SUBJECT: REPORTING OF INFECTIONS	**Policy No.: IC104** **Last Revision: 07/2016** **Reviewed: 07/2022** **Page: 1 of 13**

A. Medical or nursing staff will report the following types of infections or problems to the Infection Preventionist(s) at extension 57447 for evaluation and consultation:

1. All surgical wound infections (inpatient and outpatients)
2. All orders for isolation precautions
3. All isolation cases being transferred to or from other units or facilities.
4. Isolation being discontinued on an inpatient
5. All Central Line infections
6. All referrals to Employee Health Services for infectious problems
7. Any clustering of possible infections identified in an area (i.e., diarrhea, respiratory, or wounds)
8. Any suspected potential infectious problem
9. New procedures or devices related to direct patient care
10. Any change in current procedures related to direct patient care.
11. Report all TB or TB suspects to Infection Prevention and Control regardless of isolation status. In addition, notify Infection Prevention and Control before discharge the TB patient or TB suspect. *See Administrative Policy B839.*

The list of reportable diseases (see Attachment A) on the following page must be reported to the Los Angeles County Department of Public Health on a Confidential Morbidity Report (CMR) Form (see Attachment B). If the disease has not been reported, the form may be obtained from the Infection Prevention and Control Office. Generally, the primary physician is responsible for reporting diseases once the diagnosis has been made. For the reporting of tuberculosis, a special GOTCH bill reporting form is required, *see Tuberculosis Plan, policy IC 300 A.*

B. Report of infection that was identified after admission and the presence of infection was unknown to the referring organization at the time of transfer:
The Infection Preventionist(s) will notify the referring organization for the following conditions:

1. After receiving admission from another healthcare organization, Rancho determined that the patient had a communicable disease, e.g., TB that was not known during treatment by the referring organization.
2. Rancho determines that there is a surgical site infection within the first 30 days following surgery at the referring organization.

Attchment A
IC 104

The following table is the most current list of reportable diseases and conditions from LA County Department of Public Health Acute communicable Disease Program revised February 11, 2022.

Please Post
Revised February 11, 2022 v1

County of Los Angeles Public Health

REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR), § 2500

It is the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. "Health care provider" encompasses physicians (surgeons, osteopaths, oriental medicine practitioners), veterinarians, podiatrists, physician assistants, registered nurses (nurse practitioners, nurse midwives, school nurses), infection control professionals, medical examiners/coroners, dentists, and chiropractors, as well as any other person with knowledge of a case or suspected case.

Note: This list is specific to Los Angeles County and differs from state and federal reporting requirements ★

☎ Report **immediately** by telephone for both confirmed and suspected cases.
NOTE: Monkeypox is an unusual disease which requires immediate report by telephone or Weblink.
❶ Report by telephone **within 1 working day** from identification COVID-19 Online Reporting** OR COVID-19 Death Online reporting***
✉ Report by electronic transmission (including FAX or email), telephone or mail within **1 working day** from identification
⑦ Report by electronic transmission (including FAX or email), telephone or mail within **7 calendar days** from identification
★ Mandated by and reportable to the Los Angeles County Department of Public Health
± If enrolled, report electronically via the **National Healthcare Safety Network** (www.cdc.gov/nhsn/index.html). If not enrolled, use the LAC DPH **CRE Case Report Form** (publichealth.lacounty.gov/acd/Diseases/EpiForms/CRERepSNF.pdf)
■ For TB reporting questions: contact the TB Control Program (213) 745-0800 or visit www.publichealth.lacounty.gov/tb/healthpro.htm
■ For HIV/STD reporting questions: contact the Division of HIV and STD Programs. HIV (213) 351-8516, STDs (213) 368-7441 www.publichealth.lacounty.gov/dhsp/ReportCase.htm

For laboratory reporting: www.publichealth.lacounty.gov/lab/index.htm **For veterinary reporting**: www.publichealth.lacounty.gov/vet/index.htm

