

State of Connecticut Reportable Disease Confidential Case Report Form PD-23

(rev. 01/01/2016)

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

For information or weekday disease reporting call 860-509-7994. For reporting on evenings, weekends, and holidays call 860-509-8000.

Instructions for Submitting the PD-23

This is a three-part form for reporting diseases as required under Sections 19a-36-A3 and 19a-36-A4 (see back side of form) of the Public Health Code and Sections 19a-2a and 19a-215 of the Connecticut General Statutes. The list of reportable diseases, emergency illnesses, and health conditions is revised annually. Mail the *white* copy to the Connecticut Department of Public Health, Epidemiology and Emerging Infections Program at the address above. Mail the *canary* copy to the Director of Health of the patient's town of residence. Retain the *pink* copy in the patient's medical record. Mail reports in envelopes marked "Confidential."

Use Other Forms or Methods to Report

<ul style="list-style-type: none"> • Epidemiology and Emerging Infections Program 860-509-7994 Confidential Case Report Form PD-23 Hospitalized and Fatal Cases of Influenza Case Report Form • Healthcare-associated infections 860-509-7995 Use the National Healthcare Safety Network (NHSN) • HIV/AIDS 860-509-7900 Adult HIV Confidential Case Report Form 	<ul style="list-style-type: none"> • Immunization Program 860-509-7929 Chickenpox (Varicella) Case Report Form • Occupational Diseases 860-509-7740 Physician's Report Form • Sexually Transmitted Diseases 860-509-7920 STD-23 Form • Tuberculosis 860-509-7722 TB-86 Form – TB Disease LTBI Form – Latent TB Infection
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Category 1 Diseases: Report immediately by telephone on the day of recognition or strong suspicion of disease for those diseases marked with a telephone (☎). Call 860-509-7994. These diseases must also be reported by mail within 12 hours.

Category 2 Diseases: All other diseases not marked with a telephone are Category 2 diseases. These diseases must be reported by mail within 12 hours of recognition or strong suspicion of disease.

<ul style="list-style-type: none"> Acquired Immunodeficiency Syndrome (1,2) Acute flaccid myelitis ☎ Anthrax Babesiosis ☎ Botulism ☎ Brucellosis California group arbovirus infection Campylobacteriosis Carbon monoxide poisoning (3) Chancroid Chickenpox Chickenpox-related death Chikungunya Chlamydia (<i>C. trachomatis</i>) (all sites) ☎ Cholera Cryptosporidiosis Cyclosporiasis Dengue ☎ Diphtheria Eastern equine encephalitis virus infection <i>Ehrlichia chaffeensis</i> infection <i>Escherichia coli</i> O157:H7 gastroenteritis Gonorrhea Group A Streptococcal disease, invasive (4) Group B Streptococcal disease, invasive (4) <i>Haemophilus influenzae</i> disease, invasive all serotypes (4) Hansen's disease (Leprosy) Healthcare-associated infections (5) Hemolytic-uremic syndrome (6) Hepatitis A Hepatitis B <ul style="list-style-type: none"> • acute infection (2) • HBsAg positive pregnant women 	<ul style="list-style-type: none"> Hepatitis C <ul style="list-style-type: none"> • acute infection (2) • positive rapid antibody test result HIV-1 / HIV-2 infection in (1) <ul style="list-style-type: none"> • persons with active tuberculosis disease • persons with a latent tuberculous infection (history or tuberculin skin test ≥ 5mm induration by Mantoux technique) • persons of any age • pregnant women HPV: biopsy proven CIN 2, CIN 3, or AIS or their equivalent (1) Influenza-associated death Influenza-associated hospitalization (7) Lead toxicity (blood level ≥ 15 μg/dL) Legionellosis Listeriosis Lyme disease Malaria ☎ Measles ☎ Melioidosis ☎ Meningococcal disease Mercury poisoning Mumps Neonatal bacterial sepsis (8) Neonatal herpes (≤ 60 days of age) Occupational asthma ☎ Outbreaks: <ul style="list-style-type: none"> • Foodborne (involving ≥ 2 persons) • Institutional • Unusual disease or illness (9) Pertussis ☎ Plague Pneumococcal disease, invasive (4) 	<ul style="list-style-type: none"> ☎ Poliomyelitis ☎ Q fever ☎ Rabies ☎ Ricin poisoning Rocky Mountain spotted fever Rotavirus Rubella (including congenital) Salmonellosis ☎ SARS-CoV Shiga toxin-related disease (gastroenteritis) Shigellosis Silicosis ☎ Smallpox St. Louis encephalitis virus infection ☎ Staphylococcal enterotoxin B pulmonary poisoning ☎ <i>Staphylococcus aureus</i> disease, reduced or resistant susceptibility to vancomycin (1) <i>Staphylococcus aureus</i> methicillin-resistant disease, invasive, community acquired (4,10) <i>Staphylococcus epidermidis</i> disease, reduced or resistant susceptibility to vancomycin (1) Syphilis Tetanus Trichinosis ☎ Tuberculosis ☎ Tularemia Typhoid fever Vaccinia disease ☎ Venezuelan equine encephalitis <i>Vibrio</i> infection (<i>parahaemolyticus</i>, <i>vulnificus</i>, other) ☎ Viral hemorrhagic fever West Nile virus infection ☎ Yellow fever
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FOOTNOTES:

1. Report only to State.
2. CDC case definition.
3. Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
4. Invasive disease: confirmed by isolation from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body sites, or other normally sterile site including muscle.
5. Report HAI according to current CMS pay-for-reporting or pay-for-performance requirements. Detailed instructions on the types of HAIs, facility types and locations, and methods of reporting are available on the DPH website: www.ct.gov/dph/HAI.
6. On request from the DPH and if adequate serum is available, send serum from patients with HUS to the DPH Laboratory for antibody testing.
7. Reporting requirements are satisfied by submitting the Hospitalized and Fatal Cases of Influenza—Case Report Form to the DPH in a manner specified by the DPH.
8. Clinical sepsis and blood or CSF isolate obtained from an infant ≤ 72 hours of age.
9. Individual cases of "significant unusual illness" are also reportable.
10. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.

