2023

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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April 2023

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 by the next business day after diagnosis. However, please remember that HIV/AIDS reports should be mailed never faxed.

To better 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, AAHIVS
Director

Yesenia Villalta, DNP, MSN, APRN, Administrator/Health Officer

REPORTABLE NOTIFIABLE DISEASES/CONDITIONS CONTACT LIST- April 2023

Disease	Phone (O=Office, F=Fax)	Contact Person	Address
AFTER HOURS and WEEKENDS	305-470-5660 (O)	To reach on-call staff	
CONGENITAL ANOMALIES	850-617-1440 (O) 850-922-8473 (F)	Heather Lake-Burger, Manager	Florida Birth Defects Registry Florida Department of Health Division of Community Health Promotion, Public Health Research 4052 Bald Cypress Way, BIN# A12 Tallahassee, FL 32399
CANCER	305-243-4600 305-243-2625 (O)	Florida Cancer Data System Megsys C. Herna, BA, CTR, Data Acquisition Manager fcds.med.miami.edu	Florida Cancer Data System 1550 NW 10th Ave, Fox Bldg. Suite 410 Miami, Florida 33136
HIV/AIDS	305-470-6953 305-470-6984 (O) No fax reporting	Main Number Anthoni Llau, Surveillance	Dr. Rafael A. Peñalver Clinic AIDS Surveillance Unit 971 NW 2nd St Miami, Florida 33128
EPIDEMIOLOGY			Florida Department of Health in Miami-Dade County Epidemiology, Disease Control, and Immunization Services 1350 NW 14th St Miami, Florida 33126
Immunization	786-845-0550 305-470-5670 (O)	For Appointments Only Lydia Sandoval, RN, Program Manager Maria B. Martinez, RN	
Hepatitis	305-470-6820 (O)	Marie K. Etienne, RN, Program Manager	Florida Department of Health in Miami-Dade County Epidemiology, Disease Control, and Immunization Services 1350 NW 14th St, Annex Bldg. Miami, Florida 33126
Lead Poisoning	305-499-2082 (O)	Sandra Echeverry-Varona, MPA, BS, Program Manager	
Other Communicable Diseases/Conditions	305-470-5660 305-470-5533 (F)	Main Number Reynald Jean, MD, MPH, MSN, AGPCNP-BC, AAHIVS, Director Edhelene "Gigi" Rico, MPH, General Surveillance Alvaro Mejia-Echeverry, MD, MPH, Bioterrorism Had Die, Food and Waterborne Program	
SEXUALLY TRANSMITTED DISEASES	305-575-5423 305-575-5430 (O) 305-575-5429 (O) 305-575-3812 (F)	Main Number STD Surveillance Staff Josephine Gilbert, Surveillance Manager Secured Fax	Florida Department of Health in Miami-Dade County STD Surveillance Unit 1350 NW 14th Street, Suite 401 Miami, Florida 33125
TUBERCULOSIS	305-575-3800 305-575-5415 (O) 305-575-5418 (O) 305-575-5413 (O) 305-575-5402 (O) 305-575-3804 (F)	Main Number Oswaldo Curbelo, Health Services Manager Gina Bispham, RN, Assistant Director of Nursing Frantz Fils-Aime, MD, MPH, MSHIA, CEHP Reynald Jean, MD, MPH, MSN, AGPCNP-BC, AAHIVS, Program Director	Florida Department of Health in Miami-Dade County Tuberculosis Control & Prevention Program 1350 NW 14th Street Miami, Florida 33125

Reportable Diseases/Conditions in Florida

Practitioner List (Laboratory Requirements Differ)

Per Rule 64D-3.029, Florida Administrative Code, promulgated August 18, 2021

Florida Department of Health in Miami-Dade

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) 243-2625 (Tel)

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

Hepatitis (Viral) (305) 470-5660 (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) 470-5660 (Tel) (305) 470-5533 (Fax)

• Lead poisoning (blood lead level ≥3.5 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) 575-3804 (Fax)

• Tuberculosis

Epidemiology (305) 470-5660 (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
☎ Coronavirus disease (COVID-19)
• 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, novel or pandemic strain
☎ Influenza-associated pediatric mortality (in persons < 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 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 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
- ☐ ! Arboviral diseases not otherwise listed
- ☐ • Babesiosis
- ☐ ! Botulism; foodborne, wound, unspecified,
- ☐ • Botulism, infant
- ☐ ! Brucellosis
- ☐ • California serogroup virus disease
- ☐ • Campylobacteriosis
- ☐ • Carbon monoxide poisoning
- ☐ • Chikungunya fever
- ☐☎ Chikungunya fever, locally acquired
- ☐ ! Cholera (Vibrio cholerae type 01)
- ☐ • Ciguatera fish poisoning
- ☐☎ Coronavirus disease (COVID-19)
- ☐ • 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)
- ☐☎ 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 due to novel or pandemic strain
- ☐☎ Influenza-associated pediatric mortality (in persons < 18 yrs)
- ☐ • Lead poisoning (blood lead level >3.5µg/dL)
- ☐ • Legionellosis
- ☐ • Leptospirosis
- ☐☎ Listeriosis
- ☐ • Lyme Disease
- ☐ • Malaria
- ☐ ! Measles (Rubeola)
- ☐ ! Melioidosis
- ☐ • Meningitis (bacterial, cryptococcal, 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, paralytic and nonparalytic
- ☐ • Psittacosis (Ornithosis)
- ☐ • Q Fever
- ☐☎ Rabies (human, animal)
- ☐ ! Rabies (possible exposure)
- ☐ ! Ricin toxin poisoning
- ☐ • Rocky Mountain spotted fever and other spotted fever rickettsiosis
- ☐ ! Rubella (including congenital)
- ☐ • St. Louis encephalitis
- ☐ • Salmonellosis
- ☐ • Saxitoxin poisoning (paralytic shellfish poisoning)
- ☐ ! Severe acute respiratory disease syndrome associated with coronavirus infection
- ☐ • Shigellosis
- ☐ ! Smallpox
- ☐☎ Staphylococcus 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, cases, or exposure to an infectious or non-infectious disease, condition, or agent found in the general community or any defined setting school, other institution) not listed that is of urgent public health significance.

Comments:

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:

Updated: March 2018

CHILDHOOD LEAD POISONING REPORT FORM

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control and Immunization Services (EDC-IS)
1350 N.W. 14th Street, Annex Building Florida, 33125

The Florida Department of Health in Miami-Dade received a positive laboratory result that is listed in the *Table of Reportable Diseases or Conditions to Be Reported Rule 64D-3.0029, Florida Administrative Code (FAC)* on the following patient:

Patient name: _____ DOB: _____ Lab report date: _____

Please complete the sections below and return to confidential fax# (305) 470- 5533

Completing the information will supplement information provided for public health surveillance and Epidemiologic investigations as per Chapter 64D-3.030, *FAC*. HIPPA* does not change reporting obligations.

A. PATIENT DEMOGRAPHIC INFORMATION

Name of parent/guardian: _____

Relationship to child: _____ Phone Number: _____

Patient address: _____ City & State: _____ Zip code: _____

Phone number: _____ Emergency Phone number: _____

Gender: ☐Female ☐Male Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Unknown

Race: ☐ American Indian/Alaskan Native ☐Asian/Pacific Islander ☐Black ☐ White ☐Other: _____

Country of Birth: _____ Entry Date to US: _____

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

B. CLINICAL INFORMATION

Name of primary physician: _____

Physician Office: _____

Provider Address: _____

City: _____State: _____ Zip:_____

Provider Phone #: _____ Fax #: _____

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

Blood Lead Result: _____µg/dL

Sample Date: ____/____/____

Analyzed Date: ____/____/____

Lab Report Date: ____/____/____

Hemoglobin Test Result: _____ Date: _____

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

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

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

PLEASE ATTACH COPY OF LAB TEST RESULT

*HIPPA Section 45 CFR 160.203(c) and 45 CFR Section 164.512 (b)

Health Department use only: *Date:* _____ *Investigator:* _____ *Merlin#:*_____

Florida Lead Testing Reporting Requirements

Sections 381.982 – 381.985, Florida Statutes (F.S) require the Florida Department of Health (FDOH) to establish a lead screening program to promote the standard of care for lead poisoning case management.

