

TITLE 173 COMMUNICABLE DISEASES
CHAPTER 1 REPORTING AND CONTROL OF COMMUNICABLE DISEASES

TABLE OF CONTENTS

<u>SECTION</u>	<u>SUBJECT</u>	<u>PAGE</u>
1-001	SCOPE AND AUTHORITY	1
1-002	DEFINITIONS	1
1-003	WHO MUST REPORT	2
1-003.01	Health Care Providers (Physicians and Hospitals)	2
1-003.01A	Reporting by PA's and APRN's	2
1-003.01B	Reporting Lead Analysis	2
1-003.01C	Electronic Ordering of Laboratory Tests	2
1-003.02	Laboratories	2
1-004	REPORTABLE DISEASES, POISONINGS, AND ORGANISMS: LISTS AND FREQUENCY OF REPORTS	2
1-004.01	Immediate Reports	3
1-004.01A	List of Diseases, Poisonings, and Organisms	3
1-004.01B	Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks	4
1-004.02	Reports Within Seven Days – List of Reportable Diseases, Poisonings, and Organisms	4
1-004.03	Reports Once a Month – List of Antibiotic-Resistant Organisms	6
1-004.04	Reporting of Antibiotic Susceptibility	7
1-004.05	New, Emerging, or Reemerging Diseases and Other Syndromes and Exposures – Reporting and Submissions	7
1-004.05A	Criteria	7
1-004.05B	Surveillance Mechanism	7
1-004.06	Sexually Transmitted Diseases	7
1-005	METHODS OF REPORTING	8
1-005.01	Health Care Providers	
1-005.01A	Immediate Reports of Diseases, Poisonings, and Organisms	8
1-005.01B	Immediate Reports of Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks	8
1-005.01C	Reports Within Seven Days	9

1-005.01D	Reporting to Laboratories	10
1-005.02	Laboratories	10
1-005.02A	Electronic Reporting	10
1-005.02B	Laboratories Using NEDSS Manual Online Reporting	10
1-005.02C	Laboratories Using Automated Electronic Laboratory Reporting	12
1-006	WHERE TO REPORT	14
1-006.01	Cases Reported by Health Care Providers and Laboratories	14
1-006.01A	HIV/AIDS Cases Reported by Health Care Providers and Labs	14
1-006.02	Duties of Local Public Health Departments to Report to DHHS	15
1-006.02A	Immediate Reports	15
1-006.02B	Reports Within Seven Days	15
1-006.02C	Reports Once a Month	16
1-007	CONTROL MEASURES FOR COMMUNICABLE DISEASES	16
1-007.01	Public Health Interventions, Directed Health Measures, and Noncompliance	16
1-007.01A	Public Health Interventions	16
1-007.01B	Noncompliance	16
1-007.02	Contact Notification in Reportable Communicable Disease and Poisoning Investigations	17
1-007.02A	Notification of Possible Contacts	17
1-007.02B	Partner Identification and Notification in STD Cases	17
1-007.03	Responsibilities of Laboratories	17
1-007.04	Responsibilities of Schools	17
1-007.05	Significant Exposure to Infectious Disease or Condition	18
1-007.05A	Significant Exposure Report Form for Emergency Services Providers	18
1-008	RABIES	19

ATTACHMENTS

Attachment A	Reportable Diseases, Poisonings and Organisms
Attachment B	Health Care Provider Confidential Communication
Attachment C	Laboratory Summary of Reportable Diseases, Poisonings and Organisms
Attachment D	Adult HIV/AIDS Confidential Case Report
Attachment E	Pediatric HIV/AIDS Confidential Case Report
Attachment F	Antimicrobial Resistance Surveillance (Laboratory-Based)
	Significant Exposure Report Form for Emergency Services Provider or Public Safety Official

TITLE 173 COMMUNICABLE DISEASES

CHAPTER 1 REPORTING AND CONTROL OF COMMUNICABLE DISEASES

1-001 SCOPE AND AUTHORITY: These regulations apply to the content, control, and reporting of communicable diseases, poisonings, and organisms pursuant to the provisions of Neb. Rev. Stat. §§ 71-501 to 71-514.05, 71-531 to 71-538~~2~~, and 71-1626.

1-002 DEFINITIONS: When terms are used in 173 NAC 1, the following definitions apply:

Advanced practice registered nurse (APRN) means a registered nurse who holds a current APRN license as a Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Clinical Nurse Specialist, or Nurse Practitioner.

Case means an instance of a suspected or confirmed disease or condition in a person or animal.

Communicable disease, illness, or poisoning means an illness due to an infectious or malignant agent, which is capable of being transmitted directly or indirectly to a person from an infected person or animal through the agency of an intermediate animal, host, or vector, or through the inanimate environment

Confirmed case means a case of reportable disease that meets the case definitions specified and published by the Council of State and Territorial Epidemiologists (CSTE) for each disease, and available at http://www.cdc.gov/ncphi/diss/nndss/casedef/case_definitions.htm Confirmed cases generally require a positive laboratory test for the given disease, together with some clinical or epidemiologic data consistent with the clinical signs and symptoms of that disease.

Contact means a person or animal that has been in close proximity/association with a communicable disease, illness, or poison for such a period that they have had an opportunity to become affected.

Department means the Department of Health and Human Services (DHHS).

Epidemic or outbreak means the occurrence of one or more than one case of an illness of similar nature in persons of a community, institution, region, or other geographically defined area which is clearly in excess of normal expectancy.

Laboratory means any facility that receives, forwards, or analyzes specimens from the human body, or referred cultures of specimens from the human body, and reports the results to physicians and public health authorities.

Local public health department means a county, district, or city-county health department approved by the Department of Health and Human Services as a local full-time public health service.

NEDSS means the Nebraska Electronic Disease Surveillance System for manual online reporting.

ORNAO means the Online Reporting of Nebraska-reportable Antimicrobial-resistant Organisms system for electronic reporting.

Suspected case means a person or deceased person having a condition or illness in which the signs and symptoms resemble those of a recognizable disease.

1-003 WHO MUST REPORT

1-003.01 Health Care Providers: Physicians and hospitals ~~shall~~ must make reports of communicable diseases and poisonings as described in 173 NAC 1-003, ~~173 NAC 1-004.04~~ and ~~173 NAC 1-005;~~ unless a report is made under 173 NAC 1-003.01A or 1-003.01B.

1-003.01A Reporting by Physician Assistants and Advanced Practice Registered Nurses, and Certified Nurse Midwives: A physician assistant or advanced practice registered nurse, ~~or certified nurse midwife~~ who in lieu of a physician attends to any patient suspected of having a reportable disease ~~may make any of the reports of communicable diseases or poisoning~~ must make the report as required by 173 NAC 1 in lieu of the physician making the report.

