccine footnote has been updated to indicate that LAIV should not be used during the 2016-2017 influenza season

Meningococcal vaccine

- The 16-year age column of the schedule has been separated from the 17–18-year age column to highlight the need for a meningococcal conjugate vaccine booster dose at age 16 years.
- The meningococcal vaccines footnote has been updated to include recommendations for meningococcal vaccination of children with human immunodeficiency virus (HIV) infection and to reflect recommendations for the use of a 2-dose Trumenba (meningococcal B vaccine) schedule.

Pneumococcal vaccine

- Within the pneumococcal vaccine footnote, references to 7-valent pneumococcal conjugate vaccine (PCV7) have been removed. All healthy children who may have received PCV7 as part of a primary series have now aged out of the recommendation for pneumococcal vaccine

Recommended Immunization Schedules for Adults, UNITED STATES, 2017.

Changes to the schedule include:

Influenza

- LAIV should not be used during the 2016–2017 influenza season.
- Adults with a history of egg allergy who have only hives after exposure to egg should receive age-appropriate inactivated influenza vaccine (IIV) or recombinant influenza vaccine (RIV).
- Adults with a history of egg allergy with symptoms other than hives (e.g., angioedema, respiratory distress, lightheadedness, or recurrent emesis, or who required epinephrine or another emergency medical intervention) may receive age-appropriate IIV or RIV. The selected vaccine should be administered in an inpatient or outpatient medical setting and supervised by a health care provider who is able to recognize and manage severe allergic conditions.

Hep B

Adults with chronic liver disease, including, but not limited to, hepatitis C virus infection, cirrhosis, fatty liver disease, alcoholic liver disease, autoimmune hepatitis, and an alanine aminotransferase (ALT) or aspartate aminotransferase (AST) level greater than twice the upper limit of normal should receive a Hep B series.

HPV

- Adult females through age 26 years and adult males through age 21 years who have not received any HPV vaccine should receive a 3-dose series of HPV vaccine at 0, 1–2, and 6 months. Males aged 22 through 26 years may be vaccinated with a 3-dose series of HPV vaccine at 0, 1–2, and 6 months.
- Adult females through age 26 years and adult males through age 21 years (and males aged 22 through 26 years who may receive HPV vaccine) who initiated HPV vaccination series before age 15 years and received 2 doses at least 5 months apart are considered adequately vaccinated and do not need an additional dose of HPV vaccine.
- Adult females through age 26 years and adult males through age 21 years (and males aged 22 through 26 years who may receive HPV vaccine) who initiated HPV vaccination series before age 15 years and received only 1 dose, or 2 doses less than 5 months apart, are not considered adequately vaccinated and should receive 1 additional dose of HPV vaccine.

Meningococcal Disease

- Adults with anatomical or functional asplenia or persistent complement component deficiencies should receive a 2-dose primary series of MenACWY, with doses administered at least 2 months apart, and revaccinate every 5 years. They should also receive a series of MenB with either MenB-4C (2 doses administered at least 1 month apart) or MenB-FHbp (3 doses administered at 0, 1–2, and 6 months).
- Adults with HIV infection who have not been previously vaccinated should receive a 2-dose primary MenACWY vaccination series, with doses administered at least 2 months apart, and be revaccinated every 5 years. Those who previously received 1 dose of MenACWY should receive a second dose at least 2 months after the first dose. MenB is not routinely recommended for adults with HIV infection, because meningococcal disease in this population is caused primarily by serogroups C, W, and Y.
- Microbiologists who are routinely exposed to isolates of *Neisseria meningitidis* should receive 1 dose of MenACWY and be revaccinated every 5 years if the risk for infection remains, as well as either MenB-4C (2 doses administered at least 1 month apart) or MenB-FHbp (3 doses administered at 0, 1–2, and 6 months).
- Adults at risk because of a meningococcal disease outbreak should receive 1 dose of MenACWY if the outbreak is attributable to serogroup A, C, W, or Y; or, if the outbreak is attributable to serogroup B, either MenB-4C (2 doses administered at least 1 month apart) or MenB-FHbp (3 doses administered at 0, 1–2, and 6 months).
- Young adults aged 16 through 23 years (preferred age range is 16 through 18 years) who are healthy and not at increased risk for serogroup B meningococcal disease may receive either a 2-dose series of MenB-4C at least 1 month apart or a 2-dose series of MenB-FHbp at 0 and 6 months for short-term protection against most strains of serogroup B meningococcal disease.

FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

Report to: Josephine Gilbert, STD Surveillance Manager	**Report from:**
Florida Department of Health - Miami-Dade County	**Practice name:**
STD Prevention & Control Program	Address:
Secured Fax: (305) 575-3812 Phone: (305) 575-5430	Phone:

Patient Information

Name:	**Race**	**Reason for exam (visit):**
Date of birth (DOB):	☐ White ☐ Black/African American	
Sex: ☐ Male ☐ Female	☐ American Indian/Alaska Native	**Signs/symptoms:**
Address:	☐ Asian ☐ Native Hawaiian/Pacific Islander	
	☐ Other	**For females only**
Phone:	**Ethnicity**	**Pregnancy status:**
Social Security #:	☐ Hispanic ☐ Non-Hispanic	☐ Pregnant ☐ Not pregnant
Emergency contact name:		**If pregnant, estimated delivery date:**
Emergency contact phone:		**If unknown, last menstrual period:**

DO NOT FAX HIV/AIDS RESULTS ON THIS FORM. CONTACT HIV / AIDS SURVEILLANCE STAFF AT 305-470-69999

Chlamydia	Gonorrhea	Syphilis
Specimen collection date:	**Specimen collection date:**	**Specimen collection date:**
Result date:	**Result date:**	**RPR titer:**
Reporting laboratory:	**Reporting laboratory:**	**Reporting laboratory:**
Treatment (CDC Recommended)	**Treatment (CDC Recommended)**	**Confirmatory test type**
☐ Azithromycin 1g oral single dose	☐ Ceftriaxone 250mg single IM dose ***PLUS*** Azithromycin 1g oral single dose	☐ FTA-ABS ☐ IgG-EIA ☐ TP-AB
☐ Doxycycline 100mg oral 2 times per day for 7 days	☐ Ceftriaxone 250mg single IM dose ***PLUS*** Doxycycline 100mg oral 2 times per day for 7 days	☐ TP-PA ☐ Confirmatory not ordered
Treatment (CDC Alternative)	**Treatment (CDC Alternative)**	**Confirmatory test result**
☐ Erythromycin base 500mg oral 4 times per day for 7 days	☐ Cefixime 400mg oral single dose ***PLUS*** Azithromycin 1g oral single dose ***PLUS*** Test-of-cure 1 week	☐ Reactive ☐ Non-reactive ☐ N/A
☐ Erythromycin ethylsuccinate 800mg oral 4 times per day for 7 days	☐ Cefixime 400mg oral single dose ***PLUS*** Doxycycline 100mg oral 2 times per day for 7 days ***PLUS*** Test-of-cure in 1 week	**Previous RPR test date:**
☐ Levofloxacin 500mg oral one time per day for 7 days	☐ Azithromycin 2g oral single dose	**Previous RPR titer:**
☐ Ofloxacin 300mg oral 2 times per day for 7 days	☐ Other:	**Treatment (CDC Recommended)**
Treatment date:	**Treatment date:**	☐ Benzathine penicillin 2.4 MU IM single dose
Was Patient Contacted? Yes NO	Comments:	☐ Benzathine penicillin 7.2 MU total, administered as 3 doses of 2.4 MU IM at 1-week intervals
		☐ Other**:** Doxycycline 100mg oral 2 times per day ☐ For 14 days ☐ For 28 days
Comments:		Treatment date(s):
		Partner Information
		Name: DOB:
		Address:
		Phone:

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.

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, MSN, AGPCNP-BC
Director, TB Program

Florida HEALTH
Miami-Dade County

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

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

Language Spoken if NOT English: _____

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 ☐ Military ☐ 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

Florida HEALTH
Miami-Dade County

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

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

(11) Symptoms

☐ Asymptomatic ☐ Wt. Lost _____ Lbs. Over _____ (Amount / Months)

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

☐ Night Sweet ☐ 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 _____

Florida HEALTH
Miami-Dade County

Clinical Diagnosis Form for Tuberculosis

Patient _____, DOB:_____,
SSN _____, is under my care for the treatment of active tuberculosis. I plan to treat him/her until cured.

I have based the diagnosis on the following criteria: (**Check and complete all that apply**).

☐ Tuberculin skin test (Mantoux method):
Date Done: _____ Date Read:_____ Size:_____(mm)

☐ Cultures for Mycobacterium Tuberculosis (MTB):
- ☐ Negative for MTB Specimen: _____
- ☐ Not Done Reason: _____
- ☐ Unavailable Reason: _____

☐ Signs and Symptoms consistent with active TB that have improved after TB therapy was instituted: (**Check all that apply**).
- ☐ Productive cough lasting 3 or more weeks.
- ☐ Hoarseness lasting 3 or more weeks.
- ☐ Unplanned weight loss.
- ☐ Fever lasting more than one week.
- ☐ Night sweats lasting more than one week.
- ☐ Other: _____

☐ Chest radiograph consistent with active TB disease that has worsened without TB therapy or has improved after TB therapy was instituted.
- ☐ Initial CXR: Date: _____ Findings: _____
- ☐ Follow-up CXR: Date: _____ Findings: _____

☐ Patient improved on the following medications: (**Check all that apply**). (Patient must be on at least two anti-tuberculosis medications for the diagnosis of clinical TB).
☐ Isoniazid ☐ Rifampin ☐ Pyrazinamide ☐ Ethambutol ☐ Other_____

☐ Site of Disease (i.e. Lung, Lymph node, Meningeal, etc.) _____

☐ Date the Diagnosis was made by the provider: _____

Physician's name (Please print): _____
Physician's signature: _____
Office Address: _____
Phone Number: _____ Today's Date: _____

Florida HEALTH
Miami-Dade County

Provider Diagnosis Form for Tuberculosis

Patient, _____ DOB_____ SSN _____
is under my care for the treatment of active tuberculosis. I plan to treat him/her until cured.