In accordance with Florida Administrative Code rule 64 D-3.029, Florida Administrative Code (F.A.C.), health care providers and laboratories are required to report **ALL** blood lead level (BLL) results to FDOH.

- BLLs ≥ 3.5 µg/dL must be reported to FDOH by the **next business day**
- BLLs < 3.5 µg/dL produced by on-site blood lead analysis devices must be reported to FDOH **within 10 business days**

Health care providers are responsible for obtaining and providing patient demographic and contact information as well as BLL testing methos to the laboratories at the time the specimen is sent to or received by the laboratory.

Screening Methods and Recommendations

Provide a blood test to:

- **Targeted screening recommendations:** targeted testing based on established risk factors is recommended for most areas of the state. Recommendations focused on population most at risk in terms of age, socioeconomic states, age of housing and renovation status of home, refugee status, immigration status, and potential exposures in utero and during lactation.
- **Children enrolled in Medicaid:** All children enrolled in Medicaid are required to be screened for lead at ages 12 months and 24 months; any child between 24 and 72 months with no record of previous screening must also be screened.
- **Screening refugee populations:** Refugee children aged 6 months to 16 years should be screened upon entry into the United States. Screening should be repeated 3 to 6 months after placement in a permanent residence regardless of initial test results.
- **Additional screening should be strongly considered if children:**
  - Are < 6 years old and not previously screened
  - Live in a house built before 1978 or in a high-risk ZIP code where pre-1978 housing is prevalent
  - Enrolled in the Women, Infant and Children Supplemental Nutrition Program or Head Start
  - Have any of the risk factors in the Verbal Risk Assessment
  - Are adopted outside of the United States, in foster care, or are immigrants
  - Have known history of lead exposure after the age of 2 years old
  - Have a sibling or playmate with lead poisoning
  - Have parents requesting testing
  - Live near a lead-emitting facility
  - Live in housing built before 1978 or a home that was recently repaired or renovated
  - Are exhibiting neurodevelopmental disabilities or conditions such as autism, attention-deficit/hyperactivity disorder, and learning delays
  - Have a history of ingested non-food items or exhibit pica behavior

Blood Lead Level (µg/dL)	Follow-up test within	Later follow-up testing after BLL declining
≥ 3.5-9.9	3 months*	6-9 months
10.9-19.9	1-3 months*	3-6 months
20.9-24.9	1-3 months*	1-3 months
25.9-44.9	2 weeks-1 month	1 month
≥ 45	As soon as possible	Retest every 2 to 4 weeks (or more based on most recent BLLs)

*Health care providers may choose to repeat blood lead tests on all new patients within a month to ensure that their BLL is not rising more quickly than anticipated. Greater exposure in summer months may necessitate more frequent follow-ups.

Childhood Lead Poisoning Case Management Guidelines

General medical evaluation recommendations:

- Perform routine history and assessment of physical and mental development.
- Assess nutrition and risk for iron deficiency.
- Evaluate for lead exposure risks.
- Initial and routine test may be a capillary or venous test. Children with identified risk factors must be retested with a venous sample.

General clinical management recommendations:

- Notify parent or, caregiver by phone or letter.
- Report the blood lead result to your local county health department.
- Discuss result with family and counsel on any identified risk factors.
- Provide health education located at FloridaHealth.gov/environmental-health/lead-poisoning/educational-materials.html
- Counsel on healthy eating especially iron, calcium, and Vitamin C.
- Consider referral to Supplemental Nutrition Program for Women, Infants, and Children.

Medical Evaluation Recommendations and Testing	Case Management
BLL < 3.5 µg/dL	
General Medical evaluation recommendations (given above) **Who to screen?** • Medicaid recipients at 12 and 24 months, or any time before 6 years old if not previously screened. • Children in homes built before 1978 or with other risk factors (see FloridaHealth.gov/environmental-health/lead-poisoning). • Anyone < 21 years old when indicated by changed circumstances or at the request of a parent or guardian. • Follow-up with a venous blood lead level as indicated in the CDC schedule.	**General clinical management recommendations (given above)** **Chelation is NOT recommended in this blood lead level range.**
BLL 3.5-19.9 µg/dL	
General medical evaluation recommendations PLUS: • Note the child's environmental history. Identify potential sources of exposure and provide preliminary advice on reducing/eliminating them. • Ensure iron sufficiency with laboratory testing and treatment per American Academy of Pediatrics guidelines. • Perform structured developmental screening evaluations at periodic health visits as lead effects may manifest over years. • Evaluate risk to household contacts such as siblings and pregnant/lactating women in the home. **Monitor BLLs:** • Retest within 1–3 months until BLL declines. • If retest result is in another range, follow up as for that range. • If BLLs are stable or decreasing, monitor initially with venous BLLs every 3 months and thereafter based on venous BLL trend. If retest result is in another range, follow-up or retest as for that range.	**General clinical management recommendations PLUS:** • Assess the child's environmental risk factors, eating habits, housing, and family's social service needs. • If a past exposure is noted, perform developmental screenings at periodic health visits. Health effects of lead manifest over time. • Test for iron sufficiency. Consider starting a multivitamin tablet with iron. • Test siblings, other children younger than six years of age, and household contacts, especially pregnant and lactating women. • Make referrals to the local Children's Medical services office, if necessary. • Include primary/secondary residence and childcare facility as part of the investigation. • If BLL is persistent or rising, contact FDOH's Lead Poisoning Prevention Program at (850) 245-4401 for an environmental investigation and recommendations for remediation services. **Chelation is NOT recommended in this BLL range.**
BLL 20-44.9 µg/dL	
General medical evaluation recommendations **Monitor BLLs:** • Retest within 1 week to 1 month to ensure BLL is not rising. • Monitor monthly and afterward based on the BLL trend. If retest result is in another range, follow up as for that range. • Any treatment for BLLs in this range should be done in consultation with a toxicologist.	**General clinical management recommendations** **Chelation is NOT recommended in this BLL range.**

<table>
<tr><th colspan="2">BLL 45-69.9 µg/dL (Urgent Medical Situation)</th></tr>
<tr><td>General medical evaluation recommendations

Monitor BLLs:
• Retest within 48 hours.
• If confirmed in this range, monitor BLL’s during chelation.
• Retest every 2 to 4 weeks (or more based on most recent BLLs).
• Modify treatment guidelines if BLL remains elevated.
• Monitor frequently until BLL declines.</td><td>General clinical management recommendations PLUS:

• Evaluate whether hospitalization is needed to reduce lead exposure.

Consider chelation therapy
• Consult with a provider experienced in managing chelation therapy.
• Consider bowel decontamination as an adjunct to chelation if abdominal X-ray indicates enteral lead is present.
• Succimer can be prescribed.
• A minimum of two weeks between courses is recommended, unless more prompt treatment is indicated.
• Discontinue iron supplements.
• Monitor for anemia and neutropenia.

Post-Chelation Therapy Guidelines:
• Repeat venous lead test in 1 to 3 weeks after hospital discharge.
• Repeat venous lead test every two weeks for 6 to 8 weeks after hospital discharge.
• Monitor lead level closely for 4 to 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.</td></tr>
<tr><th colspan="2">BLL ≥ 70 µg/dL (Urgent Medical Situation)</th></tr>
<tr><td>General medical evaluation recommendations

Blood lead levels:
• Retest within 1 week to 1 month to ensure BLL is not rising.
• Monitor monthly and afterward based on the BLL trend. If retest result is in another range, follow up as for that range.
• Any treatment for BLLs in this range should be done in consultation with an expert.
• Refer to CDC and American Academy of Pediatrics recommendations related to chelation management.</td><td>General clinical management recommendations PLUS:

Follow chelation therapy and post-chelation therapy guidelines.</td></tr>
</table>

Lead Poisoning Verbal Risk Assessment Questionnaire

The Verbal Risk Assessment helps healthcare providers assess if a child, up to age 6, should be screened for lead poisoning if they do not meet targeted screening recommendations listed on page 4 of the 2022 Childhood Lead Poisoning Screening and Case Management Guide.