REPORTABLE COMMUNICABLE DISEASES

- ⑦ Anaplasmosis
- ☎ Anthrax, human or animal
- ✉ Babesiosis
- ☎ Botulism: infant, foodborne, or wound
- ⑦ Brucellosis, animal; except infections due to *Brucella canis*
- ☎ Brucellosis, human
- ✉ Campylobacteriosis
- ✉ *Candida auris* ★
- ⑦ Carbapenem-Resistant *Enterobacteriaceae* (CRE), including *Klebsiella sp.*, *E. coli*, and *Enterobacter sp.*, in acute care hospitals or skilled nursing facilities ★±
- ⑦ Chagas Disease ★
- ⑦ Chancroid ■
- ☎ Chickenpox (Varicella), only hospitalizations, deaths, and outbreaks (≥3 cases, or one case in a high-risk setting)
- ✉ Chikungunya Virus Infection
- ☎ Cholera
- ☎ Ciguatera Fish Poisoning
- ⑦ Coccidioidomycosis
- ❶ COVID-19 hospitalizations (COVID-19 Online Reporting**)
- ❶ COVID-19, deaths (COVID-19 Death Online Reporting***)
- ⑦ Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- ✉ Cryptosporidiosis
- ⑦ Cyclosporiasis
- ⑦ Cysticercosis or Taeniasis
- ✉ Dengue Virus Infection
- ☎ Diphtheria
- ☎ Domoic Acid (Amnesic Shellfish) Poisoning
- ⑦ Ehrlichiosis
- ✉ Encephalitis, specify etiology: viral, bacterial, fungal or parasitic
- ✉ *Escherichia coli*, shiga toxin producing (STEC) including *E. coli* O157
- ☎ Flavivirus infection of undetermined species
- ✉ Foodborne Disease
- ☎ Foodborne Outbreak; 2 or more suspected cases from separate households with same assumed source
- ⑦ Giardiasis
- ⑦ Gonococcal Infection ■
- ✉ *Haemophilus influenzae*, invasive disease only, all serotypes, less than 5 years of age
- ✉ Hantavirus Infection
- ☎ Hemolytic Uremic Syndrome
- ✉ Hepatitis A, acute infection
- ⑦ Hepatitis B, specify acute, chronic, or perinatal
- ⑦ Hepatitis C, specify acute, chronic, or perinatal
- ⑦ Hepatitis D (Delta), specify acute or chronic
- ⑦ Hepatitis E, acute infection
- ❶ Human Immunodeficiency Virus (HIV), acute infection ■ (§2641.30-2643.20)
- ⑦ Human Immunodeficiency Virus (HIV) infection, any stage ■*
- ⑦ Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS) ■*
- ⑦ Influenza-associated deaths in laboratory confirmed cases, all ages ★
- ☎ Influenza, due to novel strains, human
- ⑦ Legionellosis
- ⑦ Leprosy (Hansen's Disease)
- ⑦ Leptospirosis
- ✉ Listeriosis
- ⑦ Lyme Disease
- ✉ Malaria
- ☎ Measles (Rubeola)
- ✉ Meningitis, specify etiology: viral, bacterial, fungal, or parasitic
- ☎ Meningococcal Infection
- ☎ Middle East Respiratory Syndrome (MERS)
- ⑦ Mumps
- ⑦ Myelitis, acute flaccid ★
- ⑦ Nontuberculosis mycobacteria (extrapulmonary) ★
- ☎ Novel virus infection with pandemic potential
- ☎ Paralytic Shellfish Poisoning
- ✉ Paratyphoid Fever
- ✉ Pertussis (Whooping Cough)
- ☎ Plague, human or animal
- ✉ Poliovirus Infection
- ✉ Psittacosis
- ✉ Q Fever
- ☎ Rabies, human or animal
- ✉ Relapsing Fever
- ⑦ Respiratory Syncytial Virus, only deaths in a patient less than 5 years of age
- ⑦ Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- ⑦ Rocky Mountain Spotted Fever
- ⑦ Rubella (German Measles)
- ⑦ Rubella Syndrome, Congenital
- ✉ Salmonellosis, other than Typhoid Fever
- ☎ Scombroid Fish Poisoning
- ☎ Shiga Toxin, detected in feces
- ✉ Shigellosis
- ☎ Smallpox (Variola)
- ✉ *Streptococcus pneumoniae*: Invasive cases only (sterile body site infections) ★
- ✉ *Streptococcus pyogenes* (Group A *Streptococcus*): Invasive cases only, including necrotizing fasciitis and STSS ★
- ✉ Syphilis, all stages including congenital ■
- ⑦ Tetanus
- ✉ Trichinosis
- ✉ Tuberculosis ■
- ⑦ Tularemia, animal
- ☎ Tularemia, human
- ✉ Typhoid Fever, cases and carriers
- ✉ *Vibrio* Infection
- ☎ Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)
- ✉ West Nile Virus (WNV) Infection
- ✉ Yellow Fever
- ✉ Yersiniosis
- ✉ Zika Virus Infection
- ☎ **OCCURRENCE OF ANY UNUSUAL DISEASE**
- ☎ **OUTBREAKS OF ANY DISEASE**, including diseases not listed above. Specify if in an institution and/or the open community.

* *Use of FAX for HIV reporting is highly discouraged in order to protect patient confidentiality.*

REPORTABLE NON-COMMUNICABLE DISEASES OR CONDITIONS

⑦ Disorders Characterized by Lapses of Consciousness (CCR § 2806, § 2810) ⑦ Cancer, including benign and borderline brain tumors (CCR §2593)
✉ Pesticide-Related Illnesses (Health and Safety Code §105200)

To report a case or outbreak of any disease, contact the Communicable Disease Reporting System
Tel: (888) 397-3993 or (213) 240-7821 • Fax: (888) 397-3778 or (213) 482-5508 • Email: ACDC-MorbidityUnit@ph.lacounty.gov
**** COVID-19 Cases Only: COVID19@ph.lacounty.gov • Fax (310) 605-4274 •** COVID-19 Online Reporting
*****COVID-19 Deaths Only: COVIDdeath@ph.lacounty.gov •** COVID-19 Death Online Reporting
Use secure transmission for emailed reports.
Health Professionals Reporting Webpage: www.publichealth.lacounty.gov/clinicians/report

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County of Los Angeles Public Health

REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR), § 2500

It is the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or conditions listed below, to report to the local health officer for the jurisdiction where the patient resides. "Health care provider" encompasses physicians (surgeons, osteopaths, oriental medicine practitioners), veterinarians, podiatrists, physician assistants, registered nurses (nurse practitioners, nurse midwives, school nurses), infection control professionals, medical examiners/coroners, dentists, and chiropractors, as well as any other person with knowledge of a case or suspected case.

