

Patient Last Name: _____ First: _____ D.O.B. _____ Age: _____
 Street Address: _____ City: _____ State/Zip Code: _____
 Patient Telephone: _____ Gender: Male Female Other specify: _____ Hispanic/Latino: Yes No Unk.
 Race: White Black/African Amer. Asian Amer. Indian/Alaska Nat. Nat. Hawaiian/Other Pacific Islander
 Other specify: _____ Unknown If patient resides in a LTC facility please check: Yes
 Occupation: _____ Name and address of workplace: _____
 Attending Physician Last Name: _____ First: _____
 Address: _____ Telephone: _____

Person Reporting: _____
 Lab Telephone: _____
 Submitting Laboratory: (name/address or label) _____
 Specimen collection date: _____
 Date laboratory finding reported to physician: _____
 Date OL-15C completed: _____
 Hospital Chart No: _____ Lab Specimen No: _____
 Source/Type specimen: _____
 Submitted to state lab: (see reverse) Yes No

<ul style="list-style-type: none"> <input type="checkbox"/> <i>Anaplasma phagocytophilum</i> by PCR only <input type="checkbox"/> Babesiosis <ul style="list-style-type: none"> <input type="checkbox"/> IFA IgM (titer) _____ IgG (titer) _____ <input type="checkbox"/> Blood smear <input type="checkbox"/> PCR <input type="checkbox"/> Other _____ <input type="checkbox"/> <i>microti</i> <input type="checkbox"/> <i>divergens</i> <input type="checkbox"/> <i>duncani</i> <input type="checkbox"/> Unspecified <input type="checkbox"/> California group virus (species) ¹ _____ <input type="checkbox"/> Carbapenem-resistant Enterobacteriaceae ² Genus _____ Species _____ <input type="checkbox"/> Carboxyhemoglobin \geq 5% _____ % COHb <input type="checkbox"/> Chancroid <input type="checkbox"/> Chickenpox, acute <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> DFA <input type="checkbox"/> Other _____ <input type="checkbox"/> Chikungunya virus <input type="checkbox"/> Chlamydia (<i>C. trachomatis</i>) (test type) _____ <input type="checkbox"/> <i>Clostridium difficile</i> ³ <input type="checkbox"/> Dengue <input type="checkbox"/> Diphtheria ⁴ <input type="checkbox"/> Eastern equine encephalitis virus <input type="checkbox"/> <i>Ehrlichia chaffeensis</i> by PCR only <input type="checkbox"/> Giardiasis <input type="checkbox"/> Gonorrhea (test type) _____ <input type="checkbox"/> Group A streptococcal disease, invasive ^{2,4} <input type="checkbox"/> Group B streptococcal disease, invasive ² <input type="checkbox"/> <i>Haemophilus influenzae</i> disease, invasive, all serotypes ^{2,4} <input type="checkbox"/> Hansen's disease (Leprosy) <input type="checkbox"/> Hepatitis A IgM anti-HAV ⁵ ALT _____ AST _____ <input type="checkbox"/> Not Done <input type="checkbox"/> Hepatitis B <input type="checkbox"/> HBsAg <input type="checkbox"/> IgM anti-HBc <input type="checkbox"/> Hepatitis C (anti-HCV) <input type="checkbox"/> Rapid antibody <input type="checkbox"/> RNA ⁶ <input type="checkbox"/> Genotype ⁶ _____ <input type="checkbox"/> Herpes simplex virus (infants \leq 60 days of age) (specify type) _____ <input type="checkbox"/> Culture <input type="checkbox"/> PCR <input type="checkbox"/> IFA <input type="checkbox"/> Ag detection HIV Related Testing (report only to the State) ⁷ <ul style="list-style-type: none"> <input type="checkbox"/> Detectable Screen (IA) Antibody Confirmation (WB/IFA/Type-diff) ^{4,7} HIV 1 <input type="checkbox"/> Positive <input type="checkbox"/> Negative/Ind HIV 2 <input type="checkbox"/> Positive <input type="checkbox"/> Negative/Ind <input type="checkbox"/> HIV NAAT (or qualitative RNA) <input type="checkbox"/> Detectable <input type="checkbox"/> Not Detectable <input type="checkbox"/> HIV Viral Load: _____ copies/mL <input type="checkbox"/> Not Detectable <input type="checkbox"/> HIV genotype ⁷ <input type="checkbox"/> CD4 count: _____ cells/uL; _____ % ⁷ <input type="checkbox"/> HPV (report only to the State) ⁸ Biopsy proven <input type="checkbox"/> CIN2 <input type="checkbox"/> CIN3 <input type="checkbox"/> AIS or their equivalent, (specify) _____ <input