This assessment is to help determine if a child has been exposed to lead. Please circle **"Yes", "No" or "I don't know"** for each question.

If the answer to any question is **Yes** or **I Don't Know**, screen the child for lead.

In the past year, has your child lived in, near, or regularly visited:			
A house built before 1978 that has peeling, chipping, or flaking paint?	Yes	No	I don't know
A house built before 1978 that has been remodeled within the past 6 months?	Yes	No	I don't know
A sibling, cousin, or friend who has been diagnosed or treated for lead poisoning?	Yes	No	I don't know
A factory or industrial plant or mine?	Yes	No	I don't know
Mexico, India, Middle East, Central America, South America, Africa, or Asia?	Yes	No	I don't know
In the past year, has your child been around adults who:			
Hunt, fish, reload bullets, refinish furniture, stain glass, work with metal, or paint with fine artist paints?	Yes	No	I don't know
Work as plumbers, mechanics, metal/battery recycling, construction workers, miners, or welders?	Yes	No	I don't know
In the past year, has your child consumed:			
Food or beverages from ceramic cookware/dishware or imported pottery?	Yes	No	I don't know
Food with spices imported or brought in from another country (such as turmeric)?	Yes	No	I don't know
Candies from other countries containing tamarind or chili powder?	Yes	No	I don't know
Ayurvedic medicines or home remedies (such as Azarcón, Greta, Rueda, or Pay-loo-ah)?	Yes	No	I don't know
Dirt or non-food items regularly (more than the typical baby mouthing behavior)?	Yes	No	I don't know

If the answer to any question is **Yes** or **I don't know**, screen the child for lead.

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 **Race:** ____ American Indian/Alaskan Native **Ethnicity:**_____ Hispanic

____ Female ____ Asian or Pacific Islander ____ Non-Hispanic
____ Black
____ White

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 contact the Hepatitis Prevention Program at (305) 470-5660.

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

Comments: _____

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control & Immunization Services
1350 NW 14th Street, Annex Bldg, Miami, Florida 33125
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 the next business day following diagnosis. 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** ☐

If Yes or Postpartum, please complete Part III

Part III: Delivery Hospital Information Request

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: _____

If you have any additional questions or concerns, please contact the Hepatitis Prevention Program at (305) 470-5660.

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

Ron DeSantis
Governor

Joseph A. Ladapo, MD, PhD
State Surgeon General

Vision: To be the **Healthiest State** in the Nation

Hepatitis C Report Form

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

Part I: Demographics

Date: _____

Patient name:

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

Birthdate: _____ **Occupation**: _____

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

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

Sex: ____ Male
____ Female

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

Ethnicity: _____ Hispanic
____ Non-Hispanic

Clinical Information

Was patient **hospitalized for hepatitis**? …….. [Yes] [No] [Unk]
If yes, name of **hospital**: Date of Admission: Discharge:

_____ _____ _____

Was this patient diagnosed clinically with **acute** or **chronic** hepatitis C? …… ___ Acute ___ Chronic

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

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

_____

Has the patient had hepatitis A? ..... [Yes] [No] [Unk]
Has the patient received the **hepatitis A vaccine**? …… [Yes] [No] [Unk]
Dates? _____ Both doses? …… [Yes] [No] [Unk

Please Mark **Symptoms:**

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

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

Florida Department of Health in Miami-Dade County
Epidemiology, Disease Control & Immunization Services
1350 NW 14th Street, Annex Bldg, Miami, Florida 33125
PHONE: 305/470-5660 • FAX: 305/470-5533
Miamidade.floridahealth.gov

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 ☐ Military ☐ Other ☐ 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 and 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 (CDC)

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

Form approved OMB no. 0920-0573 Exp. 11/30/2022

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 Event Type (check all that apply to address below) ☐ Residence at HIV diagnosis ☐ Residence at stage 3 (AIDS) diagnosis ☐ Check if SAME as current address
Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary
*Street Address

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 ☐ Stage 3 (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 nonprescription drugs	☐ Yes ☐ No ☐ Unknown
Received clotting factor for hemophilia/coagulation disorder Specify clotting factor: Date received __ __/__ __/__ __ __ __	☐ 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)	☐ Yes ☐ No ☐ Unknown
First date received __ __/__ __/__ __ __ __ Last date received __ __/__ __/__ __ __ __	
Received transplant of tissue/organs or artificial insemination	☐ Yes ☐ No ☐ Unknown
Worked in a healthcare or clinical laboratory setting	☐ Yes ☐ No ☐ Unknown
If occupational exposure is being investigated or considered as primary mode of exposure, specify occupation and setting:	
Other documented risk (please include detail in Comments)	☐ Yes ☐ No ☐ Unknown

Clinical: Acute HIV Infection and Opportunistic Illnesses (record all dates as mm/dd/yyyy)

Suspect acute HIV infection? *If YES, complete the two items below; enter documented negative HIV test data in Laboratory Data section, and enter patient or provider report of previous negative HIV test in HIV Testing History section.*	☐ Yes ☐ No ☐ Unknown
Clinical signs/symptoms consistent with acute retroviral syndrome (e.g., fever, malaise/fatigue, myalgia, pharyngitis, rash, lymphadenopathy)? Date of sign/symptom onset __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown
Other evidence suggestive of acute HIV infection? *If YES, please describe:* Date of evidence __ __/__ __/__ __ __ __	☐ Yes ☐ No ☐ Unknown

Opportunistic Illnesses

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[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
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	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

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

HIV Immunoassays (Nondifferentiating)

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 _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

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 _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay** (differentiates between HIV-1 Ab and HIV-2 Ab) **Role of test in diagnostic algorithm** ☐ Screening/initial test ☐ Confirmatory/supplemental test
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity ☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate [1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index value** _____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test** [2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ 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)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
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)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified) **Test brand name/Manufacturer** _____
Lab name _____ **Facility name** _____
Provider name _____ **Collection Date** __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

First CD4 result <200 cells/μL or <14%: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

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 were positive for **HIV-1**: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.*

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:

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

Evidence of receipt of HIV medical care other than laboratory test result (select one; record additional evidence in Comments)
☐ 1-Yes, documented ☐ 2-Yes, client self-report, only Date of medical visit or prescription __ __/__ __/__ __ __ __

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 Date of Birth __ __/__ __/__ __ __ __

Child's Last Name Soundex

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 _____

***Street Address**

***ZIP Code**

City

County

State/Country

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 (specify reason)_____			
	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 the 24 months before the first positive test __ __ ☐ Unknown

Comments

☐ CHECK OOS STATE:_____ If pregnant, list EDD(due date): ___/___/_____

Link With e-HARS stateno(s):

***Local/Optional Fields**

STARS#_____

Other Risks: A☐B/C☐D☐F☐M☐V☐J☐O☐

Hepatitis: A☐B☐C☐Other☐Unknown☐

Test and Treat (Yes/No):

NIR STATUS:

NIR OP☐ Date___/___/_____

NIR CL☐ Date___/___/_____

NIR RE☐ Date___/___/_____

Initials(3)_____ Source code:_____

This report to 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).