1-003.01B Reporting Lead Analysis: If a laboratory performing lead analysis provides a report containing the required information to the Department, the physician ~~is not required to make the report to the Department.~~ and hospital are exempt from 173 NAC 1-002.01.

1-003.01C Electronic Ordering of Laboratory Tests: For all laboratory tests which may identify a reportable disease (e.g., microbiology tests, hepatitis tests, etc.) and which are ordered through submission of an electronic requisition or other automated electronic mechanism, providers must include the following information at the time the test order is placed to the laboratory so that the laboratory may fulfill reporting requirements:

1. Patient first and last name;
2. Patient address including street, city, and zip;
3. Patient date of birth;
4. Patient gender;
5. Date of specimen collection;
6. Specimen source;
7. Ordered test;
8. Submitting provider's name;
9. Submitting provider's address and telephone number;
10. Pregnancy status, if available and if applicable;
11. Race, if available; and
12. Ethnicity (Hispanic / non-Hispanic), if available.

1-003.02 Laboratories: Laboratories ~~shall~~ must make reports as described in 173 NAC 1-004, ~~173 NAC 1-005.02,~~ and ~~173 NAC 1-006.~~

1-004 REPORTABLE DISEASES, POISONINGS, AND ORGANISMS: LISTS AND FREQUENCY OF REPORTS: The following diseases, poisonings, and organisms are declared to be communicable or dangerous or both to the public. Incidents of diseases, poisonings, and

organisms shall must be reported as described in 173 NAC 1-004.01 through 1-004.03, 473 NAC 1-005, and 473 NAC 1-006.

1-004.01 Immediate Reports

1-004.01A The following diseases, poisonings, and organisms shall must be reported immediately:

Anthrax (*Bacillus anthracis*)* ±
Botulism (*Clostridium botulinum*)*
Brucellosis (*Brucella abortus*^, *B. melitensis*^, and *B. suis* species)* ±
Cholera (*Vibrio cholerae*^)^ ±
Diphtheria (*Corynebacterium diphtheriae*) ±
Eastern equine encephalitis (EEE virus)^*
Food poisoning, outbreak-associated
Glanders [*Burkholderia (Pseudomonas) mallei*]* ±
Haemophilus influenzae infection (invasive disease only)^ ±
Hantavirus pulmonary syndrome (Sin Nombre virus)
Hemolytic uremic syndrome (post-diarrheal illness)
Hepatitis A (IgM antibody-positive or clinically diagnosed during an outbreak)
Influenza due to novel or pandemic strains (includes highly pathogenic avian influenza virus^*)
~~Maarburg virus*~~
Measles (Rubeola)
Melioidosis [*Burkholderia (Pseudomonas) pseudomallei*]* ±
Meningitis (*Haemophilus influenzae*^ or *Neisseria meningitidis*^)
Meningococcal disease, invasive (*Neisseria meningitidis*^)
~~Meningococemia (*Neisseria meningitidis*)~~
Monkeypox virus infection*
Pertussis [whooping cough] (*Bordetella pertussis*^)^ ±
Plague (*Yersinia pestis*^)^ ±
Poliomyelitis, paralytic
Q fever (*Coxiella burnetii*)* ±
Rabies (human and animal cases and suspects)
Ricin poisoning*
Rift Valley fever*
Rubella and congenital rubella syndrome
Severe Acute Respiratory Syndrome [SARS] (SARS-associated coronavirus)
Smallpox*
Staphylococcal enterotoxin B intoxication* ±
Staphylococcus aureus, vancomycin-intermediate/resistant (MIC ≥ 4 µg/mL) ±
Tick-borne encephalitis, virus complexes (Central European Tick-borne encephalitis virus, Far Eastern Tick-borne encephalitis virus, Kyasanur Forest disease virus, Omsk Hemorrhagic Fever virus, Russian Spring and Summer encephalitis virus)*
Typhoid fever (*Francisella tularensis*^)* ±
Typhus Fever, louse-borne (*Rickettsia prowazekii*^)* and flea-borne / endemic murine (*Rickettsia typhi*)

Venezuelan equine encephalitis*
Viral hemorrhagic fever (including but not limited to Ebola virus, Marburg virus,
and Lassa fever virus)*
Yellow Fever

- * Potential agents of bioterrorism (designated as select agents by CDC)
- ^ Laboratories must submit the specimen to the Nebraska Public Health Laboratory as specified in 173 NAC 1-007.03
- ± Laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C must report any antibiotic susceptibility test results

1-004.01B Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks*: Clusters, outbreaks, or epidemics of any health problem, infectious or other, including food poisoning, healthcare-associated outbreaks or clusters, influenza, or possible bioterroristic attack; increased disease incidence beyond expectations; unexplained deaths possibly due to unidentified infectious causes; and any unusual disease or manifestations of illness must be reported immediately.

1-004.02 Reports Within Seven Days: The following diseases, poisonings, and organisms shall must be reported within seven days of detection or diagnosis:

Acinetobacter spp., all isolates (applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C) ±
Acquired Immunodeficiency Syndrome (AIDS), as described in 173 NAC 1-005.01C2
Adenovirus infection (conjunctivitis, respiratory)
Amebae-associated infection (Acanthamoeba spp., Entamoeba histolytica, and Naegleria fowleri)
Amebiasis (Entamoeba histolytica)
Arboviral infections (including, but not limited to, West Nile virus, St. Louis encephalitis virus, Western Equine Encephalitis virus, and Dengue virus)
Babesiosis (*Babesia* species)
Campylobacteriosis (*Campylobacter*^ species) ±
Carbon monoxide poisoning (use breakpoint for non-smokers)
Chancroid (Haemophilus ducreyi) ±±
Chlamydia trachomatis infections (nonspecific urethritis, cervicitis, salpingitis, neonatal conjunctivitis, pneumonia) ±±
Clostridium difficile (antibiotic-associated colitis and pseudomembranous colitis)
Coccidioidomycosis (Coccidioides immitis/posodasi)^
Creutzfeldt-Jakob Disease (subacute spongiform encephalopathy [14-3-3 protein from CSF or any laboratory analysis of brain tissue suggestive of CJD])
Cryptosporidiosis (*Cryptosporidium parvum*)
Cyclosporiasis (Cyclospora cayetanensis)
Dengue virus infection
Ehrlichiosis, human monocytic (*Ehrlichia chaffeensis*) ±
Ehrlichiosis, human granulocytic (*Ehrlichia phagocytophila*)
Encephalitis (caused by viral agents)
Enterococcus spp., all isolates (applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C) ±