Note: This list is specific to Los Angeles County and differs from state and federal reporting requirements ★

☎ Report immediately by telephone (for both confirmed and suspected cases)

NOTE: Monkeypox is an unusual disease which requires immediate report by telephone or Weblink.

OCCURRENCE OF ANY UNUSUAL DISEASE

OUTBREAKS OF ANY DISEASE, including diseases not listed above. Specify if in an institution and/or the open community

- Anthrax, human or animal
- Botulism: infant, foodborne, or wound
- Brucellosis, human
- Chickenpox (Varicella), only hospitalizations, deaths, and outbreaks (≥3 cases, or one case in a high-risk setting)
- Cholera
- Ciguatera Fish Poisoning
- Diphtheria
- Domoic Acid (Amnesic Shellfish) Poisoning
- Flavivirus infection of undetermined species
- Foodborne Outbreak; 2 or more suspected cases from separate households with same assumed source
- Hemolytic Uremic Syndrome
- Influenza, due to novel strains, human
- Measles (Rubeola)
- Meningococcal Infection
- Middle East Respiratory Syndrome (MERS)
- Novel virus infection with pandemic potential
- Paralytic Shellfish Poisoning
- Plague, human or animal
- Rabies, human or animal
- Scombroid Fish Poisoning
- Shiga Toxin, detected in feces
- Smallpox (Variola)
- Tularemia, human
- Viral Hemorrhagic Fevers, human or animal (e.g., Crimean-Congo, Ebola, Lassa and Marburg viruses)

❶ COVID-19, hospitalizations (COVID-19 Online Reporting**)

❶ COVID-19, deaths (COVID-19 Death Online Reporting***)

❶ Human Immunodeficiency Virus (HIV), acute infection (telephone within 1 working day)

✉ Report by electronic transmission (including FAX or email), telephone or mail within 1 working day from identification

- Babesiosis
- Campylobacteriosis
- *Candida auris* ★
- Chikungunya Virus Infection
- Cryptosporidiosis
- Dengue Virus Infection
- Encephalitis, specify etiology: viral, bacterial, fungal or parasitic
- *Escherichia coli*, shiga toxin producing (STEC) including *E. coli* O157
- Foodborne Disease
- *Haemophilus influenzae*, invasive disease only, all serotypes, less than 5 years of age
- Hantavirus Infection
- Hepatitis A, acute infection
- Listeriosis
- Malaria
- Meningitis, specify etiology: viral, bacterial, fungal, or parasitic
- Paratyphoid Fever
- Pertussis (Whooping Cough)
- Pesticide-Related Illnesses (Health and Safety Code §105200)
- Poliovirus Infection
- Psittacosis
- Q Fever
- Relapsing Fever
- Salmonellosis, other than Typhoid Fever
- Shigellosis
- *Streptococcus pneumoniae*: Invasive cases only (sterile body site infections) ★
- *Streptococcus pyogenes* (Group A *Streptococcus*): Invasive cases only, including necrotizing fasciitis and STSS ★
- Syphilis, all stages including congenital
- Trichinosis
- Tuberculosis
- Typhoid Fever, cases and carriers
- *Vibrio* Infection
- West Nile Virus (WNV) Infection
- Yellow Fever
- Yersiniosis
- Zika Virus Infection

⑦ Report by electronic transmission (including FAX or email), telephone or mail within 7 calendar days from identification

- Anaplasmosis
- Brucellosis, animal; except infections due to *Brucella canis*
- Cancer, including benign and borderline brain tumors (CCR §2593)*
- Carbapenem-Resistant *Enterobacteriaceae* (CRE), including *Klebsiella sp.*, *E. coli*, and *Enterobacter sp.*, in acute care hospitals or skilled nursing facilities ★±
- Chagas Disease ★
- Chancroid
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease and other Transmissible Spongiform Encephalopathies
- Cyclosporiasis
- Cysticercosis or Taeniasis
- Disorders Characterized by Lapses of Consciousness (CCR § 2806, § 2810)
- Ehrlichiosis
- Giardiasis
- Gonococcal Infection
- Hepatitis B, specify acute, chronic, or perinatal
- Hepatitis C, specify acute, chronic, or perinatal
- Hepatitis D (Delta), specify acute or chronic
- Hepatitis E, acute infection
- Human Immunodeficiency Virus (HIV) infection, any stage **
- Human Immunodeficiency Virus (HIV) infection, progression to stage 3 (AIDS) **
- Influenza-associated deaths in laboratory confirmed cases, all ages ★
- Legionellosis
- Leprosy (Hansen's Disease)
- Leptospirosis
- Lyme Disease
- Mumps
- Myelitis, acute flaccid ★
- Nontuberculosis mycobacteria (extrapulmonary) ★
- Respiratory Syncytial Virus, only deaths in a patient less than 5 years of age
- Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like Illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- Tetanus
- Tularemia, animal

*Except basal and squamous skin cancer unless on genital, and carcinoma in-situ and CIN III of the Cervix.

Use of FAX for **HIV reporting is highly discouraged in order to protect patient confidentiality.