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

*First Name	*Middle Name	*Last Name	Last Name Soundex

Alternate Name Type (example: Birth, Call Me)	*First Name	*Middle Name	*Last Name

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ 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 and Human Services

Pediatric HIV Confidential Case Report Form

(Patients aged <13 years at time of diagnosis) *Information NOT transmitted to CDC

Centers for Disease Control and Prevention (CDC)

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

Form approved OMB no. 0920-0573 Exp. 11/30/2022

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 Event Type (check all that apply to address below)	☐ Residence at HIV diagnosis	☐ Residence at stage 3 (AIDS) diagnosis	☐ Residence at perinatal exposure	☐ Residence at pediatric seroreverter	☐ Check if SAME as current address

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary

*Street Address

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 ☐ Stage 3 (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 test to confirm infection __ __ /__ __ /__ __ __ __	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 nonprescription 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
Biological mother had:	
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 nonprescription 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

Clinical: Opportunistic Illnesses (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[1]	
Candidiasis, esophageal		Histoplasmosis, disseminated or extrapulmonary		M. tuberculosis, disseminated or extrapulmonary[1]	
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		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	

[1]If a diagnosis date is entered for either tuberculosis diagnosis above, provide RVCT Case Number:

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

HIV Immunoassays (Nondifferentiating)

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 _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

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 _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

HIV Immunoassays (Differentiating)

☐ **HIV-1/2 type-differentiating immunoassay**
(differentiates between HIV-1 Ab and HIV-2 Ab)
Role of test in diagnostic algorithm
☐ Screening/initial test ☐ Confirmatory/supplemental test
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result[1] ***Overall interpretation***: ☐ HIV-1 positive ☐ HIV-2 positive ☐ HIV positive, untypable ☐ HIV-2 positive with HIV-1 cross-reactivity
☐ HIV-1 indeterminate ☐ HIV-2 indeterminate ☐ HIV indeterminate ☐ HIV negative
Analyte results: HIV-1 Ab: ☐ Positive ☐ Negative ☐ Indeterminate **Collection Date** __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**
HIV-2 Ab: ☐ Positive ☐ Negative ☐ Indeterminate
[1]Always complete the overall interpretation. Complete the analyte results when available.

☐ **HIV-1/2 Ag/Ab differentiating immunoassay** (differentiates between HIV Ag and HIV Ab)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Ag positive ☐ Ab positive ☐ Both (Ag and Ab positive) ☐ Negative ☐ Invalid
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**

☐ **HIV-1/2 Ag/Ab and type-differentiating immunoassay** (differentiates among HIV-1 Ag, HIV-1 Ab, and HIV-2 Ab)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result[2] ***Overall interpretation***: ☐ Reactive ☐ Nonreactive ☐ **Index value** _____
Analyte results: HIV-1 Ag: ☐ Reactive ☐ Nonreactive ☐ Not reportable due to high Ab level **Index value** _____
HIV-1 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
HIV-2 Ab: ☐ Reactive ☐ Nonreactive ☐ Reactive undifferentiated **Index value** _____
Collection Date __ __ /__ __ /__ __ __ __ ☐ **Point-of-care rapid test**
[2]Complete the overall interpretation and the analyte results.

HIV Detection Tests (Qualitative)

TEST ☐ HIV-1 RNA/DNA NAAT (Qualitative) ☐ HIV-1 culture ☐ HIV-2 RNA/DNA NAAT (Qualitative) ☐ HIV-2 culture
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Positive ☐ Negative ☐ 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)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
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)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Result ☐ Detectable ☐ Undetectable **Copies/mL** _____ **Log** _____ **Collection Date** __ __ /__ __ /__ __ __ __

Drug Resistance Tests (Genotypic)

TEST ☐ HIV-1 Genotype (Unspecified)
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____
Collection Date __ __ /__ __ /__ __ __ __

Immunologic Tests (CD4 count and percentage)

CD4 at or closest to diagnosis: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

First CD4 result <200 cells/μL or <14%: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

Other CD4 result: CD4 count _____ cells/μL **CD4 percentage** _____ % **Collection Date** __ __ /__ __ /__ __ __ __
Test brand name/Manufacturer _____ **Lab name** _____
Facility name _____ **Provider name** _____

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 were positive for **HIV-1**: Western blot, IFA, culture, viral load, qualitative NAAT (RNA or DNA), HIV-1/2 type-differentiating immunoassay (supplemental test), stand-alone p24 antigen, or nucleotide sequence.*

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** __ __ /__ __ /__ __ __ __

Birth History (for Perinatal Cases only)

Birth history available? ☐ Yes ☐ No ☐ Unknown

Residence at Birth ☐ Check if SAME as current address

Address Type ☐ Residential ☐ Bad address ☐ Correctional facility ☐ Foster home ☐ Homeless ☐ Military ☐ Other ☐ Postal ☐ Shelter ☐ Temporary

*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 ( )

Facility Type *Inpatient*: ☐ Hospital ☐ Other, specify_____ *Outpatient:* ☐ Other, specify_____ *Other Facility*: ☐ Emergency room ☐ Corrections ☐ Unknown ☐ Other, specify_____

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

Birth History **Birth Weight** ____lbs ____oz _____grams **Type** ☐ 1-Single ☐ 2-Twin ☐ 3-More than two ☐ 9-Unknown

Delivery ☐ 1-Vaginal ☐ 2-Elective Cesarean ☐ 3-Nonelective Cesarean ☐ 4-Cesarean, unknown type ☐ 9-Unknown

Birth Defects ☐ Yes ☐ No ☐ Unknown **If yes, specify types**

Neonatal Status ☐ 1-Full-term ☐ 2-Premature ☐ 9-Unknown **Neonatal Gestational Age in Weeks** (99 = Unknown, 00 = None)

Prenatal Care—Month of Pregnancy Prenatal Care Began (99 = Unknown, 00 = None)	Prenatal Care—Total Number of Prenatal Care Visits (99 = Unknown, 00 = None)

Did mother receive any antiretrovirals (ARVs) prior to this pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown Date began __ __/__ __/__ __ __ __ Date of last use __ __/__ __/__ __ __ __	If yes, specify all ARVs
Did mother receive any ARVs during pregnancy? ☐ Yes ☐ No ☐ Refused ☐ Unknown **Date began** __ __/__ __/__ __ __ __ **Date of last use** __ __/__ __/__ __ __ __	**If yes, specify all ARVs**
Did mother receive any ARVs during labor/delivery? ☐ Yes ☐ No ☐ Refused ☐ Unknown **Date began** __ __/__ __/__ __ __ __ **Date of last use** __ __/__ __/__ __ __ __	**If yes, specify all ARVs**

Maternal Information	Maternal DOB __ __/__ __/__ __ __ __	Maternal Last Name Soundex
Maternal State ID Number	**Maternal Country of Birth**	

***Other Maternal ID (specify type of ID and ID number)**

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

This child 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 (specify reason)_____	ARV medications _____	Date began __ __/__ __/__ __ __ __	Date of last use __ __/__ __/__ __ __ __

Has this child ever taken 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

CHECK OOS STATE: _____

*Local/Optional Fields

NIR STATUS:

STARS#	NIR RE☐ Date___/___/_____
Link with e-HARS stateno (s):	NIR CL☐ Date___/___/_____
Hepatitis: A☐ B☐ C☐ Other☐ Unknown☐	NIR OP☐ Date___/___/_____
	Initials(3)_____ Source code:_____

2023 Updated Immunization Recommendations

The **2023 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, 2023

COVID-19 vaccine

A new row has been added with the columns for age 6 months–18 years highlighted in yellow to indicate the recommended age for COVID-19 vaccination. The overlying text "2- or 3-dose primary series and booster (See Notes) has also been added.

A new section was added to provide additional details on the use of COVID-19 vaccines. The routine vaccination section describes the recommendations for primary series in the general population, and the special situations section describes the recommendations for primary series in persons who are moderately or severely immunocompromised. For booster dose vaccination in all populations, and guidance for Janssen (Johnson & Johnson) COVID-19 vaccine recipients, hyperlinks are included referring health care providers to the latest guidance. In addition, hyperlinks to the current COVID-19 vaccination schedules, use of COVID-19 preexposure prophylaxis in persons who are moderately or severely immunocompromised, as well as Emergency Use Authorization indications for COVID-19 vaccines, have been added.

Dengue vaccine

A new bullet was added to clarify that dengue vaccine should not be administered to children traveling to or visiting endemic dengue areas. Language was added stating that lack of laboratory confirmation of previous dengue virus infection is a contraindication.