Escherichia coli gastroenteritis (E. coli O157-H7^Δ and other pathogenic Shigatoxin-positive E. coli from gastrointestinal infection^Δ)
Giardiasis (*Giardia lamblia*)
Gonorrhea (*Neisseria gonorrhoeae*): venereal infection and ophthalmia neonatorum ±±
Hansen's Disease (Leprosy [*Mycobacterium leprae*]) ±
~~Hantavirus infection~~
Hepatitis B infection (positive surface antigen tests ~~or and all~~ IgM core antibody tests, both positive and negative) ±; ~~for laboratories doing confirmatory tests (e.g., blood banks), results of confirmatory tests for surface antigen or core antibody supersede results of screening tests]~~
Hepatitis C infection (all positive screening tests [e.g. EIA, ELISA, etc.] to include signal-to-cutoff ratio [S:CO] are reportable; all confirmatory tests [e.g. RIBA, NAT tests such as PCR for qualitative, quantitative, and genotype testing] are reportable regardless of result [i.e., both positive and negative tests]) (requires a positive serologic test; when a confirmatory test is done, the results of the confirmatory test supersede results of the screening test)
Hepatitis D and E infection
Herpes simplex, primary genital infection ± and neonatal, less than 30 days of age;
Histoplasmosis (*Histoplasma capsulatum*)
Human immunodeficiency virus infection, as described in 173 NAC 1-005.01C2, Type 1 and suspected cases of HIV Type 2 +
Immunosuppression as described in 1-004.02C1e
Influenza deaths, pediatric (< 18 years of age)
Influenza (DFA Antigen or PCR positive or culture confirmed)
Influenza, all tests (applies only to laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C)
Influenza, rapid tests summary report only (laboratories only)
Kawasaki disease (mucocutaneous lymph node syndrome)
Klebsiella sp., all isolates (applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C) ±
Lead poisoning (all analytical values for blood lead analysis shall must be reported by the laboratory)
Legionellosis (*Legionella* species) ±
~~Leprosy (*Mycobacterium leprae*)~~
Leptospirosis (*Leptospira interrogans*)
Listeriosis (*Listeria monocytogenes*^Δ) ±
Lyme disease (*Borrelia burgdorferi*)
Lymphocytic choriomeningitis virus infection
Lymphogranuloma venereum (LGV [*Chlamydia trachomatis*]) ±
Malaria (*Plasmodium* species)
Meningitis, including viral, bacterial, and fungal (all such cases must be reported within seven days except those caused by Haemophilus influenzae and Neisseria meningitidis, which must be reported immediately) ~~viral or caused by *Streptococcus pneumoniae*~~
Methemoglobinemia / nitrate poisoning (methemoglobin greater than 5% of total hemoglobin)
Mumps

Mycobacteria spp. (including *M. tuberculosis* complex and all "atypical" species, to include culture, nucleic acid tests, or positive histological evidence indicative of tuberculosis infection or disease) ‡

Necrotizing fasciitis

Norovirus infection (laboratories only)

Poisoning or illness due to exposure to agricultural chemicals (herbicides, pesticides, and fertilizers), industrial chemicals, or mercury, or radiologic exposures

Psittacosis (*Chlamydia psittaci*)

Respiratory syncytial virus infection (laboratories only)

Retrovirus infections (other than HIV)

Rheumatic fever, acute (cases meeting the Jones criteria only)

Rocky Mountain Spotted Fever (*Rickettsia rickettsii*)[^]

Rotavirus ([all positive and negative tests] applies only to laboratories performing electronic lab reporting as described in 173 NAC 1-005.02C)

Salmonellosis, including typhoid fever (*Salmonella* serogroups species[^]) ‡

Shiga toxin-positive gastroenteritis (enterohemorrhagic *E. coli* and other shiga toxin-producing bacteria[^]) resulting in gastroenteritis

Shigellosis (*Shigella* species[^]) ‡

Staphylococcus aureus (applies only to laboratories performing electronic lab reporting as specified in 1-005.02C)

Streptococcal disease (all invasive disease caused by Groups A and B streptococci) ‡
Streptococcus pneumoniae, all isolates (applies only to laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C) ‡

Syphilis (*Treponema pallidum*) RPR and FTA reactive ±

Syphilis, congenital

Tetanus (*Clostridium tetani*) ‡

Toxic shock syndrome

Toxoplasmosis, acute (*Toxoplasma gondii*)

Transmissible spongiform encephalopathies

Trichinosis (*Trichinella spiralis*)

Tuberculosis (to include all *M. tuberculosis* complex organisms) (*Mycobacterium tuberculosis* and human cases of *Mycobacterium bovis*)

Varicella primary infections (chicken pox)

Varicella death (all ages)

Yersiniosis (*Yersinia* species not *Y. pestis*) ‡

[^] Laboratories must submit the specimen to the Nebraska Public Health Laboratory as specified in 173 NAC 1-007.03

[‡] Laboratories performing electronic lab reporting as specified in 173 NAC 1-005.02C must report any antibiotic susceptibility test results

[±] STD in accordance with Neb. Rev. Stat. § 71-502.01

1-004.03 Reports Once a Month: The following antibiotic-resistant organisms will be reported monthly by tabular summary. Laboratories unable to submit individual antibiotic susceptibility data via automated electronic laboratory reporting (ELR) must submit monthly tabular summaries of antibiotic-resistant organisms. Reports must be submitted no later than one week after the end of the reporting month. Reports must be submitted electronically to the ORNAO system. If Internet access is not available, reports may be submitted via postal

service, telephone, facsimile, or other secure electronic mail system. Reports must be submitted on or include the same information as Attachment E, incorporated in these regulations by this reference. See 173 NAC 1-006, Where to Report. The following antibiotic-resistant organisms must be reported:

Enterococcus spp., vancomycin-resistant (MIC \geq 32 μ g/mL and/or resistant by disk diffusion) and intermediate (MIC = 8-16 μ g/mL)

Staphylococcus aureus, methicillin-resistant (MIC \geq 4 μ g/mL to oxacillin, \geq 8 μ g/mL to cefoxitin, and/or resistant by disk diffusion);

Staphylococcus aureus, vancomycin-intermediate/resistant (MIC \geq 4 μ g/mL);

Streptococcus pneumoniae

Non-CSF

Penicillin-intermediate (MIC = 0.12-4.0 4 μ g/mL) and

Penicillin-resistant (MIC \geq 2.0 8 μ g/mL)

CSF

Penicillin-resistant (MIC \geq 0.12 μ g/mL)

1-004.04 Reporting of Antibiotic Susceptibility: All laboratories reporting via automated electronic laboratory reporting (ELR) must report all antimicrobial susceptibility results, if performed for bacterial isolates listed in 173 NAC 1-004.01 and 1-004.02 (indicated by a \pm). Laboratories not reporting via automated ELR are exempt from this requirement.