type="checkbox"/> Influenza <input type="checkbox"/> Rapid antigen ⁹ <input type="checkbox"/> RT-PCR <input type="checkbox"/> Culture-confirmed <input type="checkbox"/> Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type Unknown Subtype: _____ <input type="checkbox"/> Lead poisoning (blood lead \geq 10 μg/dL) ¹⁰ <input type="checkbox"/> Finger stick lead level _____ μg/dL <input type="checkbox"/> Venous lead level _____ μg/dL <input type="checkbox"/> Legionellosis <input type="checkbox"/> Culture <input type="checkbox"/> DFA <input type="checkbox"/> Ag positive <input type="checkbox"/> Four-fold serologic change (titers) _____ <input type="checkbox"/> Lyme disease ⁹ <input type="checkbox"/> Malaria/blood parasites ^{1,4} _____ <input type="checkbox"/> Measles (Rubeola) ¹¹ (titer) _____ <input type="checkbox"/> PCR 	<ul style="list-style-type: none"> <input type="checkbox"/> Meningococcal disease, invasive ^{2,4} <ul style="list-style-type: none"> <input type="checkbox"/> Culture ^{2,4} <input type="checkbox"/> PCR ² <input type="checkbox"/> Other _____ <input type="checkbox"/> Mercury poisoning <ul style="list-style-type: none"> <input type="checkbox"/> Urine \geq 35 μg/g creatinine _____ μg/g <input type="checkbox"/> Blood \geq 15 μg/L _____ μg/L <input type="checkbox"/> Mumps ¹¹ (titer) _____ <input type="checkbox"/> PCR <input type="checkbox"/> Neonatal bacterial sepsis ¹² spp _____ <input type="checkbox"/> Pertussis (titer) _____ <input type="checkbox"/> Culture ⁴ <input type="checkbox"/> Non-pertussis <i>Bordetella</i> ⁴ (specify) _____ <input type="checkbox"/> DFA <input type="checkbox"/> PCR <input type="checkbox"/> Pneumococcal disease <input type="checkbox"/> Culture ^{2,4} <input type="checkbox"/> Urine antigen <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Rabies <input type="checkbox"/> Rocky Mountain spotted fever <input type="checkbox"/> Rotavirus <input type="checkbox"/> Rubella ¹¹ (titer) _____ <input type="checkbox"/> St. Louis encephalitis virus <input type="checkbox"/> SARS-CoV infection ⁴ <input type="checkbox"/> IgM/IgG <input type="checkbox"/> PCR _____ (specimen) <input type="checkbox"/> Other _____ <input type="checkbox"/> <i>Staphylococcus aureus</i> with MIC to vancomycin \geq 4 μg/mL ⁴ MIC to vancomycin _____ μg/mL <input type="checkbox"/> <i>Staphylococcus aureus</i> disease, invasive methicillin-resistant ² Date pt. admitted _____ <input type="checkbox"/> <i>Staphylococcus epidermidis</i> with MIC to vancomycin \geq 32 μg/mL ⁴ MIC to vancomycin _____ μg/mL <input type="checkbox"/> Syphilis <input type="checkbox"/> RPR (titer) _____ <input type="checkbox"/> FTA <input type="checkbox"/> VDRL (titer) _____ <input type="checkbox"/> TPPA <input type="checkbox"/> Trichinosis <input type="checkbox"/> Tuberculosis ⁴ AFB Smear <input type="checkbox"/> Positive <input type="checkbox"/> Negative If positive <input type="checkbox"/> Rare <input type="checkbox"/> Few <input type="checkbox"/> Numerous NAAT <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Indeterminate Culture <input type="checkbox"/> <i>Mycobacterium tuberculosis</i> <input type="checkbox"/> Non-TB mycobacterium (specify <i>M.</i>) _____ <input type="checkbox"/> West Nile virus <input type="checkbox"/> Yellow fever <p>BIOTERRORISM possible disease indicators ¹³</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anthrax ⁴ <input type="checkbox"/> Botulism <input type="checkbox"/> Brucellosis ⁴ <input type="checkbox"/> Glanders ⁴ <input type="checkbox"/> Melioidosis ⁴ <input type="checkbox"/> Plague ⁴ <input type="checkbox"/> Q fever <input type="checkbox"/> Ricin poisoning <input type="checkbox"/> Smallpox ⁴ <input type="checkbox"/> Staphylococcal enterotoxin B pulmonary poisoning <input type="checkbox"/> Tularemia <input type="checkbox"/> Venezuelan equine encephalitis <input type="checkbox"/> Viral hemorrhagic fever
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SPECIFIC DISEASES RELATING TO FOODBORNE ILLNESS ACTIVE SURVEILLANCE NETWORK (FoodNet)