Hepatitis B vaccine

The language in the routine vaccination section was revised to highlight the recommendations for infants born to mothers who have received positive test results for hepatitis B surface antigen (HBsAg), or whose HBsAg status is unknown. In addition, the catch-up vaccination section was updated to include Heplisav-B and PreHevbrio vaccines for persons aged 18 years.

Language was added to the contraindicated or not recommended column stating that Heplisav-B and PreHevbrio are not recommended during pregnancy; other HepB products should be used if vaccination is indicated. A footnote providing information on the pregnancy exposure registries for persons who were inadvertently vaccinated with Heplisav-B or PreHevbrio while pregnant was added.

Human papillomavirus (HPV) vaccine

Language was added to the contraindicated or not recommended column stating that HPV is not recommended during pregnancy.

Influenza vaccine

The note has been updated to reflect the recommendations for the 2022–23 influenza season. Language was added to the "Special situations" section to clarify that live attenuated influenza vaccine should not be administered to close contacts of immunosuppressed persons who require a protected environment. In addition, the language for persons with egg allergy with symptoms other than hives was moved from the appendix to the "Special situations" section.

In the precautions for egg-based inactivated and live attenuated vaccines, the language for persons with egg allergy with symptoms other than hives has been moved to the Notes section.

Measles, mumps, and rubella (MMR) vaccine

The "Special situations" section was updated to include recommendations for additional MMR doses in a mumps outbreak setting. Measles, mumps, rubella, and varicella virus vaccine (MMRV) was added. In addition, language was added to the precautions stating that a personal or family history of seizure of any etiology is a precaution for using MMRV.

Measles, mumps, rubella, and varicella virus vaccine (MMRV) was added to the Contraindications and Precautions table in the appendix. In addition, language was added to the precautions stating that a personal or family history of seizure of any etiology is a precaution for using MMRV.

Meningococcal vaccines

• MenACWY

Language clarifying that the newly licensed Menveo one-vial (all liquid) formulation should not be administered before age 10 years was added.

• MenB

The "Special situations" section was updated to include the recommendations for situations in which the second or third dose of Trumenba is administered earlier or later than the recommended minimum interval. If the second dose is administered ≥6 months after the first dose, then the third dose is not needed. If the third dose is administered earlier than 4 months after the second dose, a fourth dose should be administered ≥4 months after the third dose.

Pneumococcal vaccine

The routine vaccination, catch-up vaccination, and "Special situations" sections have been updated with the recommendations for use of PCV15. In addition, language was added stating that 13-valent pneumococcal conjugate vaccine (PCV13) and PCV15 can be used interchangeably in both healthy children and those with any risk for invasive pneumococcal disease. In addition, a hyperlink to the CDC app that can be used to determine a patient's pneumococcal vaccination needs has been included.

Language for the minimum interval between doses 3 and 4 has been revised to clarify when a fourth dose is indicated. The text now reads "This dose is only necessary for children aged 12–59 months regardless of risk, or aged 60–71 months with any risk, who received 3 doses before age 12 months."

Poliovirus vaccine

A new "Special situations" section was created to describe the use of IPV in persons aged 18 years who are at increased risk for exposure to polioviruses.

Varicella vaccine

Language was added stating that if MMRV is used, the precautions for MMR/MMRV should be reviewed.

Recommended Immunization Schedules for Adults, UNITED STATES, 2023.

Covid-19 vaccine

The COVID-19 vaccine row is a new addition to the tables this year. The color of this row is yellow, indicating that COVID-19 vaccination is now routinely recommended for all adults. The text overlay states, “2- or 3-dose primary series and booster.

The text overlay for the immunocompromised and HIV infection columns states, “See Notes,” referring providers to the notes for specific recommendations for this population.

A new section was added to provide additional details for use of COVID-19 vaccines. The “Routine vaccination” section describes the primary series recommendations for the general population. The “Special situations” section describes the primary series recommendations for persons who are moderately or severely immunocompromised. Hyperlinks have been provided referring health care providers to the latest guidance for booster dose recommendations in both populations, and to the recommendation for persons who received the Janssen (Johnson & Johnson) COVID-19 vaccine. Additionally, hyperlinks to the current COVID-19 vaccination schedules, use of COVID-19 preexposure prophylaxis in persons who are moderately or severely immunocompromised, as well as Emergency Use Authorization indications for COVID-19 vaccines, have been added.

Hepatitis A vaccine

In the Routine Immunization Schedule and the Immunization by Medical Indication Schedule, the overlaying text has been updated to “2, 3, or 4 doses depending on vaccine,” to account for the possibility of an accelerated Twinrix series requiring 4 doses.

Hepatitis B vaccine

In the “Routine vaccination” section, PreHevbrio was added to the description of the 3-dose series, and information on the 4-dose series for persons on hemodialysis was moved to the “Special situations” section. HepB vaccination continues to be universally recommended for all adults aged 19–59 years. Language has been added stating that persons aged ≥60 years with known risk factors for hepatitis B virus infection should complete a HepB vaccination series, whereas persons aged ≥60 years without known risk factors for hepatitis B virus infection may complete a HepB vaccination series.

The language regarding the use of Heplisav-B and PreHevbrio in pregnant persons was modified. The language now states that “Heplisav-B and PreHevbrio are not recommended because of lack of safety data in pregnant persons. Use other hepatitis B vaccines if HepB is indicated.” A footnote providing information on the pregnancy exposure registries for persons who were inadvertently vaccinated with Heplisav-B and PreHevbrio while pregnant was added.

Human papillomavirus (HPV) vaccine

The language regarding the use of human papillomavirus (HPV) vaccination among pregnant persons was modified. The language now states, “pregnancy: HPV vaccination not recommended.”

Influenza vaccine

Information was added to the routine vaccination section for persons aged ≥65 years stating that any one of quadrivalent high-dose inactivated influenza vaccine, quadrivalent recombinant influenza vaccine, or quadrivalent adjuvanted inactivated influenza vaccine is preferred for this age group. A hyperlink to the 2022–23 influenza recommendations and a bullet for the 2023–24 influenza recommendations were added. In the “Special situations” section, guidance for close contacts of severely immunocompromised patients who require a protected environment was added. In addition, the text describing guidance for persons with egg allergy who have experienced any symptom other than hives was moved from the appendix to the “Special situations” section.

The information for persons with history of egg allergy was moved from the precautions column to the influenza vaccination notes section.

Measles, mumps, and rubella (MMR) vaccine

Overlaying text has been added to the column for persons aged ≥65 years referring providers to the notes for vaccination considerations for health care personnel in this age group.

In the “Special situations” section, a hyperlink was provided that describes the recommendation for additional doses of MMR vaccine (including the third dose of MMR vaccine) in the context of a mumps outbreak setting.

Meningococcal vaccine

In the "Special situations" section for meningococcal serogroup B vaccine, guidance was added stating that if the third dose of Trumenba is administered earlier than 4 months after the second dose, a fourth dose should be administered ≥4 months after the third dose.

Pneumococcal vaccine

The section has been substantially updated to reflect ACIP's new recommendations for the use of PCV15 and PCV20 in persons who previously received pneumococcal vaccines. In addition, a hyperlink to the CDC app that can be used to determine a patient's pneumococcal vaccination needs has been included.

Poliovirus vaccine

A new section was added summarizing poliovirus vaccination recommendations for adults. Although routine vaccination of adults residing in the United States is not necessary, the "Special situations" section describes the use of IPV in adults who are at increased risk for exposure to poliovirus.

Tetanus, diphtheria, and pertussis (Tdap) vaccine

Minor changes were made to the "Special situations" section to improve clarity in the language.

Zoster vaccine

The "Routine vaccination" section was revised to clarify that serologic evidence of prior varicella is not necessary for zoster vaccination and to provide guidance for situations in which serologic evidence of varicella susceptibility becomes available. The "Special situations" section was updated to provide guidance for persons with immunocompromising conditions who do not have a documented history of varicella, varicella vaccination, or herpes zoster. In addition, minor changes were made to the immunocompromising conditions bullet to clarify that this includes persons with HIV regardless of CD4 count.