1-004.05 New, Emerging, or Reemerging Diseases and Other Syndromes and Exposures: Reporting and Submissions

1-004.05A Criteria: The Director of the Division of Public Health or the Chief Medical Officer may require reporting, or a change in method or frequency of reporting, of newly recognized or emerging diseases, syndromes suspected to be of infectious origin, or exposures of large numbers or specific groups of persons to known or suspected public health hazards if:

1. The disease, syndrome, or exposure can cause or is suspected to cause serious morbidity or mortality; and
2. Reporting of the disease, syndrome, or exposure is necessary to monitor, prevent, or control the disease, syndrome, or exposure and to protect public health.

1-004.05B Surveillance Mechanism: The Director of the Division of Public Health or the Chief Medical Officer may describe a specific mechanism for surveillance of the disease, syndrome, or exposure including persons and entities required to report, a time frame for reporting, and protocols for the submission of clinical specimens collected from cases, suspected cases, or exposed persons to referral laboratories designated by the DHHS Division of Public Health.

1-004.06 Sexually Transmitted Diseases: For the purpose of implementing Neb. Rev. Stat. \S 71-502.01, sexually transmitted diseases include, but are not limited to, the following diseases:

1. Bacterial vaginosis;
2. Candidiasis;
3. Chancroid;
4. *Chlamydia trachomatis* infection;
5. Genital herpes infection;
6. Gonorrhea;
7. Granuloma inguinale;
8. Hepatitis B infection;
9. Human immunodeficiency virus (HIV) infection;
10. Human papilloma virus (HPV) infection;
11. Lymphogranuloma venereum;
12. Syphilis; and
13. Trichomoniasis.

1-008 SEXUALLY TRANSMITTED DISEASES: For the purpose of implementing Neb. Rev. Stat. Section 71-502.01, sexually transmitted diseases shall include, but not be limited to, the following diseases:

1. ~~Bacterial Vaginosis;~~
2. ~~Candidiasis;~~
3. ~~Chancroid;~~
4. ~~*Chlamydia trachomatis* infection;~~
5. ~~Gonorrhea;~~
6. ~~Granuloma inguinale;~~
7. ~~Hepatitis B;~~
8. ~~Herpes genital infection;~~
9. ~~Human Immunodeficiency Virus (HIV) infection;~~
10. ~~Human Papillomavirus (HPV) infection;~~
11. ~~Lymphogranuloma Venereum;~~
12. ~~Syphilis;~~
13. ~~Trichomoniasis.~~

1-005 METHODS OF REPORTING

1-005.01 Health Care Providers

1-005.01A Immediate Reports of Diseases, Poisonings and Organisms: Health care providers ~~shall~~ must make immediate reports of diseases, poisonings and organisms, listed in 173 NAC 1-004.01A, by telephone, facsimile or other secure electronic mail system within 24 hours of diagnosis or detection. Reports ~~will~~ must be submitted on or include the same information as Attachment A, ~~attached hereto and~~ incorporated in these regulations by this reference. See 173 NAC 1-006, Where to Report.

1-005.01B Immediate Reports of Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks: ~~When diagnosed or detected, h~~ Health care providers ~~shall make immediate~~ must reports by telephone, facsimile, or other secure electronic mail system, information relating to confirmed, diagnosed, detected, or suspected clusters, outbreaks, or epidemics of any health problem, infectious or other, including

food poisoning, influenza or possible bioterroristic attack; increased disease incidence beyond expectations; unexplained deaths possibly due to ~~unidentified~~ infectious causes; any unusual disease or manifestations of illness. Reports ~~should~~ must include the patient's first and last name, date of birth, address, and telephone number; time of onset of symptoms, date of diagnosis, and mode of transmission, names, addresses, and telephone numbers of physician; and name and location of hospital or clinic. ~~cases, times of onsets of symptoms, and modes of transmission, if known.~~ See 173 NAC 1-006, Where to Report.

1-005.01C Reports Within Seven Days: Health care providers ~~shall~~ must make reports of diseases, poisonings and organisms listed in 173 NAC 1-004.02, within seven days of diagnosis or detection.

1-005.01C1 Except for lead analysis and AIDS and HIV disease, reports ~~can~~ may be made by postal service, telephone, facsimile, or other secure electronic mail system, submitted on or including the same information as Attachment A. Health care providers ~~shall~~ must report AIDS and HIV as described in 173 NAC 1-005.01C2 and report lead analysis as described in 1-005.01C3. See 173 NAC 1-006, Where to Report.

1-005.01C2 Reporting HIV Disease and AIDS: Health care providers ~~shall~~ must make HIV disease and AIDS reports by postal service or telephone. Adult cases of AIDS and HIV disease (patients \geq 13 years of age at time of diagnosis) ~~shall~~ must be submitted on or include the same information as Attachment C, ~~attached hereto and~~ incorporated in these regulations by this reference. Pediatric cases of AIDS and HIV disease (patients < 13 years of age at time of diagnosis) and perinatally exposed HIV cases ~~shall~~ must be submitted on or include the same information as Attachment D, ~~attached hereto and~~ incorporated in these regulations by this reference. AIDS and HIV case reports are required from health care providers responsible for:

1. Treating or diagnosing a person with HIV-1 or HIV-2 disease, based on the laboratory tests listed in 173 NAC ~~1-005.02B3a1~~ 1-004.02C1 ~~items 1. a-e~~, as being definitive for HIV infection, or based on clinical criteria, as outlined in the National Centers for Disease Control's (CDC) most recent case definition for HIV; ~~or~~
2. Treating or diagnosing a person with AIDS as outlined in CDC's most recent case definition for AIDS; ~~or~~
3. Providing medical care to a pregnant woman with HIV disease; ~~or~~
4. Providing medical care to a baby under 19 months of age born to a woman with HIV disease (perinatally HIV exposed). The diagnosis of HIV infection or determination of noninfection is determined by CDC's most recent case definition for HIV; and

5. Treating or diagnosing potential cases of public health importance related to HIV infection including:
 - a. Unusual strains of HIV (HIV-2 or non-B subtype of HIV-1); and
 - b. Unusual modes of transmission (such as, but not limited to transplant or artificial insemination; transfusion of blood or blood components, child sexual abuse, occupational, household, or other unusual exposure).

1-005.01C3 Reporting Lead Analysis: Health care providers ~~shall~~ must report the following information to the Department:

1. The date of sample collection and analysis;
2. Whether the sample is a capillary or venous blood sample;
3. The date of birth, address, and sex of the patient;
4. The name and address of the physician; and
5. The race and ethnicity of the patient, ~~should be reported~~ if known.