± If enrolled, report electronically via the **National Healthcare Safety Network** (www.cdc.gov/nhsn/index.html).
If not enrolled, use the LAC DPH CRE Case Report Form (publichealth.lacounty.gov/acd/Diseases/EpiForms/CRERepSNF.pdf)

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Use secure transmission for emailed reports.
Health Professionals Reporting Webpage: www.publichealth.lacounty.gov/clinicians/report

Attachment B
IC 104

LOS ANGELES COUNTY SEXUALLY TRANSMITTED DISEASE CONFIDENTIAL MORBIDITY REPORT

County of Los Angeles Public Health

DATE OF REPORT (MMDDYY): ☐☐ — ☐☐ — ☐☐

REPORT STATUS: ☐ NEW ☐ UPDATE

REPORT DONE BY: (First+Space+Last)

1 PROVIDER

DIAGNOSING MEDICAL PRACTITIONER LAST NAME | FIRST NAME | TITLE ABBREVIATION

FACILITY/CLINIC NAME | SUITE/UNIT NO.

FACILITY/CLINIC STREET ADDRESS

CLINIC STAMP

CITY/TOWN

STATE | OFFICE TEL. (Enter 999-999-9999 as 9999999999)

ZIP CODE | OFFICE FAX (Enter 999-999-9999 as 9999999999)

2 PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST NAME | M.I.

MEDICAL RECORD NUMBER | AGE | BIRTHDAY (MMDDYYYY): | OCCUPATION

PATIENT STREET ADDRESS | APT/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

HIV cases must be reported to **LA County HIV Epidemiology Program** (see section 5)

DAY TEL. (Enter 999-999-9999 as 9999999999) | EVENING TEL. (Enter 999-999-9999 as 9999999999)

CELL PHONE (Enter 999-999-9999 as 9999999999) | E-MAIL ADDRESS

PREGNANT? ☐ Unknown ☐ No ☐ Yes ▶ If yes, date of LMP (MMDDYY): ☐☐-☐☐-☐☐

If patient has HIV infection, have they received HIV partner servcies? ☐ Yes ☐ No ☐ Unknown

GENDER (X one):
- ☐ Male
- ☐ Female
- ☐ Transgender (M to F)
- ☐ Transgender (F to M)
- ☐ Unknown
- ☐ Other

MARITAL STATUS (X one):
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Living with Partner

RACE (X all that apply):
- ☐ White
- ☐ Black or African American
- ☐ Native American or Alaska Native
- ☐ Asian or Asian American
- ☐ Native Hawaiian or Pacific Islander
- ☐ Unknown
- ☐ Other:

ETHICITY (X one):
- ☐ Hispanic or Latino
- ☐ Non-Hispanic/ Non-Latino

GENDER of SEX PARTNERS (X all that apply):
- ☐ Male
- ☐ Female
- ☐ Transgender (M to F)
- ☐ Transgender (F to M)
- ☐ Unknown
- ☐ Other
- ☐ Refused

3 DIAGNOSIS & TREATMENT

CHLAMYDIA (including PID)

DIAGNOSIS (X one):
- ☐ Asymptomatic
- ☐ Symptomatic - uncomplicated
- ☐ Pelvic Inflammatory Disease
- ☐ Opthalmia/Conjunctivitis
- ☐ Other:

SITE/SPECIMEN(S) (X all that apply):
- ☐ Urine
- ☐ Cervix
- ☐ Vagina
- ☐ Urethra
- ☐ Rectum
- ☐ Other:

Specimen Collection Date (MMDDYY): ☐☐ — ☐☐ — ☐☐

Treatment Date (MMDDYY): ☐☐ — ☐☐ — ☐☐ ☐ Not Treated

Medication & Dose:

Partner Information: Number Partners (last 60 days): | Number Treated (not including PDPT): | Number Given Patient Delivered Partner Therapy (PDPT)

GONORRHEA (including PID)

DIAGNOSIS (X one):
- ☐ Asymptomatic
- ☐ Symptomatic - uncomplicated
- ☐ Pelvic Inflammatory Disease
- ☐ Opthalmia/Conjunctivitis
- ☐ Disseminated
- ☐ Other:

SITE/SPECIMEN(S) (X all that apply):
- ☐ Urine
- ☐ Cervix
- ☐ Vagina
- ☐ Urethra
- ☐ Rectum
- ☐ Nasopharynx
- ☐ Other:

Specimen Collection Date (MMDDYY): ☐☐ — ☐☐ — ☐☐

Treatment Date (MMDDYY): ☐☐ — ☐☐ — ☐☐ ☐ Not Treated

Medications & Doses:

Partner Information: Number Partners (last 60 days): | Number Treated (not including PDPT): | Number Given Patient Delivered Partner Therapy (PDPT)

SYPHILIS, CONGENITAL SYPHILIS, OTHER REPORTABLE STDS AND REPORTING INFORMATION ON BACK PAGE.

County of Los Angeles • Department of Public Health • TB Control Program
TEL (213) 745-0800 FAX (213) 749-0926

Confidential Hospitalized TB Suspect/Case Report (H-803)

**PATIENT: _____
Last First MI

ADDRESS: _____

PHONE ( ) _____

BIRTH DATE: / / Sex: ☐ Male ☐ Female

Social Security Number: _____

**IF PT. UNDER 18, (PARENT NAME/DOB):

Employer/School: _____

OCCUPATION: _____

Race: ☐ White ☐ Black ☐ Am. Indian ☐ Alaska Native
☐ Asian (*Specify*)_____ ☐ Pacific Islander (*Specify*)_____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Country of Origin: _____ Date of Entry: / /

Contact Person (name/ph#) _____

Date of Diagnosis / / Pulmonary TB ☐

Skin Test Date / / Chest X-ray Date: / /

Result _____ MM

☐ Not done ☐ Unknown

If Pulmonary, check symptoms.

