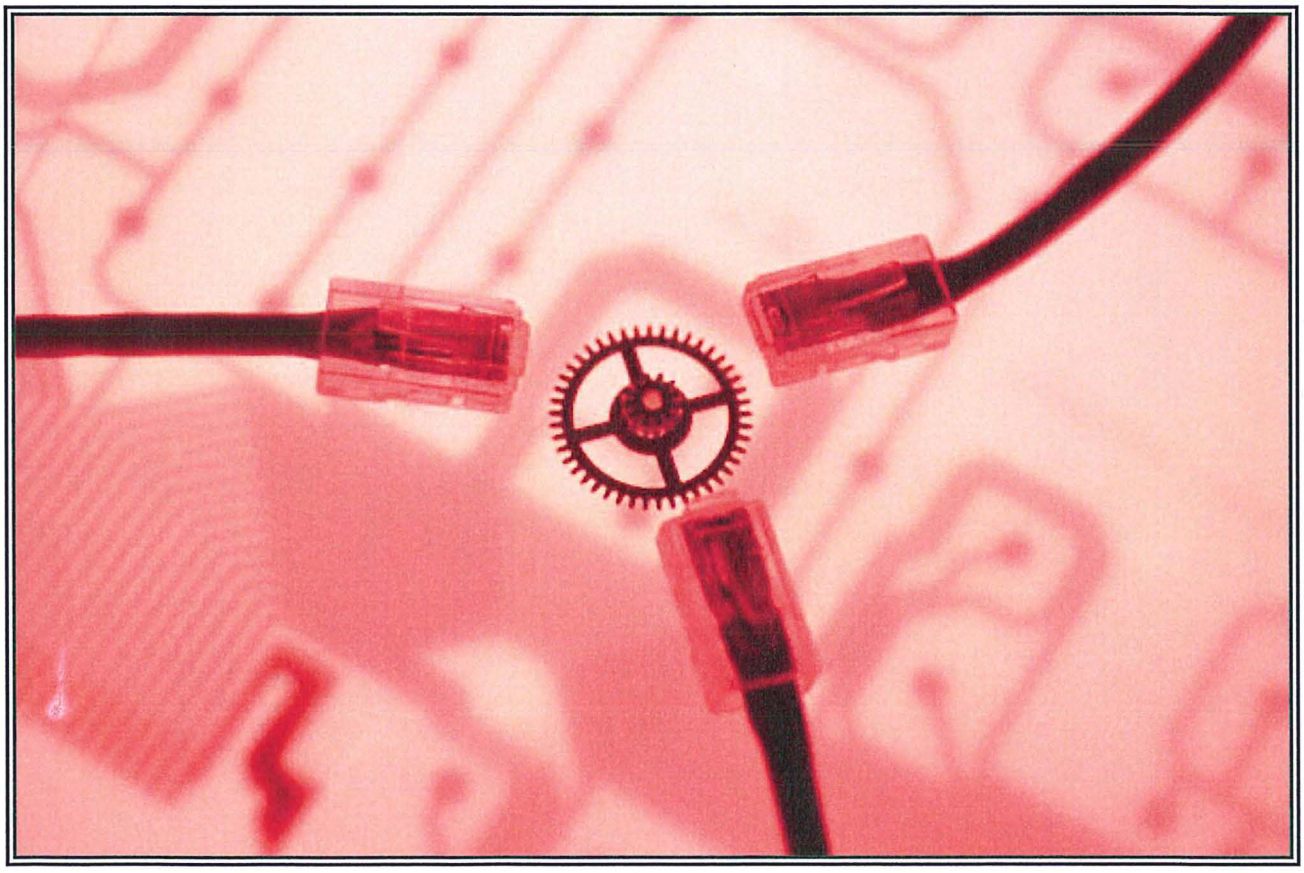
Florida HEALTH
St. Lucie County

Provider Reporting Resource



Rick Scott
Governor

John H. Armstrong, MD, FACS
State Surgeon General

Acknowledgement of Receipt for Provider Reporting Resource

I, _____, acknowledge receipt of the Provider Reporting Resource which the staff
(print)

of the St. Lucie County Health Department has delivered to

_____ on
(provider name)

_____.
(date)

_____	_____	_____
Signature	Title	Date
Provider designee		

_____	_____	_____
Signature	Title	Date
Florida Department of Health, St. Lucie County Employee		

ST. LUCIE COUNTY HEALTH DEPARTMENT
5150 NW Milner Drive
Port St. Lucie, FL 34983
(772) 462-3800
Website: http://www.stluciecountyhealth.com

Fort Pierce Site
714 Avenue "C"

Port St. Lucie Site
5150 NW Milner Dr
FAX: (772) 873-4913

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PROVIDER CONTACT UPDATE FORM

1. **Physician Name**:

   _____

2. **Practice Name** (if any):

   _____

3. **Contact Person & Title/Position**:

   _____

4. **Designated Reporting Person**:

   _____

5. **Phone Number**:

   _____

6. **Fax Number**:

   _____

7. **Additional Physicians/ARNPs/PAs in practice**:

   a._____

   b._____

   c._____

8. **Date Updated**:

   _____

It is important for us to know whom to contact in your office for reporting purposes. If any of the above information has changed, please submit this completed form to the Florida Department of Health in St. Lucie County via fax at (772) 873-4913 or mail to the Epidemiology Department at 5150 NW Milner Drive, Port St. Lucie, FL 34983. Your assistance in this matter is very much appreciated.