1-005.01C4 Reporting of Tuberculosis: Health care providers must report positive TB diagnostic tests (culture and nucleic acid amplification) or positive histological evidence indicative of tuberculosis infection or disease.

1-005.01D Reporting to Laboratories: For all laboratory tests which may identify a reportable disease (e.g. microbiology tests, hepatitis tests, etc.) and which are ordered through submission of an electronic requisition or other automated electronic mechanism, providers must include the following information at the time the test order is placed to the laboratory so that the laboratory may fulfill reporting requirements:

1. Patient first and last name;
2. Patient address including street, city, and zip;
3. Patient date of birth;
4. Patient gender;
5. Date of specimen collection;
6. Specimen source;
7. Ordered test;
8. Submitting provider's name;
9. Submitting provider's address and telephone number;
10. Pregnancy status, if available and if applicable;
11. Race, if available; and
12. Ethnicity (Hispanic / non-Hispanic), if available.

1-005.02 Laboratories

1-005.02A Electronic Reporting: Beginning no later than three months after the effective date of these regulations, all laboratories performing clinical testing on Nebraska residents must electronically report laboratory test results for the diseases specified in 173 NAC 1-004 and the tests specified in 1-005.02. This may be

accomplished either through manual online data entry into Nebraska's electronic disease reporting system, or through automated electronic laboratory reporting. Paper reports will be accepted only when established electronic transmission methods are inoperable.

1-005.02B Laboratories Using NEDSS Manual Online Reporting

1-005.02B1 Immediate Reports of Diseases, Poisonings, and Organisms: Laboratories shall ~~must~~ make immediate reports of diseases, poisonings, and organisms listed in 173 NAC 1-004.01A, ~~both~~ by telephone, ~~facsimile or other secure electronic mail system~~ to a live public health surveillance official within 24 hours of diagnosis or detection ~~and by electronic reporting to NEDSS~~. Reports ~~will~~ ~~must~~ be ~~submitted on or~~ include the ~~same~~ information specified on as Attachment B, ~~attached hereto and~~ incorporated in these regulations by this reference. See 173 NAC 1-006, Where to Report.

1-005.02B2 Immediate Reports of Clusters, Outbreaks, or Unusual Events, Including Possible Bioterroristic Attacks: ~~When diagnosed or detected,~~ Laboratories shall ~~must~~ make immediate reports by telephone, ~~facsimile or other secure electronic mail system~~, to a live public health surveillance official within 24 hours of diagnosis or detection, information relating to ~~diagnosed, detected, or suspected~~ clusters, outbreaks, or epidemics of any health problem, infectious or other, including food poisoning, influenza, or possible bioterroristic attack; increased disease incidence beyond expectations; unexplained deaths possibly due to ~~unidentified~~ infectious causes; ~~and~~ any unusual disease or manifestations of illness. Reports ~~should~~ ~~must~~ include the same information as Attachment B, ~~dates and results of the tests performed, the names (and when available, the ages) of the persons from whom the specimens were obtained, and the names and addresses of the physicians for whom such examinations or tests were performed.~~

1-005.02B3 Reports Within Seven Days: Laboratories shall ~~must~~ make reports of diseases, poisonings, and organisms diagnosed or detected, listed in 173 NAC 1-004.02, collected during one calendar week. Reports ~~will~~ ~~must~~ be submitted no later than the following Tuesday and ~~submitted on or~~ ~~must~~ include the same information as Attachment B. Laboratories ~~shall~~ ~~must~~ make reports by manual online reporting to the NEDSS postal service, telephone, facsimile or other secure electronic mail system.

1-005.02B3a For the purposes of reporting AIDS and HIV, the laboratory reporting requirement applies as follows:

1. Any test or combination of tests indicative of HIV-1 or HIV-2 that has acceptable specificity and sensitivity to reliably detect HIV infection is reportable. (At the time of promulgation of these rules, there are no FDA-approved lab tests for HIV-2. Please contact the DHHS Division of Public Health, HIV Surveillance, for further instructions regarding HIV-2 testing.)

2. A laboratory analyzing samples for any of the tests as listed below ~~shall~~ must report all of the following results:
 - a. A positive result on a confirmatory test for HIV antibody (e.g. Western blot or immunofluorescence antibody test, usually preceded by a positive screening test for HIV antibody, e.g. repeatedly reactive enzyme immunoassay);
 - b. An indeterminate result on a confirmatory test for HIV antibody (e.g. Western blot or immunofluorescence antibody test, usually preceded by a positive screening test for HIV antibody, e.g. repeatedly reactive enzyme immunoassay);
 - c. All qQuantitative HIV RNA PCR tests regardless of the result. Include the detailed name of the test, detection limits of test, and/or interpretation of results. (This applies only to laboratories performing ELR.); detectable or below detectable level;
 - d. All pPositive results on any of the following HIV virologic tests:
 - (1) Qualitative HIV nucleic acid (DNA or RNA) detection [e.g. DNA polymerase chain reaction (PCR)];
 - (2) HIV p24 antigen test, including neutralization assay;
 - (3) HIV isolation (viral culture); and
 - e. All CD4 counts less than 800 per microliter and all CD4 percentages. (report CD4 percentage if available).

1-005.02B3b Reporting Lead Analysis: Laboratories ~~shall~~ must report the following information to the Department:

1. The date of sample collection and analysis;
2. Whether the sample is a capillary or venous blood sample;
3. The date of birth, address, and sex of the patient;
4. The name and address of the physician; and
5. The race and ethnicity of the patient, ~~should be reported if known.~~

1-005.02B4 Reports Once a Month: Laboratories ~~shall~~ unable to submit individual antibiotic susceptibility data via automated ELR must submit monthly tabular summaries of antibiotic resistant organisms listed in 173 NAC 1-004.03.

Reports ~~should~~ must be submitted no later than one week after the end of the reporting month. Reports ~~shall~~ must be submitted by postal service, telephone, facsimile or other secure electronic mail system. Reports ~~will~~ must be submitted on or include the same information as Attachment E, ~~attached hereto and incorporated in these regulations by this reference.~~ See 173 NAC 1-006, Where to Report.