☐ Cough ☐ Night sweats

☐ Sputum production ☐ Hemoptysis

☐ Weight loss _____(No. of lbs.)

RECORDED BY: _____

Phone ( ) Fax ( )

Hospital/Clinic where diagnosed _____

Medical Record # _____

Pt. currently hospitalized? ☐ Yes ☐ No Adm. Date: / /

Treating Physician: _____

Address: _____

Phone ( ) _____

Referred for F/U _____

Address: _____

Phone ( ) _____

Will MD be continuing TB care? ☐ Yes ☐ No

Extra Pulmonary TB ☐ (Site) _____

Cavitary ☐ Non-Cavitary ☐

Impression: _____

Past history of TB Treatment? ☐ Yes ☐ No

If yes, where, when treated?

_____

If asymptomatic, reason for evaluation _____

Other medical conditions relevant to diagnosis:

_____

_____

BACTERIOLOGY

Pathology Report: _____

_____

Lab Name and Account #: _____

HIV STATUS DATE: / /

☐ POSITIVE ☐ NEGATIVE ☐ UNKOWN

☐ NOT DONE ☐ REFUSED ☐ PENDING

Patient weight _____

Psychosocial History: _____

_____

Allergies: _____

Specimen Number	Specimen Collection Date	Specimen Type	Smear AFB	Culture M.TB +/-

MEDICATIONS	DOSE	START DATE
Isoniazid		
Rifampin		
Ethambutol		
Pyrazinamide		
Rifamate®		
Rifater®		

Additional Comments: _____

_____

Date Reported / /

H-803

Rev: 7/06

County of Los Angeles • Department of Public Health • TB Control Program

Confidential Hospitalized TB Suspect/Case Report (H-803) Instructions

Reporting of all patients with confirmed or suspected Tuberculosis is mandated by the State Health and Safety Codes (HSC) Division 105, Part 5 and Administrative Codes, Title 17, Chapter 4, Section 2500 and must be done within 1 day of diagnosis.

Why do you report?

Because it is required. The Health Department performs many vital functions to ensure public health and safety. These functions include contact investigation, home visits, patient education, patient compliance assessment and directly observed therapy (DOT). Tuberculosis Control staff also will assist in facilitating appropriate discharge planning. HSC section 121361 also mandates that, prior to discharge, all tuberculosis suspects and cases in hospitals and prisons have an individualized, written, discharge plan approved by the Local Health Officer (i.e. TB Controller).

Who must report?

1. All health care providers (including administrators of healthcare facilities and clinics) in attendance of a patient suspected to have, or confirmed with, active tuberculosis, must report within 1 working day from the time of identification (California Code: Title 17, Chap. 4, Sec. 2500).

2. The director of any clinical lab or designee must report laboratory evidence suggestive of tuberculosis to the Health Department on the same day that the physician who submitted the specimen is notified (California Code: Title 17, Chap. 4, Sec. 2505).

When do you report?

1. When the following conditions are present:
   - ⋆ signs and symptoms of tuberculosis are present, and/or
   - ⋆ the patient has an abnormal CXR consistent with tuberculosis, or
   - ⋆ the patient is placed on two or more anti-TB drugs
2. When bacteriology smears or cultures are positive for acid fast bacilli (AFB)
3. When the patient has a positive culture for *M. tuberculosis* complex (i.e., *M. tuberculosis, M. bovis, M. canettii, M. africanum, M. microti).*
4. When a pathology report is consistent with tuberculosis

How do you report?

The Confidential Hospitalized TB Suspect/Case report (H-803) (on the back of this form) is to be completed in its entirety and submitted to Tuberculosis Control. The Confidential Morbidity Report (CMR) should not be used for hospitalized patients.

1. BY FAX: (213) 749-0926

2. BY PHONE: (213) 745-0800: After hours, leave your name, phone or pager #, patient's name, DOB and medical record number on voicemail.

3. BY MAIL: Tuberculosis Control Program
   2615 S. Grand Avenue, Room 507
   Los Angeles, CA 90007

Reporting tuberculin skin test

Definition of a Positive Tuberculin Skin Test:

≥ 5 mm of induration is considered positive for contacts, suspects and HIV+ or immuno-suppressed individuals of any age.

≥10 mm of induration is considered positive for all other screening subjects of any age.

A positive tuberculin skin test with a normal chest x-ray is not reportable unless the patient is age 3 years or younger. However, health department follow-up may be requested for PPD reactors who also meet one of the following criteria. The reason for referral must be noted on the Remarks section.

a. HIV infected or at risk for HIV infection
b. Contact to infectious case of tuberculosis
c. Abnormal chest film consistent with old TB or silicosis
d. Children 3 years old or under with a positive tuberculin skin test
e. Documented converters
f. Medical conditions that increase TB risk:
   - ♦ Diabetes mellitus
   - ♦ Prolonged steroid therapy
   - ♦ Immunosuppressive therapy
   - ♦ End stage renal disease
   - ♦ Unexplained rapid weight loss

County of Los Angeles • Department of Public Health • TB Control Program
TEL (213) 745-0800 FAX (213) 749-0926