THE INITIAL CONTACT INFORMATION IS COLLECTED UPON RECEIPT OF THIS *PROVIDER REPORTING RESOURCE.* UPDATES SHOULD BE SUBMITTED WHEN ANY OF THE ABOVE INFORMATION CHANGES.

FDOH - ST. LUCIE COUNTY
INTEGRATED ACTIVE SURVEILLANCE PROGRAM

MISSION: To enhance the coordination of the FDOH - St. Lucie County's surveillance resources in order to improve reporting of diseases and emerging health threats.

VISION: All reportable diseases will be reported according to Florida Statues.

Rapid reporting of communicable disease benefits everyone in St. Lucie County in the following ways:

- Sources of diseases are identified rapidly and controlled, reducing disease in the community.
- Disease counseling and education takes place rapidly, reducing the spread of disease from one person to another in the community.
- Patients can be advised of and referred to available community resources to assist with medical and social support and/or care.
- The FDOH - St. Lucie County has access to State and Federal resources, such as communicable disease experts and free laboratory testing, to assist with the diagnosis and identification of suspected emerging communicable diseases, such as Severe Acute Respiratory Syndrome (SARS) and Avian Influenza (Bird Flu).
- Monitoring of communicable disease trends allows for rapid recognition and response to bioterrorism, outbreaks, and emerging communicable diseases.
- Monitoring disease trends assists in projecting medical needs and costs so that health care officials can plan for future resource allocation and can attract funds to the area for patient care.

May 27, 2015

Dear Health Care Provider:

As the Administrator of Florida Department of Health in St. Lucie County, I would like to request your assistance in the control of reportable communicable diseases. Effective disease control relies on effective surveillance. We have created this resource manual to provide you and your staff with the information and tools necessary to assist us in this effort. Inside, you will find a list of reportable diseases, local contacts, fax numbers and email addresses, basic information you will find helpful routinely and reporting forms. To assist you in the reporting of communicable diseases and maintain the most current information in your copy of this manual, we have included several Provider Contact Update Forms for later use.

Early reporting and investigation makes the most of our resources, limits the spread of disease and reduces the severity of communicable disease through education, early intervention and treatment. The Florida Department of Health in St. Lucie County staff have developed this Provider Reporting Resource with you, our partner, in mind. It is meant to assist you in meeting your public health obligation. We trust it will assist you in complying with the mandatory reporting of suspected and confirmed communicable diseases and outbreaks.

We value your cooperation and look forward to working with you and your staff. To assist you in reporting of communicable diseases, we have personnel you will be able to reach 24 hours a day, 7 days a week, 365 days a year. The number to call outside regular business hours is (772) 462-3800.

Thank you in advance for your cooperation.

Sincerely,

Clint Sperber
Administrator

June 4, 2014

TO LICENSED HEALTH CARE PROVIDERS

Re: Communicable Disease Investigation and Reporting

As Rule 64D-3.029, *Florida Administrative Code* (*FAC*), has been revised and updated, it is important that the requirements imposed by the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) be understood and followed especially in regard to disease reporting responsibilities and protections.

Review or inspection of medical records:

Issues have occasionally arisen concerning the impact of HIPAA on the authority of the Department and its county health departments in obtaining copies of records of patients suspected of being infected with a communicable disease. The applicable section of the HIPAA regulations allowing disclosure of protected health information from patient records for communicable disease investigation is 45 CFR section 154.512(b) which provides that access without patient consent may be granted to "A public health authority that is authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions." Furthermore, Section 381.031(3), *Florida Statutes* (*F.S.*), affirmatively requires licensed health care providers to allow department personnel access to communicable disease information in patient medical records and specifically provides: "Health care practitioners, licensed health care facilities, and laboratories shall allow the department to inspect and obtain copies of such medical records and medical-related information, notwithstanding any other law to the contrary." This same statute creates an exception to confidentiality laws and also provides security to the practitioner by stating: "A health care practitioner…may not be held liable in any manner for damages and is not subject to criminal penalties for providing patient records to the department as authorized by this section."

Reporting cases of communicable disease:

HIPAA does not change the obligation of health care providers, laboratories, and hospitals to report cases of disease listed in Chapter 64D-3, *FAC*, or the obligation to cooperate with the Department's epidemiology investigations.

HIPAA Section 45 CFR 160.203(c) specifically defers to state law with respect to "reports of disease, injury, child abuse, birth, or death for the conduct of public health." Also, health care providers are specifically allowed to report these and other matters that contain protected health information to the public health authority without notice to your patient (45 CFR 164.512(b)). In fact, Section 381.0031(7), *F.S.*, requires licensed health care practitioners to report diseases of public significance to the Department of Health. Chapter 64D-3, *FAC*, specifies the diseases required to be reported. These state requirements are not reduced or changed by the federal law.