State of Connecticut

Reportable Disease Confidential Case Report Form PD-23 (rev. 01/01/2016)

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

Date Completed: _____

Check this box to request additional PD-23 forms, or call 860-509-7994.

For information or weekday disease reporting, call 860-509-7994. For reporting on evenings, weekends, and holidays, call 860-509-8000.

Patient Name (Last)	(First)	(MI)	Parent or Guardian Name	Age	Birth Date	Patient's Telephone	Home Work Cell
Address (No. and Street)		(Apt. #)	(City or Town)	(State)	(Zip Code)	(Primary Language Spoken) <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other:	

Gender Male Female Other specify: _____ Unknown

Race White Black/African American Asian
 American Indian/Alaska Native Native Hawaiian/Other Pacific Islander
 Other specify: _____ Unknown

Is patient a (please check): Health care worker Student/Day care attendee
 Day care worker Food handler LTC facility resident

Name and address of workplace, school, day care or other facility: _____

Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Due date: _____	Did patient die of this illness? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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Disease Name	Onset Date	Diagnosis Date
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Is this condition work related? Yes No Unknown

If yes, occupation: _____

Did patient have recent international travel? Yes No Unknown

If yes, country visited: _____ Dates visited: _____

Confirmatory information: If specimen obtained, collection date: _____

Laboratory data, immunization status, dates, and comments (be specific).

Reporting healthcare provider name and address:

Direct telephone: _____

If hospitalized, hospital:	Date Admitted	Date Discharged
Name	Patient ID #	
City		
State		

Name of person completing report: _____

Address: _____

Phone: _____ FAX: _____ Report Date: _____

(Please print)

Viral Hepatitis

Symptoms: Yes No Onset date: _____ Jaundice: Yes No Onset date: _____

ALT Result: _____ ALT Date: _____ AST Result: _____ AST Date: _____

IgM anti-HAV: Positive Negative Not Done

HBsAg: Positive Negative Not Done

IgM anti-HBc: Positive Negative Not Done

Anti-HCV: Method: Rapid Serology Positive Negative Not Done

HCV confirmed by: RNA Value: _____

HBV Chronic/Carrier: Yes No Unknown

Risk Factors: IDU Non-injection street drugs
 Hemodialysis Multiple sex partners
 Perinatal (infected mom to baby) Contact w/ infected person (household sexual)
 Blood Transfusion Incarcerated (present past)
 MSM (men who have sex with men) Other: _____

Lyme disease surveillance case definition signs and symptoms

Physician diagnosed EM rash ≥ 5cm	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Arthritis (objective joint swelling)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Bell's palsy or other cranial neuritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Radiculoneuropathy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Lymphocytic meningitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Encephalomyelitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
If yes, is antibody to <i>B. burgdorferi</i> higher in CSF than serum	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Myocarditis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
2nd or 3rd degree atrioventricular block	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown
Was patient diagnosed with Lyme disease in current year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Unknown

Lyme disease laboratory results

EIA/IFA <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Culture <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown
Western Blot: IgM <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown	Western Blot: IgG <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unknown

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) GUIDELINES

Pursuant to Connecticut General Statutes (CGS) § 19a-2a and § 19a-215 and to the Regulations of Connecticut State Agencies §§ 19a-36-A3 and §§ 19a-36-A4, the requested information is required to be provided to the Department of Public Health (DPH).

Please note that CGS § 52-146o(b)(1) authorizes the release of these records to the Department without the patient's consent. Additionally, the federal Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) also authorize you, as a provider, to release this information without an authorization, consent, release, opportunity to object by the patient, as information (i) required by law to be disclosed [HIPAA Privacy regulation 45 CFR § 164.512(a)] and (ii) as part of the Department's public health activities [HIPAA Privacy regulation, 45 CFR § 164.512(b)(1)(i)]. The requested information is what is minimally necessary to achieve the purpose of the disclosure, and you may rely upon this representation in releasing the requested information, pursuant to 45 CFR § 164.514(d)(3)(iii)(A) of the HIPAA Privacy regulations.

REPORTING (Section 19a-36-A4)

Each report should include: 1) name, address, and phone number of the person reporting and of the physician attending; 2) name, address, date of birth, age, sex, race/ethnicity, and occupation of person affected; and 3) the diagnosed or suspected disease, and date of onset. Reports must be mailed in envelopes marked "**CONFIDENTIAL**" within 12 hours of recognition or strong suspicion to the:

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|--|------------|---|
| 1. Local Director of Health of (Canary) | AND | 2. Connecticut Department of Public Health (White) |
| town in which the patient resides | | 410 Capitol Avenue, MS#11FDS |
| | | P.O. Box 340308 |
| | | Hartford, CT 06134-0308 |

PERSONS REQUIRED TO REPORT, REPORTABLE DISEASES (Section 19a-36-A3)

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the DPH.
2. If the case or suspected case of reportable disease is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and DPH. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable diseases shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and DPH by:
 - A. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease;
 - B. the person in charge of any camp;
 - C. the master or any other person in charge of any vessel lying within the jurisdiction of the state;
 - D. the master or any other person in charge of any aircraft landing within the jurisdiction of the state;
 - E. the owner or person in charge of any establishment producing, handling, or processing dairy products, other food, or non-alcoholic beverages for sale or distribution;
 - F. morticians and funeral directors.