Confidential Hospitalized TB Suspect / Discharge Care Plan / Approval Request

Patient Name: _____ **Submitted By:** _____

D.O.B. ___/___/___ MR# _____ Phone (___) _____ Pager (___) _____

Facility _____

Fax # (___) _____

If Pulmonary: Dates of three consecutive negative smears

___/___/___, ___/___/___, ___/___/___

Discharge to: [ ] Home [ ] Shelter [ ] SNF [ ] Jail/Prison [ ] Other _____

Discharge address and phone: _____

_____

Date patient to be discharged ___/___/___ **F/U Appt. Date** ___/___/___

Physician agreeing to assume TB care _____ Phone # (___) _____

Health Care Facility _____

Address _____

Discharge TB medication regimen:
(Indicate total daily dose)

Rifamate® (INH+RIF)* _____ pills/day
Rifater®(INH+RIF+PZA) _____ pills/day
INH _____ mg
Rifampin _____ mg
Ethambutol* _____ mg
Pyrazinamide* _____ mg
Other _____ mg
Side Effects _____

*Current CDC/ATS and Los Angeles County TB Control recommendations for treatment of uncomplicated TB for 2 months followed by INH & RIF for 4 months.

[

Medical complications *(specify):*

_____

_____

# of days of medication supply_____
(Must be sufficient to supply patient until follow up provider appointment).

Does the patient have risks that indicate Directly Observed Therapy (DOT)?

[ ] Mental Impairment
[ ] Homeless
[ ] HIV
[ ] Hx of any non-compliant behavior
[ ] Substance

*Contact TB Control if uncertain about risk.

Contact Information/Household composition:

Number of people in household? _____
Are there children age 5 years and younger? [ ] Yes [ ] No
Are there individuals immunocompromised? [ ] Yes [ ] No

Tuberculosis Control use only:

DHS Review - Problems Noted _____

_____

Action taken before discharge _____

_____

Reviewed by _____ *Date reviewed* ___/___/___
Approved by _____ *Date approved* ___/___/___

Discharge Approved
[ ] Yes [ ] No
Date ___/___/___

The Confidential Tuberculosis Suspect Case Report (H-803) form must be on file at Tuberculosis Control or submitted with this form

Los Angeles County • Department of Public Health
Tuberculosis Control Program
2615 S. Grand Ave. Room 507 Los Angeles, CA 90007
Phone: 213-745-0800 Fax: 213-749-0926

Confidential Hospitalized TB Suspect/Case Discharge Care Plan / Approval Request (H- 804) Instructions

Discharge of a Suspect or Confirmed Tuberculosis Patient

As of January 1, 1994, State Health and Safety Codes mandate that patients suspected or confirmed with tuberculosis may not be discharged or transferred from a health facility (e.g. hospital) without prior approval of the Local Health Officer (i.e., TB Controller).

To facilitate a timely and appropriate discharge, the provider should submit a written discharge plan to Tuberculosis Control 1 to 2 days prior to the anticipated discharge. Tuberculosis Control will review the discharge plan for approval or denial.

Health Department Response Plan:

Weekly discharge (Non holiday 8:00 am- 5:00 pm): The written discharge plan should be submitted preferably by FAX or mail.

Tuberculosis Control staff will review the discharge plan and notify the provider **within 24 hours** of approval or inform the provider of any additional information/action required or needed for approval prior to discharge.

If a home evaluation is required to determine if the environment is suitable for discharge, health department staff will make a visit.

Holiday and Weekend Discharge: All arrangements for discharge should be made in advance when weekend discharge is anticipated. When unusual circumstances necessitate weekend or holiday discharge, the provider will phone the Los Angeles County Operator at (213) 974-1234 and ask to speak with the **Public Health Administrative Officer of the Day** (AOD). A response will usually occur within one hour. The process outlined above will be followed. If the discharge cannot be approved, the patient must be held until the next business day until appropriate arrangements can be made *(to fulfill State requirements for communicable disease reporting, the Confidential Hospitalized Tuberculosis Suspect/Case Report must be completed and submitted prior to or concurrently with the Confidential Hospitalized Tuberculosis Suspect/Case Discharge Care Plan /Approval Request).*

(NOTE: This form is used for discharge care planning only. Call the Tuberculosis Control Program prior to faxing documents to ensure timely processing.)

PATIENT'S LAST NAME | FIRST NAME | M.I.

ADULT SYPHILIS

3. Cont. DIAGNOSIS & TREATMENT

☐ Primary Syphilis — Onset Date (MMDDYY): __-__-__ — **LESION SITES** (X all that apply): ☐ Genital ☐ Rectum ☐ Oral ☐ Other: ☐ Vagina ☐ Perirectal

☐ Secondary Syphilis — Onset Date (MMDDYY): __-__-__ — **SYMPTOMS** (X all that apply): ☐ Palmar/Plantar Rash ☐ Other: ☐ General Body Rash ☐ Alopecia

☐ Early Latent (≤1 year)
☐ Late Latent (>1 year)
☐ Latent, Unknown Duration

☐ Late Syphilis
☐ Neurosyphilis
} DESCRIBE SYMPTOMS

(The diagnosis of neurosyphilis must be accompanied by a staged diagnosis)

Specimen Collection Date (MMDDYY): __-__-__

☐ RPR or ☐ VDRL } Titer: 1 :

☐ TP-PA or ☐ FTA-ABS or ☐ Other } Reactive: ☐ Yes ☐ No

☐ CSF-VDRL Titer: 1 :