Tracking communicable disease is of great importance. This is especially so in light of bio-terrorist concerns and other emerging disease threats. Our ability to track communicable diseases has allowed this state to successfully respond to health threats, such as an anthrax bioterrorist attack, introductions of measles, chikungunya fever, Middle Eastern Respiratory Syndrome (MERS), dengue fever, an influenza pandemic, and numerous outbreaks of enteric infections related to restaurants, nursing homes, and child care centers. The backbone of communicable disease surveillance and investigation is practitioner reporting.

Let me again emphasize the importance of disease reporting and our appreciation of your efforts to report timely. Please visit our website at www.floridahealth.gov/DiseaseReporting for more information about disease reporting.

Diseases and conditions should be reported to your county health department. Please visit http://www.floridahealth.gov/CHDEpiContact to obtain your county health department disease reporting contact information.

We look forward to continued public health and health care practitioner partnership that fosters a rapid response to public health investigations and to the success of protecting, promoting, and improving the health of all people in Florida through integrated state, county, and community efforts.

Sincerely,

Kimberly A. Tendrich
Chief Privacy Officer

Anna M. Likos, MD, MPH
Director, Division of Disease Control and Health Protection
State Epidemiologist

REPORTING CASES AND EVENTS

Health care providers (physicians, laboratories, other health care providers and hospital emergency departments) play a critical role in control of communicable diseases. Section 381.0031, (1,2) of Florida Statutes requires all licensed Florida practitioners who suspect or diagnose any illness of public health significance to report the disease/condition to their county health department.

WHO should report?
All licensed health care practitioners

WHAT to report?
Suspected or diagnosed communicable diseases or outbreaks
A list of Reportable Diseases is on the following page

WHEN to report?
Outbreaks, clusters, or groupings should be reported **immediately** by telephone. Depending on the disease (See list of Reportable Diseases), either within 24 hours, the next business day, or within 14 days are the reporting timeframes.

WHERE to report?
See the "personnel to Contact for Disease Reporting" in this Resource Guide. NOTE: If the designated contact person is unavailable, any staff person in the Epidemiology Department at the FDOH - St. Lucie County may take the disease report.

HOW to report?
Use applicable disease reporting forms (STD, HIV, or Communicable Disease) located in this Resource.

WHY report?
Benefits to the patient: helping to assure compliance with medical therapy, and to provide health education and resources to patients and contacts.
Benefits to the provider: helping to assure patient compliance with prescribed regimens, assisting the provider to educate the patient and contacts, and decreasing repeat visits for all patients.
Benefits to the community: preventing the spread of disease through case investigation, providing reliable information for surveillance, identifying trends in disease, identifying demographic and geographic trends, assisting in rapid identification of health threats, acting as an early warning system of the spread of disease, and aiding in the determination of public health priorities.

HIPAA AND PUBLIC HEALTH REPORTING

As described in sections 106.203 and 164.512 of the HIPAA regulations, the restrictions on the release of personal health information (such as name, address, telephone number, and past, present or future physical or mental health condition of an individual) are superseded by the duty to report communicable diseases to public health authorities. Others that are **EXEMPTED** include child abuse, and birth and death information.

In addition, Section 381.0031 (5) of the Florida Statutes states, "The department may obtain and inspect copies of medical records, records of laboratory tests, and other medical-related information for reported cases of disease of public health significance." Medical providers who allow the department to obtain this information cannot be held liable for the records disclosure. Section 381.0031 (1,2) states that any practitioner licensed in Florida to practice medicine, who diagnoses or suspects the existence of a disease of public health significance, should report findings immediately to the Department of Health. Medical providers who allow the department to obtain this information cannot be held liable for the records disclosure.

RULE 64D-3: SURVEILLANCE AND REPORTING

This rule has been revised to incorporate new changes that have been adopted by the Florida Administrative Code and the Florida Legislature. Listed below are sections **64D-3.030, 64D-3.032, and 64D-3.041.** These sections pertain to the notification of disease by medical providers and medical facilities, along with Epidemiological Investigation Information. **64D-3.042** STD Testing Related to Pregnancy has also been included for your reference.

For the latest updates on Disease Reporting Information for Health Care Providers:

http://www.floridahealth.gov/diseases-and-conditions/disease-reporting-and-management/disease-reporting-and-surveillance/disease-reporting-information-for-health-care-providers-and-laboratories/index.html

Surveillance and Reporting Contact Information

Florida Department of Health, St Lucie County

5150 NW Milner Drive

Port St Lucie, FL 34983

	HIV/AIDS	STDs	Communicable Diseases	Tuberculosis
Phone	(772) 462-3875	(772) 462-3815 or (772) 462-3806	(772) 462-3883	(772) 462-3866
Confidential Fax	(772) 462-3809	(772) 873-4913	(772) 873-4910	(772) 462-3826

After Hours Phone: (772) 462-3800

Reportable Diseases/Conditions in Florida

Practitioner List (Laboratory Requirements Differ)

Effective June 4, 2014

Did you know that you are required* to report certain diseases to your local county health department?

