

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) ² _____ <input type="checkbox"/> Carbapenem-resistant enterobacteriaceae ³ 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"/> Dengue <input type="checkbox"/> Diphtheria ¹ <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 ^{1,3} <input type="checkbox"/> Group B streptococcal disease, invasive ³ <input type="checkbox"/> <i>Haemophilus influenzae</i> disease, invasive, all serotypes ^{1,3} <input type="checkbox"/> Hansen's disease (Leprosy) <input type="checkbox"/> Hepatitis A IgM anti-HAV ⁴ 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) Ratio: _____ <input type="checkbox"/> Rapid antibody <input type="checkbox"/> RNA ⁵ <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) ⁶ <ul style="list-style-type: none"> <input type="checkbox"/> Detectable Antibody Screen (EIA/CIA) Detectable Antibody Confirmation (WB/IFA/Multispot) ^{1,6} <ul style="list-style-type: none"> <input type="checkbox"/> HIV 1 <input type="checkbox"/> HIV 2 <input type="checkbox"/> HIV 1/HIV 2 <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 (electronic file) <input type="checkbox"/> CD4 count: _____ cells/uL; _____ % (electronic file) <input type="checkbox"/> HPV (report only to the State) ⁷ <input type="checkbox"/> 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 ⁸ <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) ⁹ <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 ⁸ <input type="checkbox"/> Malaria/blood parasites ^{1,2} _____ <input type="checkbox"/> Measles (Rubeola) ¹⁰ (titer) _____ <input type="checkbox"/> Meningococcal disease, invasive ^{1,3} <input type="checkbox"/> Culture ^{1,3} <input type="checkbox"/> PCR ³ <input type="checkbox"/> Other _____ 	<ul style="list-style-type: none"> <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 ¹⁰ (titer) _____ <input type="checkbox"/> Neonatal bacterial sepsis spp ¹¹ _____ <input type="checkbox"/> Pertussis (titer): _____ <input type="checkbox"/> Culture ¹ <input type="checkbox"/> Non-pertussis <i>Bordetella</i> (specify) ¹ _____ <input type="checkbox"/> DFA <input type="checkbox"/> PCR <input type="checkbox"/> Pneumococcal disease <input type="checkbox"/> Culture ^{1,3} <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 ¹⁰ (titer) _____ <input type="checkbox"/> St. Louis encephalitis virus <input type="checkbox"/> SARS-CoV infection ¹ <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 ¹ MIC to vancomycin _____ μg/mL <input type="checkbox"/> <i>Staphylococcus aureus</i> disease, invasive methicillin-resistant ³ Date pt. admitted _____ <input type="checkbox"/> <i>Staphylococcus epidermidis</i> with MIC to vancomycin \geq 32 μg/mL ¹ 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 ¹ 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</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anthrax ^{1, 12} <input type="checkbox"/> Botulism ¹² <input type="checkbox"/> Brucellosis ^{1, 12} <input type="checkbox"/> Glanders ^{1, 12} <input type="checkbox"/> Melioidosis ^{1, 12} <input type="checkbox"/> Plague ^{1, 12} <input type="checkbox"/> Q fever ¹² <input type="checkbox"/> Ricin poisoning ¹² <input type="checkbox"/> Smallpox ^{1, 12} <input type="checkbox"/> Staphylococcal enterotoxin B pulmonary poisoning ¹² <input type="checkbox"/> Tularemia ¹² <input type="checkbox"/> Venezuelan equine encephalitis ¹² <input type="checkbox"/> Viral hemorrhagic fever ¹²
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SPECIFIC DISEASES RELATING TO FOODBORNE ILLNESS ACTIVE SURVEILLANCE NETWORK (FoodNet)

If non-culture based method used for identification, specify test type.

<input type="checkbox"/> Campylobacteriosis ² (species/test type) _____	<input type="checkbox"/> Salmonellosis ^{1,2} (serogroup/serotype/test type) _____
<input type="checkbox"/> Cryptosporidiosis (test type) _____	<input type="checkbox"/> Shiga-toxin related disease ¹ _____
<input type="checkbox"/> Cyclosporiasis (test type) _____	<input type="checkbox"/> Shigellosis ^{1,2} (serogroup/species/test type) _____
<input type="checkbox"/> <i>Escherichia coli</i> O157 infection ¹ _____	<input type="checkbox"/> <i>Vibrio</i> infection ^{1,2} (species/test type) _____
<input type="checkbox"/> Listeriosis ¹ _____	<input type="checkbox"/> Yersiniosis ² (species/test type) _____

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:** _____

1. Send isolate, culture, or slide to the DPH Laboratory for confirmation. For *Salmonella*, *Shigella*, STEC, and *Vibrio* tested by non-culture methods, send positive broth or stool in transport media when isolate is not available. For positive HIV, send \geq 0.5mL residual serum.
 2. Specify species/serogroup/serotype.
 3. 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.
 4. 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.

5. Report all RNA results, but negative RNA results are required only by laboratories with automated electronic reporting to the DPH.
 6. Report all positive HIV antibody, antigen, and all viral load results (including non-detectable values), and all qualitative NAAT results. Laboratories conducting HIV genotype or CD4 testing should report HIV DNA sequence and all CD4 test results in an electronic file.
 7. 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.
 8. Only laboratories with automated electronic reporting to the DPH are required to report positive results.

9. Report lead results \geq 10 μ g/dL within 48 hours to the Local Health Director and the DPH; submit ALL lead results at least monthly to the DPH.
 10. Report all IgM positive titers, but only IgG titers that are considered significant by the laboratory performing the test.
 11. Report all bacterial isolates from blood or CSF obtained from an infant \leq 72 hours of age.
 12. Report by telephone to the DPH, weekdays 860-509-7994; evenings, weekends, and holidays 860-509-8000.