I have based the diagnosis on the following criteria: (**Check and complete all that apply**).

☐ Tuberculin skin test (Mantoux method). Done Not Done
Date Done:_____ Date Read: Size: (mm)

☐ Signs and Symptoms consistent with active TB: (**Check all that apply**).
- ☐ Productive cough lasting 3 or more weeks.
- ☐ Hoarseness lasting 3 or more weeks.
- ☐ Recent unplanned weight loss.
- ☐ Fever lasting more than one week.
- ☐ Night sweats lasting more than one week.
- ☐ Other: _____

☐ Chest radiograph consistent with active TB disease.
- ☐ Initial CXR: Date:_____ Results:_____
- ☐ Follow-up CXR: Date:_____ Results:_____

☐ Tissue diagnosis (Pathology) consistent with TB infection.
Date:_____ Organ: _____
Results:_____

☐ MTD or other NAA (Nucleic Acid Amplification) test.
Date: _____ Results:_____

☐ History of TB disease and/or previous incomplete treatment for TB.

Year: _____ ***Treatment received:***

_____

☐ Site of Disease (i.e. Lung, Lymph node, Meningeal, etc.): _____

☐ Date the Diagnosis was made by the provider: _____

Physician's name (Please print): _____

Physician's signature: _____

Office Address: _____

Phone Number: _____ Today's Date:_____

Who Are We?

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

Our Mission:

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

Our Vision:

To be the healthiest state in the nation.

Epidemiology, Disease Control & Immunization Services

EDC-IS Office

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Florida Department of Health in Miami-Dade County

EDC-IS Programs

EDC-IS PROGRAMS

General Surveillance

General Surveillance is the core unit of Epidemiology, Disease Control and Immunization Services. This Program conducts public health surveillance and investigations and implements response activities in the event of a communicable disease outbreak. The purpose of this surveillance is to monitor and keep diseases under control and thus protect the community of Miami-Dade County. General Surveillance is also responsible for investigating animal bites and foodborne illness outbreaks.

Immunization Services

The Immunization Program provides immunizations 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.

Administration

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

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 disasters 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.

Applied Epidemiology & Research

The applied Epidemiology & Research Unit provides assistance in the areas of epidemiological 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 to the general public. In addition, the unit performs syndromic surveillance to detect potential public health threats early. The unit includes injury surveillance, health education and community health- related special research studies, etc..

Florida HEALTH
Miami-Dade County

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's 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.

HIV/AIDS Surveillance

HIV/AIDS Surveillance is the systematic collection, compilation, and analysis of HIV/AIDS morbidity data. Surveillance also involves the dissemination of HIV/AIDS data to concerned agencies and to the public.

Healthy Homes & Lead Poisoning Prevention Program

This program is responsible for raising awareness of environmental health risks in the home, increasing 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.*

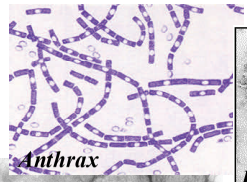
Fever and Rash Syndromes

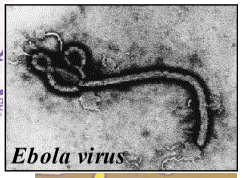
- ❖ An abrupt, influenza-like illness with fever, dizziness, myalgias, headache, nausea, abdominal pain, diarrhea and prostration. Evidence of "leaky capillary syndrome" with edema or signs of bleeding ranging from conjunctival hemorrhage, mild hypotension, flushing, petechiae, and ecchymoses to shock 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.*

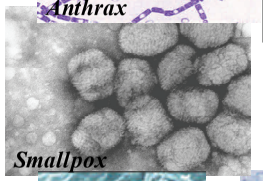
Paralytic Syndromes

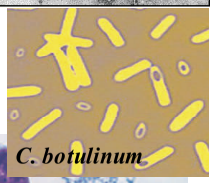
- ❖ A paralytic illness characterized by symmetric, descending flaccid paralysis of motor and autonomic nerves, usually beginning with the cranial nerves. *Consider botulism.*

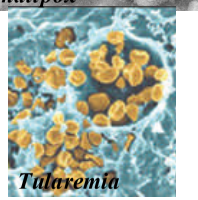
Bioterrorism Guide: Category A Agents

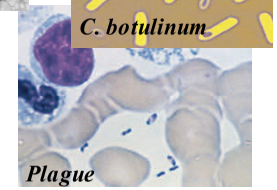












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Florida HEALTH
Miami-Dade County

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

Florida Department of Health in Miami-Dade County

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