To report a disease or cluster of illness to Florida Department of Health - St. Lucie County's Epidemiology Program (EPI), please call:
(772) 462-3883 8 am-5 pm Monday- Friday or
(772) 462-3800 for after hours, weekends or holidays
(ask to speak with the person on call to report a disease)

- ! 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

Birth Defects (850) 245-4444 ext 2198

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

Cancer For questions call (305) 243-4600

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

HIV/AIDS (772) 462-3875; f (772) 462-3809

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

STDs (772) 462-3815; f (772) 873-4913

- • 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 (772) 462-3863; f (772) 462-3826

- • Tuberculosis (TB)

All Others (772) 462-3883; f (772) 873-4910

- ! 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
- ! Botulism, foodborne, wound, and unspecified
- • Botulism, infant
- ! Brucellosis
- • California serogroup virus disease
- • Campylobacteriosis
- • Carbon monoxide poisoning
- • Chikungunya fever
- ☎ Chikungunya fever, locally acquired
- ! Cholera (*Vibrio cholerae* type O1)
- • Ciguatera fish poisoning
- • Creutzfeldt-Jakob disease (CJD)
- • Cryptosporidiosis
- • Cyclosporiasis
- • Dengue fever
- ☎ Dengue fever, locally acquired
- ! 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 or children <2 years old
- ☎ Herpes B virus, possible exposure
- ! Influenza A, novel or pandemic strains
- ☎ Influenza-associated pediatric mortality in children <18 years old
- • Lead poisoning
- • Legionellosis
- • Leptospirosis
- ☎ Listeriosis
- • Lyme disease
- • Malaria
- ! Measles (rubeola)
- ! Melioidosis
- • Meningitis, bacterial or mycotic
- ! Meningococcal disease
- • Mercury poisoning
- • Mumps
- ☎ Neurotoxic shellfish poisoning
- ☎ Pertussis
- • Pesticide-related illness and injury, acute
- ! Plague
- ! Poliomyelitis
- • Psittacosis (ornithosis)
- • Q Fever
- ☎ Rabies, animal or human
- ! Rabies, possible exposure
- ! Ricin toxin poisoning
- • Rocky Mountain spotted fever and other spotted fever rickettsioses
- ! Rubella
- • St. Louis encephalitis
- • Salmonellosis
- • Saxitoxin poisoning (paralytic shellfish poisoning)
- ! Severe acute respiratory disease syndrome associated with coronavirus infection
- • Shigellosis
- ! Smallpox
- ☎ Staphylococcal enterotoxin B poisoning
- ☎ *Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)
- • *Streptococcus pneumoniae* invasive disease in children <6 years old
- • Tetanus
- • Trichinellosis (trichinosis)
- ! Tularemia
- ☎ Typhoid fever (*Salmonella* serotype Typhi)
- ! Typhus fever, epidemic
- ! Vaccinia disease
- • Varicella (chickenpox)
- ! Venezuelan equine encephalitis
- • Vibriosis (infections of *Vibrio* species and closely related organisms, excluding *Vibrio cholerae* type O1)
- ! Viral hemorrhagic fevers
- • West Nile virus disease
- ! Yellow fever

*Section 381.0031 (2), *Florida Statutes* (F.S.), 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, Section 381.0031 (4), F.S. 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..."

COMMUNICABLE DISEASES

WHO (must report):

Any practitioner, hospital, laboratory, or other individuals that diagnose or suspect the existence of a disease of public health significance shall submit Department of Health (DH2136) Practitioner Disease Report Form to the FDOH - St. Lucie County. Such reports shall be made either immediately or the next business day by telephone (with subsequent written report within 72 hours, based upon guidance in 64D-3.029, *Table of Notifiable Diseases or Conditions to be Reported.*

HOW (to report):

Reports, whether by telephone or in writing should contain the following:

1. Diagnosis
2. Date of Onset
3. Patient's name
4. Patient's address including city, state, and zip
5. Patient's contact number – i.e. telephone, cellular phone, beeper, etc.
6. Date of birth
7. Sex
8. Race and ethnicity
9. Provider's name and phone number
10. Provider's address including city and state
11. An official laboratory report for each case (reports by telephone can follow up later with this)

WHERE (are reports sent):

Reports may be faxed, telephoned or mailed to the Communicable Disease Department:

Reports may be faxed to: (772) 873-4910
Reports may be called in to: (772) 462-3883
Reports may be mailed to:

Florida Department of Health in St. Lucie County
Communicable Diseases/Epidemiology Program
5150 NW Milner Drive
Port St. Lucie, FL 34983

WHEN (how often):

Disease reports should be made either immediately or on the next business day by telephone, and followed with a written report for specified diseases.

WHY (statutory rule authority):

Florida Statute 381.003 through 381.0031
Florida Administrative Code 64D-3.029 through 64D-3.033

TUBERCULOSIS

WHO (must report):

Each person who suspects/makes a diagnosis of tuberculosis or treats a person with tuberculosis; and each laboratory that performs a test on a specimen revealing presence of mycobacterium tuberculosis, shall report such facts to the local health department.