1-005.02C Laboratories Using Automated Electronic Laboratory Reporting (ELR)

1-005.02C1 Beginning no later than 12 months after the effective date of these regulations, clinical reference laboratories in communities with a population greater than 10,000 as determined by the July 1, 2005 U.S. Census Bureau Projections (Beatrice, Bellevue, Columbus, Fremont, Grand Island, Hastings, Kearney, LaVista, Lexington, Lincoln, Norfolk, North Platte, Omaha, Papillion, Scottsbluff, and South Sioux City) must report laboratory test results for the diseases specified in 173 NAC 1-004 and the tests specified in 1-005.02 via automated electronic laboratory reporting. Such lab tests must be identified by a computer algorithm, and forwarded to public health computer systems in a secure fashion according to the data format and specifications stipulated by the Department. Required data fields include:

1. Patient first and last name;
2. Patient address including street, city, state, and zip;
3. Patient date of birth;
4. Patient sex;
5. Patient ID number;
6. Performing laboratory's name, address, and phone number;
7. Date and time of specimen collection;
8. Date and time the test was performed;
9. Specimen source;
10. Type of test performed;
11. Test result;
12. Result units;
13. Date and time the test was verified;
14. Accession number;
15. Date of report; and
16. Submitting provider's name, address, phone number, and office name; and, if available,
17. Pregnancy status;
18. Ethnicity (Hispanic / non-Hispanic);
19. Code for ordered test;
20. Code for test result;
21. Result flag;
22. High and low result reference range;
23. Provider ID number;
24. Provider office ID number;
25. ELR report date; and
26. The following data elements stored in the PV1 segment of HL7:

<u>Element Name</u>	<u>Sequence</u>	<u>Item Number</u>
<u>Patient Class</u>	<u>2</u>	<u>132</u>
<u>Assigned Patient Location</u>	<u>3</u>	<u>133</u>
<u>Admission Type</u>	<u>4</u>	<u>134</u>
<u>Prior Patient Location</u>	<u>6</u>	<u>136</u>
<u>Readmission Indicator</u>	<u>13</u>	<u>143</u>
<u>Admit Source</u>	<u>14</u>	<u>144</u>
<u>Patient Type</u>	<u>18</u>	<u>148</u>
<u>Discharge Disposition</u>	<u>36</u>	<u>166</u>
<u>Discharged to Location</u>	<u>37</u>	<u>167</u>
<u>Admit Date and Time</u>	<u>44</u>	<u>174</u>
<u>Discharge Date and Time</u>	<u>45</u>	<u>175</u>

A laboratory's test results must be screened via an automated computer algorithm no less than once every 24 hours, and a file or files meeting this reporting requirement must be forwarded electronically to the Department no less than once every 24 hours. Automated computer screening algorithms must be validated initially and once each year to ensure the screening process will capture all reportable disease test results that may be generated by the reporting laboratory. Results of this validation must be documented and maintained on file for two years at the laboratory for review by the Department.

Beginning no later than 24 months after the effective date of these regulations, clinical reference laboratories in communities with a population greater than 5,000 as determined by the July 1, 2005 U.S. Census Bureau Projections (Alliance, Blair, Chadron, Crete, Elkhorn, Gering, Holdrege, McCook, Nebraska City, Plattsmouth, Ralston, Schuyler, Seward, Sidney, Wayne, and York) must report laboratory test results for the diseases specified in 173 NAC 1-004 and the tests specified in 1-005.02 via automated electronic laboratory reporting.

Electronic reporting does not exempt the laboratory from reporting by telephone those diseases that must be reported immediately.

1-005.02C2 Reporting of Antibiotic Susceptibility Results: Laboratories with automated electronic reporting capability which perform antibiotic susceptibility testing (AST) for bacterial diseases listed under 173 NAC 1-004 must report antibiotic susceptibility results for these tests. This requirement includes traditional broth, agar, and newer automated methods of AST, as well as molecular-based methods that assay for the molecular determinants of antibiotic resistance. Reports must include the method used for AST. Clinical laboratories must report AST results to the DHHS Division of Public Health via automated ELR. When necessary for the protection of the public health, the DHHS Division of Public Health may request additional reporting of AST results on other infectious agents that have increased in either incidence or severity.

~~1-004.03 When health care providers and laboratories do not have complete information, as shown on Attachments A, B, C, D or E or as required regarding lead analysis, the designated official from the official local health department or Nebraska Department of Health and Human Services Regulation and Licensure may contact the health care provider or laboratory to obtain the missing information.~~

1-006 WHERE TO REPORT

~~1-006.01 Cases Reported by Health Care Providers and Laboratories: Except as stated for AIDS and HIV reporting in 173 NAC 1-006.01A and except for reports made through NEDSS, reports are to must be made to the local health department if the area is served by an approved local full-time health service public health department as defined in Neb. Rev. Stat. § 71-1626, and where the health director of the service public health department has specified this method of reporting. In all other areas, the reports are to be made directly to the DHHS Division of Public Health. Nebraska Department of Health and Human Services Regulation and Licensure.~~

~~1-006.01A HIV/AIDS Cases Reported by Health Care Providers and Laboratories: To report an AIDS or HIV case in Douglas or Lancaster County, mail the report form (Attachment C or D) to or contact the local agency listed below, based upon the county in which the health care practitioner, provider or laboratory is located. In all other areas, the reports are to must be made to the infectious disease surveillance staff at the DHHS Division of Public Health. Nebraska Department of Health and Human Services Regulation and Licensure, HIV/AIDS Program:~~

Douglas County

Epidemiologist
Douglas County Health Department
1819 Farnam Street, Room 401
Omaha, NE 68183-0401
402/444-7214

Lancaster County

Communicable Disease Coordinator
Lincoln-Lancaster County Health Department
3140 "N" Street
Lincoln, NE 68510-1514
402/441-8053

Nebraska Department of Health and Human Services, Division of Public Health Regulation and Licensure

~~Communicable Disease
Infectious Disease
Nebraska Department of Health and Human Services Regulation and Licensure
DHHS Division of Public Health
P.O. Box 95026 95007
Lincoln, NE 68509-5026 5007
402/471-0360 2937~~

~~1-006.02 Duties of Local Full-Time Public Health Service Departments to Report to DHHS: the Department: It shall be is the duty of the approved local full-time public health service~~

department to report all cases of reportable diseases, poisonings, and organisms that occurred within the most recent reporting period in the jurisdictional area of the respective service public health department when the local director has specified that such diseases be reported to the local service public health department.

1-006.02A Immediate Reports: The ~~approved local full-time public health service shall~~ department must make immediate reports of diseases, poisonings, and organisms listed in 173 NAC 1-004.01 to ~~the DHHS Division of Public Health Nebraska Department of Health and Human Services Regulation and Licensure.~~ Reports ~~will~~ must be made by the health director or authorized representative of the respective service public health department by telephone to a live public health surveillance official ~~facsimile or other secure electronic mail system~~ within 24 hours of diagnosis or detection. Reports ~~will be submitted on or~~ must include the same information as Attachments A and B.