Partner information: Number elicited: __ Number treated: __ PREGNANT? ☐ Yes ☐ No ☐ Unknown

Patient Treated: ☐ Yes ☐ No (If **yes,** give treatment/dose & dates below)

DATE(S) TREATED (MMDDYY) | Medication & Dose:

__-__-__ |
__-__-__ |
__-__-__ |

CONGENITAL SYPHILIS (SEPARATE CMRS SHOULD BE SUBMITTED FOR MOTHER & INFANT)

INFANT INFORMATION

(Complete sections A & B if this is mother's CMR; Complete only B if this is infant's CMR)

A

INFANT'S LAST NAME

INFANT'S FIRST NAME

INFANT'S BIRTH DATE (MMDDYY): __-__-__ ☐ Male ☐ Female ☐ Live Birth ☐ Still Birth

B

WEIGHT (grams)

SYMPTOMS (describe) ☐ No symptoms

GESTATION(wks)

Long Bone X-rays: ☐ Pos. ☐ Neg. ☐ Not Done

Serum RPR Lab Test Date (MMDDYY): __-__-__

☐ Reactive → Titer: 1 :
☐ Non-Reactive
☐ Not Done

Titer 4x > mothers? ☐ Yes ☐ No

DATE INFANT TREATED (MMDDYY): __-__-__

CSF Laboratory Test Date (MMDDYY): __-__-__

VDRL: ☐ Non-Reactive ☐ Reactive

WBC>5/mm³: ☐ Yes ☐ No

Protein>50mg/dl: ☐ Yes ☐ No

MEDICATION / DOSE

MATERNAL INFORMATION

(Complete if this is infant's CMR)

MOTHER'S LAST NAME

MOTHER'S FIRST NAME

MOTHER'S BIRTH DATE (MMDDYY): __-__-__ Lumbar Puncture Done: ☐ Yes ☐ No

MOTHER'S SEROLOGY AT DELIVERY

Lab Test Date (MMDDYY): __-__-__

☐ RPR or ☐ VDRL } Titer: 1 :

☐ TP-PA or ☐ FTA-ABS or ☐ Other } Reactive: ☐ Yes ☐ No

MOTHER'S STAGE OF SYPHILIS AT DIAGNOSIS

☐ Primary
☐ Secondary
☐ Early Latent (≤1 year)
☐ Late Latent (>1 year)
☐ Latent, Unknown Duration
☐ Late Syphilis

DATE(S) TREATED (MMDDYY) | MEDICATION / DOSE

__-__-__ |
__-__-__ |
__-__-__ |

OTHER REPORTABLE STDs

DIAGNOSIS	TREATED	DATE TREATED	MEDICATION / DOSE
☐ Pelvic Inflammatory Disease (complete if chlamydia & gonorrhea tests are negative or not available. If either test is positive, report in chlamydia and/or gonorrhea sections)	☐ Yes ☐ No	__-__-__	
☐ LGV	☐ Yes ☐ No	__-__-__	
☐ Chancroid	☐ Yes ☐ No	__-__-__	

4. SEND

FAX BOTH SIDES TO:
(213) 749-9602
OR
MAIL TO:
STD PROGRAM
2615 S. GRAND AVENUE, RM. 450
LOS ANGELES, CA 90007

5. INFO

FOR STD CMR FORMS:
Complete on-line or download from: http://publichealth.lacounty.gov/std/cmr.htm
or call (213) 741-8000 to request forms.

FOR INFORMATION AND QUESTIONS ABOUT STD REPORTING:
Visit http://publichealth.lacounty.gov/std/providers.htm or call (213) 744-3106.

FOR HIV REPORTING:
Visit http://publichealth.lacounty.gov/hiv/hivreporting.htm or call (213) 351-8516.

LOS ANGELES COUNTY STD PROGRAM
CHLAMYDIA & GONORRHEA LABORATORY REPORT

COUNTY OF LOS ANGELES Public Health

DATE OF REPORT | REPORT STATUS ☐ New ☐ Update | REPORT DONE BY

1 PATIENT

PATIENT'S LAST NAME | FIRST NAME | M.I.

PATIENT'S STREET ADDRESS | APT/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

AREA CODE - DAY TELEPHONE NUMBER

AREA CODE - EVENING TELEPHONE NUMBER

Birth Date - -

GENDER:
☐ Male
☐ Female
☐ Transgender (M to F)
☐ Transgender (F to M)
☐ Unknown or Refused

AGE:

PREGNANT:
☐ Yes ☐ Unknown
☐ No

POSTPARTUM:
☐ Yes ☐ Unknown
☐ No

RACE (X all that apply):
☐ White
☐ Black or African American
☐ Native American or Alaska Native
☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander
☐ Unknown ☐ Refused
☐ Other:

2 PROVIDER

DOCTOR'S LAST NAME | DOCTOR'S FIRST NAME | M.I.