HOW (to report):

Reports must be submitted to the FDOH - St. Lucie County on Department of Health (DH2136) and shall contain the following:

1. Patient's demographic data, i.e., name, address, home telephone number, date of birth, race, and sex.
2. Pertinent diagnostic information including, but not limited to PPD results, laboratory tests, radiographic findings, the 15-digit spoligotype (octal code) and findings of physical examination.
3. Name, title, address and telephone of the diagnosing physician and/or individual submitting the report.
4. Current anti-tuberculosis treatment regimen.

WHERE (are reports sent):

Reports may be faxed, telephoned or mailed to the Tuberculosis Unit:

Reports may be faxed to: (772) 462-3826
Reports may be called in to: (772) 462-3863
Reports may be mailed to:

Florida Department of Health in St. Lucie County
Tuberculosis Program
5150 NW Milner Drive
Port St. Lucie, FL 34983

WHEN (how often):

Tuberculosis suspects or cases shall be reported by the next business day following diagnosis or treatment.

TUBERCULOSIS

WHAT (conditions must be reported):

1. A client having CXR findings suggestive of tuberculosis
2. A client whose sputum smears indicate acid fast bacilli (AFB)
3. A client whose specimen tests positive for Mycobacterium tuberculosis on culture and/or direct testing (MTD)
4. A client who has negative cultures but has a positive PPD, is on 2 or more anti-tuberculosis medications, has signs and symptoms compatible with tuberculosis and shows radiographic or clinical improvement while on medications
5. A client with productive cough of over two (2) weeks of duration, unexplained low-grade fever, night sweats, loss of appetite, unexplained weight loss, hemoptysis or easy fatigueability.

WHY (statutory/rule authority):

Florida Statue 392.53

Each person who violates the provisions of this section may be fined by the department up to $500. The department shall report each violation of this section to the regulatory agency responsible for licensing each healthcare professional and each laboratory to which these provisions apply.

PPD positivity/reactivity is <u>not</u> reportable by law. However, the local health department would like to be notified of any children four (4) years of age and under with a positive TB skin test for the purpose of epidemiological investigation, evaluation and/or treatment.

For additional information regarding tuberculosis treatment and reporting guidelines, contact the local health department at (772) 462-3863, the Florida TB Physicians Network at 1-800-4TB-INFO, or the Florida Department of Health at:
http://www.floridahealth.gov/diseases-and-conditions/tuberculosis/index.html

HIV/AIDS

WHO (must report): Any practitioner, hospital, laboratory, or other individuals that diagnose or suspect the existence of HIV (not AIDS) shall report such fact to the FDOH - St. Lucie County, HIV/AIDS Surveillance Program Coordinator within two weeks. Positive test results and viral loads are all reportable. Laboratories are required by law to report all positive test results, all CD4s and viral loads, with or without confirmed HIV infection, within three days.

HOW (to report): Reports may be made by mailing in the CDC's Adult HIV/AIDS Confidential Case Report Form (CDC 50.42C) to the FDOH - St. Lucie County or by calling in to the FDOH - St. Lucie County HIV/AIDS Surveillance Program. All reports shall contain the following:

1. Patient's name
2. Patient's address including, city, state, and zip code
3. Patient's contact number (i.e. telephone, cellular phone, beeper, etc.)
4. Date of birth, country of birth (if other than U.S.)
5. Sex
6. Race and ethnicity
7. Social security number
8. Risk information
9. HIV test date and copy of laboratory report
10. CD4 count, if performed
11. Viral load, if performed
12. Date of patient notification if done, or note that patient did not return for results
13. Treatment referral
14. Provider's name and phone number
15. Provider's address including city and state
16. Name of person completing form and their phone number
17. Permission for patient contact and follow-up services (recommended by the Department of Health), and
18. Pregnancy status

HIV/AIDS

WHERE (are reports sent):

Reports may be telephoned or mailed to the HIV/AIDS Surveillance Program:

Reports may be called in to (772) 462-3875
Reports should be mailed to:

Florida Department of Health in St. Lucie County
HIV/AIDS Surveillance Program
5150 N W Milner Drive
Port St. Lucie, Fl 34983
Attention: Patricia Weiner

Please mark envelope **CONFIDENTIAL**

WHEN (how often):

All reports shall be made within three days by laboratories and within two weeks by providers.

WHY (statutory/rule authority):

Florida Statute 384.25
Florida Administrative Code 64D-3.029 - 64D-3.033

SEXUALLY TRANSMITTED DISEASES

WHO (must report):

Each person who makes a diagnosis of, OR treats a person with, a sexually transmitted disease (STD), and each laboratory that performs a test for STD which concludes with a positive test result, shall report such facts to the local health department.

HOW (to report):

Reports must be submitted to the FDOH - St. Lucie County on Department of Health (DH2136), Practitioner Disease Report Form, and shall contain the following:

1. Tests performed and test results (including titer for syphilis when quantitative procedures are performed)
2. Patient's name
3. Patient's address including city, state, and zip
4. Patient's phone number
5. Date of birth
6. Sex (if female, pregnancy status)
7. Race and ethnicity
8. Provider's name
9. Provider's phone number
10. Provider's address including city and state
11. An official laboratory report for each case (reports by telephone can follow up later with this)

WHERE (are reports sent):

Reports may be faxed, telephoned or mailed to the STD Department:

Reports may be faxed to (772) 873-4913
Reports may be called in to (772) 462-3815 or 462-3806
Reports may be mailed to:

Florida Department of Health, St. Lucie County
STD Program
5150 NW Milner Drive
Port St. Lucie, FL 34983
Please mark envelope **CONFIDENTIAL**

WHEN (how often):

All early syphilis and herpes simplex in neonates and infants, birth to 6 months, shall be reported **by telephone within 24 hours** of diagnosis. All other STD reports shall be submitted **by the next business day** following diagnosis.