<ul style="list-style-type: none"> <input type="checkbox"/> Campylobacteriosis ¹ (species) _____ <input type="checkbox"/> Cryptosporidiosis <input type="checkbox"/> Cyclosporiasis <input type="checkbox"/> <i>Escherichia coli</i> O157 infection ⁴ <input type="checkbox"/> Listeriosis ⁴ 	<ul style="list-style-type: none"> <input type="checkbox"/> Salmonellosis ^{1,4} (serogroup/serotype) _____ <input type="checkbox"/> Shiga toxin-related disease ⁴ <input type="checkbox"/> Stx1 <input type="checkbox"/> Stx2 <input type="checkbox"/> Type Unknown <input type="checkbox"/> Shigellosis ^{1,4} (serogroup/species) _____ <input type="checkbox"/> <i>Vibrio</i> infection ^{1,4} (species) _____ <input type="checkbox"/> Yersiniosis ¹ (species) _____
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Specify all methods yielding positive result: Culture PCR EIA Other: _____
Patient status when specimen collected: Hospitalized Outpatient Unk. If outpatient, was patient later hospitalized? Yes No Unk.
 If hospitalized, **Hospital Name:** _____ **Date Admitted:** _____ **Date Discharged:** _____

<p>1. Specify species/serogroup/serotype. 2. Sterile site: defined as sterile fluids (blood, CSF, pericardial, pleural, peritoneal, joint, or vitreous), bone, internal body site (lymph node, brain, heart, liver, spleen, kidney, pancreas, or ovary), or other normally sterile site including muscle. For CRE, also include urine or sputum, but not stool. 3. Upon request, submit reports of all <i>C. difficile</i> positive stool samples according to DPH instructions. 4. Send isolate, culture, or slide to the DPH Laboratory for confirmation. For <i>Salmonella</i>, <i>Shigella</i>, and <i>Vibrio</i> tested by non-culture methods, send the isolate from reflex testing. For Shiga toxin-related disease, send positive broth or stool in transport media. For positive HIV, send \geq 0.5mL residual serum.</p>	<p>5. Report the peak liver function tests (ALT, AST) conducted within one week of patient's HAV IgM positive test, if available. Check "Not Done" when appropriate. 6. Report all RNA results. Genotypes and Negative RNA results required only by laboratories with electronic file reporting. 7. Report all HIV antibody, antigen, viral load, and qualitative NAAT results. Laboratories conducting HIV genotype or CD4 testing should report HIV DNA sequence and all CD4 test results with electronic file reporting. 8. On request from the DPH, and if adequate tissue is available, send fixed tissue from the specimen used to diagnose CIN2, 3 or cervical AIS or their equivalent for HPV typing according to instructions from the DPH.</p>	<p>9. Only laboratories with electronic file reporting are required to report positive results. 10. Report lead results \geq 10 μg/dL within 48 hours to the Local Health Director and the DPH; submit ALL lead results at least monthly to the DPH. 11. Report all IgM positive titers, but only IgG titers that are considered significant by the laboratory performing the test. 12. Report all bacterial isolates from blood or CSF from an infant \leq 72 hours of age. 13. Report by telephone to the DPH, weekdays 860-509-7994; evenings, weekends, and holidays 860-509-8000.</p>
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This form must be completely filled out by the primary laboratory. Excerpts from the regulations of the State of Connecticut are given below.

ANNUAL LIST (*Section 19a-36-A2*)

An annual list of the laboratory reportable significant findings will be prepared and mailed to directors of clinical laboratories licensed, registered, or approved by the Department of Public Health (DPH). Please refer to the current list when reporting findings since the list will be reviewed annually and revised when necessary.

RESPONSIBILITY FOR REPORTING (*Section 19a-36-A3*)

The director of a laboratory that receives a primary specimen or sample which yields a reportable laboratory finding shall be responsible for reporting such findings within forty-eight (48) hours to the local director of health of the town in which the affected person normally resides, or, in the absence of such information, of the town from which the specimen originated, and to the DPH on forms provided by the DPH.

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, gender, race/ethnicity, and occupation of person affected;
3. Identity of the infectious agent or other reportable laboratory findings and date of collection;
4. Method of identification.

Reports must be mailed in envelopes marked "**CONFIDENTIAL**" within 48 hours of making the finding to the:

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

or submitted in a manner specified by the DPH.

CONFIRMATION (*Section 19a-36-A3(b)(1)*)

When a laboratory identifies or presumptively identifies a significant isolate or other finding that requires confirmation by the laboratory as required in the annual list, the director must submit the isolate or specimen from which the finding was made to the Department's laboratory division.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) GUIDELINES

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

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.