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 305-470-6953

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 500mg single IM dose**	☐ FTA-ABS ☐ IgG-EIA ☐ TP-AB
☐ Doxycycline 100mg oral 2 times per day for 7 days	☐ **Ceftriaxone 500mg single IM dose *PLUS* Doxycycline 100mg oral BID for 7 daysIf chlamydial infection has not been**	☐ 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 day	☐ 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
Comments:		☐ For 14 days ☐ For 28 days
		Treatment date(s):
		Partner Information
		Name: DOB:
		Address:
		Phone:

WHO must report:

Each person who makes a diagnosis of or treats a person with a sexually transmitted disease (STD) excluding reporting HIV/AIDS, and each laboratory that performs a test for STD concludes with a positive test result shall report such facts to the local Department of Health.

HOW to report:

Reports must be submitted to the Florida Department of Health- Miami Dade County on the STD Reporting Form provided and shall contain the following:

1. Test performed and test results (including titer for Syphilis when quantitative procedures are performed)
2. Patient's name, address including the city, state, and zip code
3. Patient's phone number and date of birth
4. Sex (if female, pregnancy status)
5. Race and ethnicity
6. Provider's name, address including city, state, and phone number
7. An official laboratory report for each case (cases reported by phone will be subjected to verification)

WHERE to report:

Reports may be faxed to 305-575-3812. Please see reportable form attached and use for further reporting.

Reports may be called in to: 305-575-5430

WHEN to report:

All early Syphilis and pregnant women with syphilis must be reported within 24 hours of diagnosis. All other STD can be reported by the next business day following diagnosis.

WHY to report:

Florida Statute 381.003 through 381.0031
Florida Administrative Code: 64D-3.029 through 64D-3.003

Reporting STD to the local health department will assure patient are compliant with medical therapy, health education, resources, and offer partner services to patient's partner(s) who may have been exposed. Medical providers reporting will assist with reducing the spread of STD within our community. Preventing the spread of disease through case investigation is our priority in improving the health of all Miami-Dade County residents and visitors.

April 2023

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 DOH Miami-Dade (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. The Mantoux Tuberculin Test (PPD) test can be used for children less than 2 years old and Quantiferon or T-Spot for the 2 years old and older (As recommended by CDC)

5. 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.

Florida Department of Health in Miami-Dade County
Tuberculosis Control &Prevention Program
1350 NW 14th Street, Miami, Florida 33125
PHONE: 305/575-5403 • FAX: 305/575-3805
Miamidade@floridahealth.gov

6. 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.

7. 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 or full four (4) month course of Rifampin**. Many patients are appropriately screened for Latent TB Infection 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 immunosuppressed 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) or any other biological treatments.

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, AAHIVS
Director

Florida Department of Health in Miami-Dade County
Tuberculosis Control &Prevention Program
1350 NW 14th Street, Miami, Florida 33125
PHONE: 305/575-5403 • FAX: 305/575-3805
Miamidade@floridahealth.gov

TB CASE/SUSPECT REPORT

1 Reporting Entity

Reporting Date (MM/DD/YYYY) ☐ Suspect ☐ New Case ☐ Reactivation ☐ Transfer

Entity Name

(Entity Phone Number

(Entity Fax Number

Reported by (Last Name, First Name)

2 Patient Demographics & Current Address

Last Name | First Name | Mi

Current Address (Number & Street Name) | Apt. Number

City | State | Zip Code

(Home Phone Number

Country of Origin | If not US, Date arrived in USA: / / Format (MM/DD/YYYY or MM/YYYY)

Florida Resident: ☐Yes ☐No | If Yes, Date Arrived in Florida: / / Format (MM/DD/YYYY or MM/YYYY)

Date of Birth (MM/DD/YYYY) | Social Security Number

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

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

Ethnicity: ☐ Hispanic ☐ Not Hispanic

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 ☐ Correctional Employee ☐ Migratory Agricultural Worker ☐ Unknown

☐ Student ☐ School Staff ☐ Restaurant Worker ☐

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

5 Workplace

Institution Name | Suite Number

Number & Street Name | City

State | Zip Code | ( ) - Work Phone Number

6 Past Medical (TB) History

☐ Yes ☐ No If Yes, When (Year) **Where:** Country, State or County

Med Taken: ☐ 1 Drug ☐ 2 or more Drugs

Duration of Rx. | Specify (drug Name)

Previous IGRA: ☐ Pos ☐ Neg ☐ Indeterminate Collection Date / /

Previous PPD: ☐ Positive If + Size in mm. ☐ Negative PPD Date (MM/YYYY) / /

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

Meds. Supervision:

Physician's / Institution's Name

( ) - Phone Number | ( ) - Fax Number

Admission Date (MM/DD/YYYY) | Discharge Date (mm/DD/YYYY)

Chest X-ray Date (MM/DD/YYYY) **Results:** ☐ Normal ☐ Abnormal ☐ Cavitary

Chest X-ray Comments.

Current TB Meds. Dosage/mg.: | TB Medications Start Date

Other Medications & Dosage

Current Non-TB Medications | **Patient's weight:** In Lbs.

Current IGRA: Collection Date (MM/DD/YYYY) ☐ Positive ☐ Negative

Reporting Date (MM/DD/YYYY) / / ☐ Indeter

8 Bacteriology

Specimen: ☐ Sputum ☐ Other Tissue/Fluid

Smear: ☐ Pos. ☐ Neg.

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

/ / Culture ID

Lab Name

( ) - Lab Phone Number | ( ) - Lab Fax Number

9 Site(s) of Disease

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

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

☐ Peritoneal ☐ Other (Specify)

10 HIV Status

☐ Positive ☐ Negative ☐ Indeterminate ☐ Refused ☐ Not Offered

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

Send report to: MDCHD/TB Program 1350 NW. 14th. Street, Miami, FL 33125 Fax: (305) 575-3804
If you have any questions or need clarification about this form, contact: (305) 575-5415

REV 4/24/2023 E Fils-Aime

TB CASE/SUSPECT REPORT

Last Name | First Name | Mi | Date of Birth (MM/DD/YYYY) | Social Security Number

11 Symptoms

☐ Asymptomatic ☐ Wt. Lost ____ Lbs. (Amount) Over ____ (Months) ☐ Pleurisy
☐ Cough ☐ Fatigue ☐ Hemoptysis ☐ Fever ☐ Anorexia ☐ Fistula
☐ Night Sweat ☐ Shortness of breath ☐ Other ____

12 Alcohol / Drug Use

Intra-Venous drug use: ☐ Yes ☐ No Date Last Use (MM/YYYY)
Non-Injection drug Use within past year: ☐ Yes ☐ No Date Last Use (MM/YYYY)
Excess Alcohol Use within past year: ☐ Yes ☐ No Date Last Use (MM/YYYY)

13 Contact to TB Case

Ever Exposed to a TB Case? ☐ Yes ☐ No How long? ____ (Months) Last Name | First Name | Relationship
Did any family member die with TB? ☐ Yes ☐ No Date of last Contact: / (Format (MM/YYYY))

14 Other Medical Conditions

Previously Diagnosed with Liver Disease: ☐ Yes ☐ No
If "**Yes**", What & When? ____ / (Format (mm/yyyy))
☐ Gastrectomy ☐ Diabetes Mellitus ☐ Renal Failure
☐ Organ Transplant ☐ Pregnant Expected time of Delivery /
☐ Epilepsy / (Last Episode Date (mm/yyyy)) ☐ Allergies ____ (Name)
☐ Immunosuppressive Medications ☐ Silicosis (Occupational Lung Disease)
☐ Jejuoileal Bypass ☐ Cancer of Head, Neck or Lung
☐ 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