WHY (statutory/rule authority):

Florida Statute 384
Florida Administrative Code 64D-3.029 – 64D-3.033

Florida Department of Health, Practitioner Disease Report Form

Complete the following information to notify the Florida Department of Health of a reportable disease or condition, as required by Chapter 64D-3, *Florida Administrative Code* (*FAC*). This can be filled in electronically.

Print Form

Patient Information

SSN: _____

Last name: _____

First name: _____

Middle: _____

Parent name: _____

Gender: ○ Male ○ Female ○ Unk

Pregnant: ○ Yes ○ No ○ Unk

Birth date: _____ **Death date:** _____

Race: ○ American Indian/Alaska Native ○ Asian/Pacific Islander ○ Black ○ White ○ Other ○ Unk

Ethnicity: ○ Hispanic ○ Non-Hispanic ○ Unk

Address: _____

ZIP: _____ **County:** _____

City: _____ **State:** _____

Home phone: _____

Other phone: _____

Emer. phone: _____

Email: _____

Medical Information

MRN: _____

Date onset: _____ **Date diagnosis:** _____

Died: ○ Yes ○ No ○ Unk

Hospitalized: ○ Yes ○ No ○ Unk

Hospital name: _____

Date admitted: _____ Date discharged: _____

Insurance: _____

Treated: ○ Yes ○ No ○ Unk

Specify treatment: _____

Laboratory testing: ○ Yes ○ No ○ Unk Attach laboratory result(s) if available.

Provider Information

Physician: _____

Address: _____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____ **Fax:** _____

Email: _____

Reportable Diseases and Conditions in Florida

! Notify upon suspicion 24/7 by phone **☎ Notify upon diagnosis 24/7 by phone**

HIV/AIDS and HIV-exposed newborn notification should be made using the Adult HIV/AIDS Confidential Case Report Form, CDC 50.42A (revised March 2013) for cases in people ≥13 years old or the Pediatric HIV/AIDS Confidential Case Report, CDC 50.42B (revised March 2003) for cases in people <13 years old. Please contact your local county health department for these forms (visit http://floridahealth.gov/chdepicontact to obtain CHD contact information). **Congenital anomalies** and **neonatal abstinence syndrome** notification occurs when these conditions are reported to the Agency for Health Care Administration in its inpatient discharge data report pursuant to Chapter 59E-7 *FAC*. **Cancer** notification should be directly to the Florida Cancer Data System (see http://fcds.med.miami.edu). All other notifications should be to the CHD where the patient resides.
To obtain CHD contact information, see http://floridahealth.gov/chdepicontact. See http://floridahealth.gov/diseasereporting for other reporting questions.

- ☎ ☐ Amebic encephalitis
- ! ☐ Anthrax
- ☐ Arsenic poisoning
- ☐ Arboviral disease not listed here
- ☐ Botulism, infant
- ! ☐ Botulism, foodborne
- ! ☐ Botulism, wound or unspecified
- ! ☐ Brucellosis
- ☐ California serogroup virus disease
- ☐ Campylobacteriosis
- ☐ Carbon monoxide poisoning
- ☐ Chancroid
- ☐ Chikungunya fever
- ☎ ☐ Chikungunya fever, locally acquired
- ☐ Chlamydia
- ! ☐ Cholera (*Vibrio cholerae* type O1)
- ☐ Ciguatera fish poisoning
- ☐ Conjunctivitis in neonate <14 days old
- ☐ Creutzfeldt-Jakob disease (CJD)
- ☐ Cryptosporidiosis
- ☐ Cyclosporiasis
- ☐ Dengue fever
- ☎ ☐ Dengue fever, locally acquired
- ! ☐ Diphtheria
- ☐ Eastern equine encephalitis
- ☐ Ehrlichiosis/anaplasmosis
- ☐ *Escherichia coli* infection, Shiga toxin-producing
- ☐ Giardiasis, acute
- ! ☐ Glanders
- ☐ Gonorrhea
- ☐ Granuloma inguinale
- ! ☐ *Haemophilus influenzae* invasive disease in child <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 woman or child <2 years old
- ☎ ☐ Herpes B virus, possible exposure
- ☐ Herpes simplex virus (HSV) in infant <60 days old
- ☐ HSV, anogenital in child <12 years old
- ☐ Human papillomavirus (HPV), laryngeal papillomas or recurrent respiratory papillomatosis in child <6 years old
- ☐ HPV, anogenital papillomas in child <12 years old
- ! ☐ Influenza A, novel or pandemic strains
- ☎ ☐ Influenza-associated pediatric mortality in child <18 years old
- ☐ Lead poisoning
- ☐ Legionellosis
- ☐ Leptospirosis
- ☎ ☐ Listeriosis
- ☐ Lyme disease
- ☐ Lymphogranuloma venereum (LGV)
- ☐ Malaria
- ! ☐ Measles (rubeola)
- ! ☐ Melioidosis
- ☐ Meningitis, bacterial or mycotic
- ! ☐ Meningococcal disease
- ☐ Mercury poisoning
- ☐ Mumps
- ☎ ☐ Neurotoxic shellfish poisoning
- ☎ ☐ Pertussis
- ☐ Pesticide-related illness and injury, acute
- ! ☐ Plague
- ! ☐ Poliomyelitis
- ☐ Psittacosis (ornithosis)
- ☐ Q Fever
- ☎ ☐ Rabies, animal
- ☎ ☐ Rabies, human
- ! ☐ Rabies, possible exposure
- ! ☐ Ricin toxin poisoning
- ☐ Rocky Mountain spotted fever or 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
- ☎ ☐ *Staphylococcus aureus* infection, intermediate or full resistance to vancomycin (VISA, VRSA)
- ☎ ☐ Staphylococcal enterotoxin B poisoning
- ☐ *Streptococcus pneumoniae* invasive disease in child <6 years old
- ☐ Syphilis
- ☎ ☐ Syphilis in pregnant woman or neonate
- ☐ Tetanus
- ☐ Trichinellosis (trichinosis)
- ☐ Tuberculosis (TB)
- ! ☐ 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
- ! ☐ 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 above that is of urgent public health significance. Please specify:

Comments

Revised June 4, 2014

Florida HEALTH
St. Lucie County

*****PLEASE ENCLOSE LAB*****

FLORIDA CONFIDENTIAL REPORT OF SEXUALLY TRANSMITTED DISEASES

TO REPORT STD CONTACT:
Monica Illuzzi
772-462-3806
Fax: 772-873-4913
Or
HIV/AIDS
Patricia Weiner
772-462-3875

PROVIDER INFORMATION **DATE REPORTED**_____

Physician/Provider Name **Person Reporting (Print Name)**

Address **Telephone** (_____)

City **State** **Zip code** **County**

PATIENT INFORMATION **Medical Record #:**_____

Name:_____ DOB:_____ Gender: Male ☐ Female ☐

SSN:_____ Marital Status: _____

Race: White ☐ Black ☐ Asian/Pacific Islander ☐ American Indian/Pacific Islander Ethnicity: Hispanic ☐ Non-Hispanic ☐

Address:_____ City:_____ State:_____ Zip code:_____

Phone:_____ Alternate Phone:_____

If female, pregnancy status: ☐ Not Pregnant ☐ Pregnant LMP_____ EDD_____ Weeks_____

OB Provider: _____

Most Recent HIV Test Date:_____ Result: Positive ☐ Negative ☐

Facility Name:_____ Phone:_____

Emergency Contact:_____ Phone:_____

Employer Name:_____ Phone:_____

Spouse/Partner Name:_____ Age/DOB:_____

Address:_____ Phone:_____

If pregnant, was partner treated? YES ☐ NO ☐ Treatment:_____ Date of Treatment:_____

CHLAMYDIA

☐***PLEASE ATTACH LAB***

Treatment:

☐ Azithromycin 1gm po

☐ Doxycycline 100mg po BID x7 Days

☐ Other_____

Date of Treatment_____

GONORRHEA

☐***PLEASE ATTACH LAB***

Treatment:

☐ Ceftriaxone 250mg IM x 1 dose **PLUS** Azithromycin 1 gm PO or

☐ Ceftriaxone 250mg IM x 1 dose **PLUS** Doxycycline 100 mg PO BID x 7 days

Date of Treatment_____

For allergic patient to Cephalosporin: Azythromycin 2 gm PO x1 dose **PLUS Test of cure**

SYPHILIS

☐***PLEASE ATTACH LAB***

Treatment and Date (M/D/Y):

☐ 2.4mu BIC (____/____/____)

☐ 2.4mu BIC (____/____/____)

☐ 2.4mu BIC (____/____/____)

☐ Doxycycline 100mg orally BIDx14 Days

☐ Other_____

Date of Treatment _____

Comments:_____

TO REPORT A SEXUALLY TRANSMITTED DISEASE PHONE OR FAX:
AREA 15 SURVEILLANCE DEPARTMENT, FLORIDA DEPARTMENT OF HEALTH, ST LUCIE COUNTY
5150 NW MILNER DR. PORT ST. LUCIE, FL 34983
PHONE: (772) 462-3815 CONFIDENTIAL FAX: (772) 873-4913

*****PLEASE ENCLOSE LAB*****

Patient Identification

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

*Alternate Name Type (ex: Alias, Married)	*First Name	*Middle Name	*Last Name

Address Type ☐ Residential ☐ Bad Address ☐ Correctional Facility ☐ Foster Home ☐ Homeless ☐ Postal ☐ Shelter ☐ Temporary	*Current Street Address	*Phone ( ) _____

City	County	State/Country	*ZIP Code

*Medical Record Number	*Other ID Type: Social Security	Number:

U.S. Department of Health & Human Services

Adult HIV Confidential Case Report Form

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

Centers for Disease Control and Prevention

Health Department Use Only

Form approved OMB no. 0920-0573 Exp. 02/29/2016

Date Received at Health Department __ __/__ __/__ __ __ __	eHARS Document UID _____	State Number _____

Reporting Health Dept - City/County FT PIERCE/ST LUCIE	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)

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

Public reporting burden of this collection of information is estimated to average 20 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: (PRA (0920-0573). **Do not send the completed form to this address.**

STATE/LOCAL USE ONLY	– Patient identifier information is not transmitted to CDC! –
Physician's Name: (Last, First, M.I.)	Medical Record
_____ Phone No: ( ) _____	No._____
Hospital/Facility:	Person Completing Form:
_____	_____

Facility of Diagnosis (add additional facilities in Comments)

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

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

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

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

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

Laboratory Data (record additional tests in Comments section) (record all dates as mm/dd/yyyy)

HIV Antibody Tests (Non-type-differentiating)

TEST 1: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB ☐ Other: Specify Test: _____

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

Manufacturer: _____

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 ☐ Other: Specify Test: _____

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

Manufacturer: _____

TEST 3: ☐ HIV-1 IA ☐ HIV-1/2 IA ☐ HIV-1/2 Ag/Ab ☐ HIV-1 WB ☐ HIV-1 IFA ☐ HIV-2 IA ☐ HIV-2 WB ☐ Other: Specify Test: _____

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

Manufacturer: _____

HIV Antibody Tests (Type-differentiating) [HIV-1 vs. HIV-2]

TEST: ☐ HIV-1/2 Type-differentiating (e.g., Multispot)

RESULT: ☐ HIV-1 ☐ HIV-2 ☐ Both (undifferentiated) ☐ Neither (negative) ☐ Indeterminate **Collection Date:** __ __ /__ __ /__ __ __ __

HIV Detection Tests (Qualitative)

TEST 1: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

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

TEST 2: ☐ HIV-1 RNA/DNA NAAT (Qual) ☐ HIV-1 P24 Antigen ☐ HIV-1 Culture ☐ HIV-2 RNA/DNA NAAT (Qual) ☐ HIV-2 Culture

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

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

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

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

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

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

Immunologic Tests (CD4 count and percentage)

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

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

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

Documentation of Tests

Did documented laboratory test results meet approved HIV diagnostic algorithm criteria? ☐ Yes ☐ No ☐ Unknown
If YES, provide specimen collection date of earliest positive test for this algorithm: __ __ /__ __ /__ __ __ __

Complete the above only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA]

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

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

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

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

[†]If TB selected above, indicate RVCT Case Number:

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

Has this patient been informed of his/her HIV infection? ☐ Yes ☐ No ☐ Unknown	This patient's partners will be notified about their HIV exposure and counseled by: ☐ 1-Health Dept ☐ 2-Physician/Provider ☐ 3-Patient ☐ 9-Unknown

For Female Patient

This patient is receiving or has been referred for gynecological or obstetrical services: ☐ Yes ☐ No ☐ Unknown	Is this patient currently pregnant? ☐ Yes ☐ No ☐ Unknown	Has this patient delivered live-born infants? ☐ Yes ☐ No ☐ Unknown

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

*Child's Name	Child Soundex	Child's Date of Birth
*Child's Coded ID	Child's State Number	

Hospital of Birth (if child was born at home, enter "home birth" for hospital name)

Hospital Name	*Phone	*ZIP Code
*Street Address	City	County	State/Country

HIV Testing and Antiretroviral Use History (if required by Health Department) (record all dates as mm/dd/yyyy)

Main source of testing and treatment history information (select one) ☐ Patient Interview ☐ Medical Record Review ☐ Provider Report ☐ NHM&E/PEMS ☐ Other	Date patient reported information __ __/__ __/__ __ __ __

Ever had previous positive HIV test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown — Date of first positive HIV test __ __/__ __/__ __ __ __

Ever had a negative HIV test? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown — Date of last negative HIV test *(If date is from a lab test with test type, enter in Lab Data section)* __ __/__ __/__ __ __ __

Number of negative HIV tests within 24 months before first positive test # _____ ☐ Refused ☐ Don't Know/Unknown

Ever taken any antiretrovirals (ARVs)? ☐ Yes ☐ No ☐ Refused ☐ Don't Know/Unknown — If Yes, ARV medications:

Dates ARVs taken — Date first began: __ __/__ __/__ __ __ __ — Date of last use: __ __/__ __/__ __ __ __

***Comments**

***Local/Optional Fields**

PRISM #	NIR Status:
DOC #	NIR OP __ NIR OP Date ___/___/___
Link with e-HARS stateno(s):	NIR CL __ NIR CL Date ___/___/___
Other Risks: A ___ B/C ___ D ___ F ___ M ___ V ___ J ___	NIR RE __ NIR RE Date ___/___/___
Hepatitis: A ___ B ___ C ___ Other ___ UNKnown ___	Initials (3) _____ Source Code A _____
	If pregnant, list EDD (due date) ___/___/___