FACILITY/CLINIC NAME

FACILITY STREET ADDRESS | SUITE/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

AREA CODE - TELEPHONE NUMBER | AREA CODE - FAX NUMBER

For HIV REPORTING:
Call (213) 351-8516 or visit
publichealth.lacounty.gov/hiv/

3 LABORATORY

LABORATORY'S NAME

LABORATORY'S STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

AREA CODE - TELEPHONE NUMBER | AREA CODE - FAX NUMBER

4 REFERENCE LAB

REFERENCE LABORATORY'S NAME (If specimen was sent for further testing from original lab to reference lab, reference lab info required in addition to the above information)

REFERENCE LABORATORY'S STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE | Test Date (MM-DD-YY): - -

AREA CODE - TELEPHONE NUMBER | AREA CODE - FAX NUMBER | Date reported (MM-DD-YY): - -

5 TEST RESULT

CHLAMYDIA

TEST NAME

TEST RESULT

SPECIMEN TYPE

SPECIMEN SITE:
☐ Urine ☐ Vaginal ☐ Other
☐ Cervix ☐ Rectum
☐ Urethra ☐ Nasopharynx

Spec. Coll. Date (MM-DD-YY): - -

Test Date (MM-DD-YY): - -

Specimen ID #:

Date reported (MM-DD-YY): - -

GONORRHEA

TEST NAME

TEST RESULT

SPECIMEN TYPE

SPECIMEN SITE:
☐ Urine ☐ Vaginal ☐ Other
☐ Cervix ☐ Rectum
☐ Urethra ☐ Nasopharynx

Spec. Coll. Date (MM-DD-YY): - -

Test Date (MM-DD-YY): - -

Specimen ID #:

Date reported (MM-DD-YY): - -

FAX TO: (213) 749-9602 REPORTING OR QUESTION: (213) 744-3106 DOWNLOAD FROM: HTTP://PUBLICHEALTH.LACOUNTY.GOV/STD/LABS.HTM

Updated by 11/04/2010

LOS ANGELES COUNTY STD PROGRAM
SYPHILIS LABORATORY REPORT

County of Los Angeles Public Health

DATE OF REPORT

REPORT STATUS ☐ New ☐ Update

REPORT DONE BY

1 PATIENT

PATIENT'S LAST NAME | FIRST NAME | M.I.

PATIENT'S STREET ADDRESS | APT/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

AREA CODE - DAY TELEPHONE NUMBER

AREA CODE - EVENING TELEPHONE NUMBER

Birth Date

GENDER:
☐ Male
☐ Female
☐ Transgender (M to F)
☐ Transgender (F to M)
☐ Unknown or Refused

AGE:

PREGNANT:
☐ Yes ☐ Unknown
☐ No

POSTPARTUM:
☐ Yes ☐ Unknown
☐ No

RACE (X all that apply):
☐ White
☐ Black or African American
☐ Native American or Alaska Native
☐ Asian or Asian American
☐ Native Hawaiian or Pacific Islander
☐ Unknown ☐ Refused
☐ Other:

2 PROVIDER

DOCTOR'S LAST NAME | DOCTOR'S FIRST NAME | M.I.

FACILITY/CLINIC NAME

FACILITY STREET ADDRESS | SUITE/UNIT NO.

CITY/TOWN | STATE | ZIP CODE

AREA CODE - TELEPHONE NUMBER | AREA CODE - FAX NUMBER

For HIV REPORTING:
Call (213) 351-8516 or visit
publichealth.lacounty.gov/hiv/

3 LABORATORY

LABORATORY'S NAME

LABORATORY'S STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

AREA CODE - TELEPHONE NUMBER | AREA CODE - FAX NUMBER

4 TEST RESULT — SYPHILIS

TEST NAME: (X all that apply) | TEST RESULT:

- ☐ RPR Titer: ☐ Reactive - Titer 1: ☐ Non-Reactive
- ☐ VDRL Titer: ☐ Reactive - Titer 1: ☐ Non-Reactive
- ☐ TP- PA (Serodia): ☐ Reactive ☐ Non-Reactive
- ☐ FTA - ABS: ☐ Reactive ☐ Non-Reactive
- ☐ MHA - TP: ☐ Reactive ☐ Non-Reactive
- ☐ EIA (IgG/IgM): ☐ Reactive ☐ Non-Reactive
- ☐ RPR Qualitative: ☐ Reactive ☐ Non-Reactive
- ☐ Other (Specify):

SPECIMEN TYPE:
☐ BLOOD
☐ CSF
☐ Other (Specify)

Spec. Coll. Date (MM-DD-YY):

Test Date (MM-DD-YY):

Specimen ID #:

Date reported (MM-DD-YY):

5 REFERENCE LABORATORY

REFERENCE LABORATORY'S NAME (If specimen was sent for further testing from original lab to reference lab, reference lab info required in addition to the above information)

REFERENCE LABORATORY'S STREET ADDRESS

CITY/TOWN | STATE | ZIP CODE

AREA CODE - TELEPHONE NUMBER | AREA CODE - FAX NUMBER

TEST NAME: | TEST RESULT:

- ☐ RPR Titer: ☐ Reactive - Titer 1: ☐ Non-Reactive
- ☐ TP- PA (Serodia): ☐ Reactive ☐ Non-Reactive
- ☐ FTA - ABS: ☐ Reactive ☐ Non-Reactive
- ☐ MHA - TP: ☐ Reactive ☐ Non-Reactive
- ☐ Other (Specify):

Test Date (MM-DD-YY):

Date reported (MM-DD-YY):

FAX TO: (213) 749-9602 REPORTING OR QUESTION: (213) 744-3106 DOWNLOAD FROM: HTTP://PUBLICHEALTH.LACOUNTY.GOV/STD/LABS.HTM

Updated by 11/04/2010