Updated by

1. ____ (Name) / / (Date (mm/dd/yyyy))
2. ____ (Name) / / (Date (mm/dd/yyyy))
3. ____ (Name) / / (Date (mm/dd/yyyy))
4. ____ (Name) / / (Date (mm/dd/yyyy))

Send report to: MDCHD/TB Program 1350 NW. 14th. Street, Miami, FL 33125 Fax: (305) 575-3804
If you have any questions or need clarification about this form, contact: (305) 575-5415

REV.4/24/2023 F Fils-Aime

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)

☐ Quantiferon (QFT): Date Collected: _____ Date Reported: _____
Results: ☐ Positive ☐ Negative ☐ Indeterminate

☐ 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: _____

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):
Date Done: _____ Date Read:_____ Size:_____(mm)

☐ Quantiferon (QFT): Date Collected: _____ Date Reported:_____
Results: ☐ Positive ☐ Negative ☐ Indeterminate

☐ Signs and Symptoms consistent with active TB: (**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: _____

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

☐ MDR 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 works 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 vaccinations, and providing 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

1350 N.W. 14th Street
Annex Building
Miami, Florida 33125

(P) 305.470.5660

(F) 305.470.5533

miamidade.floridahealth.gov

Florida Department of Health in Miami-Dade County

EDC-IS Programs 2023

EDC-IS PROGRAMS

2023

General Surveillance

General Surveillance is the core unit of Epidemiology, Disease Control and Immunization Services. This program conducts public health surveillance, 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, thus protecting the community of Miami-Dade County. General Surveillance is also responsible for investigating animal bites and foodborne illness outbreaks.

Healthy Homes Lead Poisoning and Asthma Prevention Program

The Healthy Homes Lead Poisoning and Asthma Prevention program is responsible for raising awareness of environmental health risks in the home, increasing lead poisoning screenings and prevention among children, administering lead risk assessment questionnaires, and providing community outreach. Additionally, the program conducts surveillance of lead poisoning cases reported in Miami-Dade County and refers those with elevated blood lead levels (BLLs) to health care providers.

Administration

Administration staff are responsible for ensuring smooth and effective operations of EDC-IS activities including but not limited to data entry, human resources, purchasing, immigration support services, leave and attendance, budget monitoring, maintenance, and recruitment-related issues.

Bioterrorism

The Bioterrorism program supports general surveillance activities and is responsible for the investigation of bioterrorism-related disease outbreaks, as well as the development and improvement of standard operating procedures (SOP) and response plans for the investigation of bioterrorism-related disasters. This unit educates the community and local agencies on the identification of and response to bioterrorism events.

Applied Epidemiology

The Applied Epidemiology and Research Unit aids in the areas of epidemiological research and study design, data management and analysis, and information technology. The unit also supports other programs within the health department and conducts syndromic surveillance for the early detection of disease outbreaks and potential public health threats. In addition, the unit conducts injury surveillance, provides community health education, and performs/supports large scale outbreak investigations.

Florida HEALTH
Miami-Dade County

Hepatitis

The Hepatitis Prevention program provides viral hepatitis education, screening, vaccination, and referrals to clients in the community. Supported by Immunization Services, the program's core activities revolve around surveillance and clinic services. Stakeholders and community partners collaborate with the program to provide access to care and treatment to hepatitis-positive clients and high-risk populations in jails, homeless shelters, and drug rehabilitation centers.

HIV/AIDS

The HIV/AIDS Surveillance program conducts surveillance and generates reports to assist in the prevention, control, and community awareness of HIV/AIDS. This program systematically collects, compiles, and analyzes HIV/AIDS morbidity data used for the planning, implementation, and evaluation of HIV/AIDS interventions. This also includes the dissemination of HIV/AIDS data to the community, stakeholders and agencies involved in HIV/AIDS interventions.

Immunization Services

The goal of the Immunization Services program is to provide barrier-free immunizations and education for infants, children, and adults. Immunization Services provides free vaccines to children ages 0 through 18 years old, and adult vaccines at a cost. This program provides ongoing surveillance and contributes to the elimination of vaccine-preventable disease in residents and visitors of Miami-Dade County.

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;* order *Bunyavirales,* family *arenaviruses*, e.g. *Lassa, Machupo*; and *flaviviruses*, e.g. *Dengue*.

Category A agents characteristics *(CDC)*

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

Reporting Protocols & Resources

(ACP/ASIM)

If you suspect bioterrorism is responsible for an illness, 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

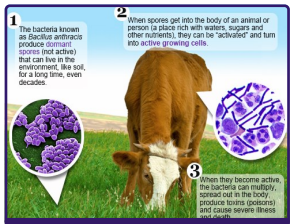
- An abrupt, influenza-like illness with fever, dizziness, myalgias, headache, nausea, abdominal pain, diarrhea and prostration. Evidence of "leaky capillary syndrome" with edema or signs of bleeding ranging from conjunctival hemorrhage, mild hypotension, flushing, petechiae, and ecchymoses to shock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

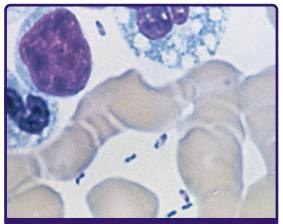
- A paralytic illness characterized by symmetric, descending flaccid paralysis of motor and autonomic nerves, usually beginning with the cranial nerves. *Consider botulism.*

Version 6.0 April. 2023
Adapted from IDSA, ACP, CDC resources, and JAMA consensus statements

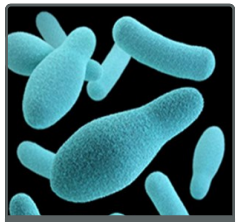
Bioterrorism Guide Category A Agents

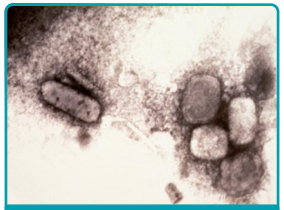


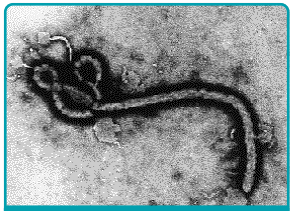
Bacillus anthracis


Yersinia pestis


Tularemia


Clostridium botulinum


Smallpox virus


Ebola virus

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Florida HEALTH
Miami-Dade County

Mission: A Healthy Community is the Heart of Public Health.
Vision: To Be a World-Class Public Health System.