1-006.02B Reports Within Seven Days: The ~~approved local full-time public health service shall~~ department must make reports of diseases, poisonings, and organisms listed in 173 NAC 1-004.02 to ~~the DHHS Division of Public Health Nebraska Department of Health and Human Services Regulation and Licensure.~~ Reports ~~will~~ must be made via NEDSS, or in the event NEDSS is not operational, by postal service, telephone, facsimile, or other secure electronic mail system within seven days of diagnosis or detection. Reports ~~will~~ must be made by the health director or authorized representative of the respective service public health department, no later than Friday of each week. Reports ~~will~~ must be submitted on or include the same information as Attachments A, B, C and D.

1-006.02C Reports Once a Month: The ~~approved local full-time public health service shall~~ department must make tabular reports of antibiotic-resistant organisms listed in 173 NAC 1-004.03 to ~~the DHHS Division of Public Health Nebraska Department of Health and Human Services Regulation and Licensure.~~ Reports ~~will~~ must be made via ORNAO or by postal service, telephone, facsimile, or other secure electronic mail system. Reports ~~will~~ must be made by the health director or authorized representative of the respective service public health department, no later than the fifteenth day of the month following the reporting period. Reports ~~will~~ must be submitted on or include the same information as Attachment E.

1-007 CONTROL MEASURES FOR COMMUNICABLE DISEASES: For the information of the public, the latest editions of these publications are used as a reference by the ~~DHHS Division of Public Health Nebraska Department of Health and Human Services Regulation and Licensure,~~ approved local full-time public health service departments, and physicians health care providers in the control of communicable diseases: "Control of Communicable Diseases Manual", published by the American Public Health Association, 800 I Street NW, Washington, D.C. 20001-3710 and disease-specific recommendations of the Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, as ~~printed~~ published in the "Morbidity and Mortality Weekly Report."

1-007.01 ~~Isolation and Noncompliance~~ Public Health Interventions, Directed Health Measures, and Noncompliance

1-007.01A ~~Isolation:~~ The ~~health care provider attending a case or suspected case of a disease requiring isolation (or, in the absence of a health care provider, the director of~~

~~the approved local full-time public health service or Nebraska Department of Health and Human Services Regulation and Licensure) shall make certain that isolation precautions are taken to prevent spread of disease to others.~~

~~1-006.02 Report of Noncompliance: Health care providers shall report immediately to the director of the Nebraska Department of Health and Human Services Regulation and Licensure or approved local full-time public health service, the name, address, and other pertinent information for all individuals with diseases requiring isolation who refuse to comply with prescribed isolation precautions.~~

1-007.01A Public Health Interventions: The health care provider attending a case or suspected case of a disease requiring isolation, quarantine, or other public health interventions, must make reasonable efforts to prevent the spread of the disease to others. The director of the local public health department or the Director of the DHHS Division of Public Health may order a directed health measure as provided in 173 NAC 6, Directed Health Measures to Prevent or Limit the Spread of Communicable Disease, Illness, or Poisoning.

1-007.01B Noncompliance: Health care providers must report immediately to the DHHS Division of Public Health, the name, address, and other pertinent information for all individuals with diseases requiring isolation, quarantine, or other public health interventions who refuse to comply with prescribed public health interventions. The DHHS Division of Public Health may order a directed health measure as provided in 173 NAC 6, or in the case of tuberculosis, advise the local county attorney for proceedings under the Tuberculosis Detection and Prevention Act.

1-007.02 Contact Notification in Reportable Communicable Disease and Poisoning Investigations

1-007.02A In order to protect the public's health and to control the spread of disease, in cases of reportable communicable disease or poisonings other than those covered by 173 NAC 1-007.02B, the DHHS Division of Public Health may notify individuals who are determined to be possible contacts of the source of the disease or poisoning by any means reasonably necessary.

1-007.02B Partner Identification and Notification in STD Cases

1-007.02B1 In order to protect the public's health, when an individual is tested and found to have an STD as defined in 173 NAC 1-004.06 HIV disease or AIDS, the Nebraska Department of Health and Human Services Regulation and Licensure DHHS Division of Public Health or approved local full-time public health service shall department will conduct partner notification and referral activities in cases of HIV disease and early syphilis, and may conduct these activities as appropriate for other STD's. Other local health-related agencies may conduct these activities if staff have received appropriate training as determined by DHHS, as outlined in Nebraska Department of Health and Human Services Regulation and Licensure or approved local full-time public health service protocol.

1-007.02B2 "Partner" is defined as any individual, including a spouse, who has shared needles, syringes, or drug paraphernalia or who has had sexual contact with an HIV-infected individual infected with an STD as defined in 173 NAC 1-004.06. In the case of HIV disease, in accordance with the Ryan White

HIV/AIDS Treatment Modernization Act, "Spouse" is defined as any individual who is the marriage partner of that person at any time within the ten-year period prior to the diagnosis of HIV disease.

1-007.03 Responsibilities of Laboratories: All laboratories performing clinical testing on Nebraska residents:

1. Must forward to the Nebraska Public Health Laboratory isolates of special public health interest indicated in 173 NAC 1-004.01A and 1-004.02;
2. Which diagnose *E.coli* gastroenteritis with a shiga toxin assay and which do not isolate the shiga toxin-producing organism must forward the stool sample testing positive for shiga toxin to the Nebraska Public Health Laboratory; and
3. Must forward at the direction of the State Epidemiologist or person acting in that capacity isolates or specimens to the Nebraska Public Health Laboratory or the Centers for Disease Control and Prevention laboratories.

1-007.04 Responsibilities of Schools: School nurses or those acting in the capacity of a school nurse must, in accordance with state and federal statutes:

1. Notify the state or local public health department of cases or suspected cases of reportable diseases as indicated in 173 NAC 1-004.01 and 1-004.02, or outbreaks and suspected outbreaks of diseases as indicated in 173 NAC 1-004.01B affecting students and/or other school-affiliated personnel and which present a reasonable threat to the safety or health of a student and/or other school-affiliated personnel; and
2. Cooperate with public health authorities in obtaining information needed to facilitate the investigation of cases and suspected cases, or outbreaks and suspected outbreaks of diseases affecting students and/or other school-affiliated personnel.

All information disclosed to a public health authority is confidential and not to be released to outside parties as stipulated by Neb. Rev. Stat. § 71-503.01.

1-007.05 Significant Exposure to Infectious Disease or Condition: Neb. Rev. Stat. §§ 71-507 to 71-513 address the risk of significant exposure of emergency services providers to infectious diseases or conditions, and Neb. Rev. Stat. §§ 71-514.01 to 71-514.05 address the risk of significant exposure of health care providers to infectious diseases or conditions. For the purpose of implementing these statutes, infectious disease or condition means:

1. Hepatitis B;
2. Hepatitis C;
3. Meningococcal meningitis;
4. Active pulmonary tuberculosis;
5. Human immunodeficiency virus infection;
6. Diphtheria;
7. Plague;
8. Hemorrhagic fevers; and
9. Rabies.