CATEGORY A AGENTS OF BIOTERRORISM

DISEASE INCUBATION PERIOD (BSL)	MICROBIOLOGY	CLINICALSYNDROME	DIFFERENTIAL DIAGNOSES	INFECTION CONTROL RISK PtP TRANSMISSION	SAMPLE/ DIAGNOSTICS	THERAPY (Preferred)	POST-EXPOSURE PROPHYLAXIS (PEP)
ANTHRAX Inhalational & GI:1-7 days (up to 60 days). Cutaneous: 1-12 days (BSL 3)	*Bacillus anthracis*: broad gram-positive bacilli, grows aerobic-ally in long chains. Produces capsule & spores. Non-motile, non-hemolytic, catalase-positive.	**INHALATIONAL**: non-specific "flu-like" illness with nausea, emesis, cough, +/- chest discomfort, without coryza or rhinorrhea → abrupt onset of respiratory distress. Chest x-ray with mediastinal widening. **CUTANEOUS**: pruritic, painless papule→ vesicle→ulcer→edematous black eschar. +/- massive edema, regional adenopathy, fevers, evolving over 3-7 days. **GI:** dysphagia, hematemesis, diarrhea, GI ulcers, regional edema & lymphadenitis	Tularemia and pneumonic plague, bacterial mediastinitis, coccidiomycosis, Q fever, psittacosis, influenza, Legionnaires' Disease, staphylococcal or streptococcal diseases, TB, cat-scratch fever, Human Orf, arachnid bites.	Standard No PtP transmission. Contact with infected livestock or wild animal, animal tissue, hides, hair, wool, or bone meal.	Nasal swab, blood, pleural fluid, BAL, sputum, serum, skin lesion, mediastinal lymph node biopsy or aspirate. Culture, RT-PCR, serologic testing, DFA, Gamma-phage lysis, Time-resolve Fluorescence (TRF) Assay, IHC, ELISA	**Inhalational, &GI**: Systemic anthrax should be immediately treated with combination of broad-spectrum I.V. antibiotics, pending confirmatory test results; any delay may prove fatal. Cephalosporins are contraindicated due to natural β-lactam resistance. Antibiotics need good penetration of the CNS. I.V. cipro is the preferred bactericidal. Carbapenem class (Meropenem) is highly resistant to β-lactamases; with good CNS penetration. Linezolid is preferred protein synthesis. inhibitor. **Cutaneous:** Cipro or Doxy x 7-10 days; 60 days if spore inhalation or BT.	Person at risk should begin antimicrobial PEP as soon as possible. Ciprofloxacin and doxycycline for 10-14 days are both recommended for first line of choice for PEP. In inhalation exposure to aerosolized spores, PEP consists on 3 doses of cell-free vaccine at 0,2, and 4 weeks in combination with 60 days of antimicrobial if 18-59 years old.
PLAGUE 1-6 days (BSL 2/3)	*Yersinia pestis:* small, gram negative bacilli, with bipolar staining-"safety-pin" appearance/	Three possible presentations: **Bubonic**: most common sign is rapid development of a swollen and painful lymph gland called a bubo. **Septicemic**: Sepsis, DIC, purpura, ecchymoses, acral gangrene, GI symptoms, hypotension, acute renal failure and other signs of shock. May involve the meninges. **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.	Meningococcemia, Gram-negative, streptococcal, pneumococcal or staphylococcal sepsis, and shock. In **bubonic plague:** tularemia, granuloma inguinale, staph or strep lymphadenitis, cat-scratch fever.	Standard; Add droplet if pneumonic, until 3 days of treatment. Yes (high)	Throat swab, blood /sputum smears, serum, bubo aspirate, CSF, lesion scraping, LN aspirate. Culture, DFA, RT-PCR antigen detection, serology (TRFIA; Gram, Wright, Giemsa, or Wayson's stained smears. MALDI-TOF MS identification systems may misidentify the cultured organism.	Gentamicin and fluoroquinolones are first-line treatments in the United States. Duration of treatment is 10 to 14 days, but treatment can be extended. Patients can be treated with intravenous or oral antimicrobials. Streptomycin is a second-line treatment option. Please, consult reference number 4 for full prescribing information https://www.cdc.gov/plague/healthcare/clinicians.html	PEP is indicated in known exposure (close: < 6 ft), sustained contact with patient or animal with pneumonic plague or direct contact with infected body fluids or tissues. PEP should be given for 7 days. *Adults*: Doxy 100 mg PO BID x 7 days, OR Cipro 500 mg PO BID x 7 days. *Children*: same as above with dose adjustment).
TULAREMIA 3-5 days (range 1-21 days) (BSL 2/3)	*Francisella tularensis:* small gram-negative coccobacillus, non-motile. Fastidious, requiring cysteine for growth/	(**Ulcero) Glandular**: after tick or deer fly bite. Localized lymphadenopathy, cutaneous ulcer at infection site. **Oculoglandular**: when the bacteria enter through the eye (photophobia, excessive lacrimation, conjunctivitis, regional lymphadenopathy). **Oropharyngeal**: after eating or drinking contaminated food or water (severe throat pain, exudative pharyngitis or tonsillitis, regional lymphadenopathy). **Pneumonic**: after breathing dusts or aerosols with the bacteria or secondary to other untreated forms (cough, substernal tightness, pleuritic chest pain, hilar lymphadenopathy). **Typhoidal**: general symptoms, lacking localizing symptoms.	Inhalational anthrax influenza, mycoplasma pneumonia, Legionnaire's disease Q fever, plague	Standard/ None	Throat swab, blood , serum, respiratory secretions DFA, Culture Microagglutination assay for serum antibodies (after 10 days). IgM and IgG may remain detectable for several years after resolution. RT- PCR, antigen detection	*Adults*: Gentamycin 5 mg/kg daily for 10-14 days or ciprofloxacin 400 mg IV or 500 mg PO twice daily for 10-14 days, or doxycycline 100 mg IV or PO twice daily for 14-21 days. *Children*: same as above (with dose adjustment)	Recommended in cases of laboratory exposure to infectious materials. Adults: Doxy 100 mg PO BID x 14 days, OR Cipro 500 mg PO BID x 14 days. *Children*: same as above (Need dose adjustment)
BOTULISM 6 hr-10 days (BSL 2)	Toxins (A-G) of *Clostridium botulinum:* spore forming, obligate anaerobe, gram positive bacilli/	Acute onset of afebrile, symmetric, descending flaccid paralysis that begins in bulbar muscles. Dilated pupils, dry mucous membranes with difficulties in swallowing and speaking. Normal mental status and absent sensory changes.	Bacterial/chemical food poisoning, CVA, chemical intoxication (e.g., CO, opioid), congenital myopathy, Guillain-Barré, meningitis, myasthenia gravis, poliomyelitis, Reye's syndrome, sepsis, West Nile Virus.	Standard/ None	Wound culture, serum, stool, vomitus or gastric aspirate, food/ Mouse bioassay, PCR test, which is only available in reference laboratories, detects bont genes A –G and identifies botulinum neurotoxin–producing species of Clostridium in cultures.	Supportive care and Botulinum antitoxin (as soon as possible) - contains antibodies against toxin types A, B, E. One 10 ml. vial slow IV infusion. If another toxin type suspected, use heptavalent toxin (US Army). Start treatment while waiting for confirmation!	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.	Acute onset of fever ≥101°F (38.3°C) followed by a rash characterized by firm, deep-seated vesicles or pustules in the same stage of development without other apparent cause. **Systemic toxicity**: prodrome of high fever, headache, backache, prostration, chills, vomiting, abdominal pain, followed by **deep-seated rash** beginning on face & extremities, synchronous, progressive: papular → vesicular → pustular.	Atypical varicella or measles, secondary syphilis, molluscum contagiosum, meningococcemia, monkeypox, vaccinia, scabies.	Standard, contact and airborne/ Yes (high): Human-to-human; inhalation of large, virus-containing airborne droplets of saliva from an infected person or skin inoculation	Fluid of skin lesion, scab, Serum during febrile illness, vesicular fluid, tonsil/NP swab in prodrome. Cell culture, RT- PCR, negative stain electron microscopy, antigen detection, serology.	Supportive care; vaccination with ACAM and APSV vaccines to lessen severity (if given 2-3 days after initial exposure; will decrease symptoms if given within first week of exposure). Three antivirals: tecovirimat (FDA-approved), brincidofovir (FDA-approved) and cidofovir show effectiveness in animals and *in vitro* studies.	Vaccination of close contacts and those living in the immediate vicinity within 4 days of exposure
VHF 4-21 days (varies with virus) (BSL 4 except Dengue; 3)	Filoviruses (*Ebola and Marburg*), Arena from Bunyavirales order (*Lassa, Junin, Machupo, Guanarito, Sabia*). Other VHF agents can be used as bioweapons	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. Host animal-to-people crossover of virus; then, PtP. Contact with: blood or body fluids, contaminated objects, semen from recovered patient; close environments.	Nasal swab, throat wash, serum, CSF/ Rapid antigen capture ELISA, acute sera antibody, RT-PCR, viral culture	Supportive therapy, but generally speaking, there is no other treatment or established cure for VHFs. Ribavirin has been effective in treating some individuals with Arenavirus infection such as Lassa fever or HFRS. Treatment with convalescent-phase plasma has been used with success in some patients with Argentine hemorrhagic fever	Medical surveillance for Symptoms for 21 days. If fever ³101°F, start Ribavirin 500mg PO Q 6h x 10 days for possible Bunyavirus or Arenavirus

"Working together to protect the health of our community"

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