1-007.05A Significant Exposure Report Form for Emergency Services Providers: For the purpose of implementing Neb. Rev. Stat. § 71-508, the form to be used by the emergency services provider to document information necessary for notification of significant exposure to an infectious disease or condition is Attachment F, incorporated in these regulations by this reference. Emergency services providers are responsible for reproduction of the form for use in the notification procedure.

1-009 SIGNIFICANT EXPOSURE TO INFECTIOUS DISEASE OR CONDITION:

1-009.01 Definition: For the purpose of implementing Neb. Rev. Stat. Sections 71-507(5) and 71-514.02(2), infectious disease or condition means:

1. ~~Hepatitis B;~~
2. ~~Hepatitis C;~~
3. ~~Meningococcal meningitis;~~
4. ~~Active pulmonary tuberculosis;~~
5. ~~Human immunodeficiency virus infection;~~
6. ~~Diphtheria;~~
7. ~~Plague;~~
8. ~~Hemorrhagic fevers; and~~
9. ~~Rabies.~~

1-009.02 SIGNIFICANT EXPOSURE REPORT FORM: For the purpose of Neb. Rev. Stat. Section 71-508, the form to be used by the emergency medical services provider to document information necessary for notification of significant exposure to an infectious disease or condition is attached hereto as Attachment F and incorporated in these regulations by this reference as though fully set forth herein. Emergency medical service providers are responsible for reproduction of the form for use in the notification procedure.

1-008 RABIES: Cases of human and animal rabies are reportable under 173 NAC 1-004.01. Rabies control is governed by Neb. Rev. Stat. §§ 71-4401 to 71-4412 and Rules and Regulations Governing Rabies Control, Title 173 NAC 5, Rabies Control Program. Copies of these rules and regulations are available from the DHHS Division of Public Health, Rabies Surveillance. Nebraska Department of Health and Human Services Regulation and Licensure, Communicable Disease.

1-008.01 In a case where a human has been bitten by one of the following animals, health care providers shall notify immediately the local rabies control authority, which includes county, township, city, or village health and law enforcement officials, to oversee the seizure of the animal:

1. ~~Species amenable to rabies protection by immunization: dogs, cats, ferrets, cattle, horses, and sheep.~~
2. ~~Species not amenable to rabies protection by immunization:~~
 - a. ~~Carnivorous: skunks, raccoons, foxes, coyotes, bobcats, bats, and hybrids (offspring of wild species bred with domestic dogs or cats).~~
 - b. ~~Non-Carnivorous: Regard these animals as rabid unless negative by the Direct Fluorescent Antibody laboratory test. This category includes but is not limited to the following species of animals: civet cats, deer, groundhogs, beavers, opossums, and badgers.~~

DRAFT
12/3/09

NEBRASKA DEPARTMENT OF
HEALTH AND HUMAN SERVICES

173 NAC 1

~~1-008.02 In a case where a human has been bitten by other species, including livestock, rodents, and lagomorphs, health care providers may call the Nebraska Department of Health and Human Services Regulation and Licensure, Communicable Disease, or the approved local full-time public health service.~~

ATTACHMENTS

ATTACHMENT A	Reportable Diseases, Poisonings, and Organisms – Health Care Provider Confidential Communication
ATTACHMENT B	Laboratory Summary of Reportable Diseases, Poisonings, and Organisms
ATTACHMENT C	Adult HIV/AIDS Confidential Case Report
ATTACHMENT D	Pediatric HIV/AIDS Confidential Case Report
ATTACHMENT E	Antimicrobial Resistance Surveillance (Laboratory-Based)
ATTACHMENT F	Significant Exposure Report form for Emergency Services Provider or Public Safety Official

Att. A

Nebraska Department of Health and Human Services
Regulation and Licensure
REPORTABLE DISEASES, POISONINGS AND ORGANISMS
Health Care Provider Confidential Communication



Case # _____

Person Reporting: _____

Week Ending _____

Provider Info.

Clinic/Institution: _____

Address/Box # _____

Fax # _____

Tower: _____

State _____

Phone # _____

Zip Code _____

Patient Information

For Physician and Hospital Reporting

TODAY'S DATE _____	ATTENDING PHYSICIAN _____	DATE OF ONSET _____
PATIENT'S NAME: (Last) _____	(First) _____	(M/D) _____
IF < 19, PARENT'S NAME: (Last) _____	(First) _____	(M/D) _____
ADDRESS: CITY/TOWN _____	COUNTY _____	STATE _____
AGE _____	DOB: _____	RACE _____
SEX _____	Male _____ Female _____	<input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Am Indian <input type="checkbox"/> Asian or Pacific Islander
PHONE _____	MARITAL STATUS _____	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	ZIP _____
Disease: _____	Status: <input type="checkbox"/> Case <input type="checkbox"/> Suspected case <input type="checkbox"/> Asympt. carrier	

Check all of the following that apply

Patient was hospitalized. Patient has contact with children in day care.

Suspected food or waterborne illness. Patient died as a result of this illness. Patient is a foodhandler.

Patient is part of an outbreak. Blood level test result _____ µg/dL.

Treatment (drug, dosage, route, administration) _____

I request additional report forms. Please send _____ copies.

White Copy - HHS Regulation and Licensure Canary Copy - Health Care Provider

HHS-9-(DC) Rev 1/01 (86009)
(Previous version 5/97 should NOT be used)

Att. C

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: () _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT -- Patient identifier information is not transmitted to CDC! --

U.S. DEPARTMENT OF HEALTH
& HUMAN SERVICES
Centers for Disease Control
and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients ≥13 years of age at time of diagnosis)



II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

DATE FORM COMPLETED: Mo. Day Yr. _____

REPORT SOURCE: _____

SOUNDEX CODE: _____

REPORT STATUS:
1 New Report
2 Update

REPORTING HEALTH DEPARTMENT:
State: _____
City/County: _____

State Patient No.: _____
City/County Patient No.: _____

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one):
1 HIV Infection (not AIDS) _____
2 AIDS _____

AGE AT DIAGNOSIS: _____ Years

DATE OF BIRTH: Mo. Day Yr. _____

CURRENT STATUS: Alive Dead Unk. 1 2 9

DATE OF DEATH: Mo. Day Yr. _____

STATE/TERRITORY OF DEATH: _____

SEX: 1 Male 2 Female

ETHNICITY: (select one) 1 Hispanic 9 Unk 2 Not Hispanic or Latino

RACE: (select one or more) American Indian/Alaska Native Black or African American Asian Native Hawaiian or Other Pacific Islander White Unk

COUNTRY OF BIRTH: (including U.S. Dependencies and Possessions Puerto Rico) (specify):
1 U.S. 7 U.S. Dependencies and Possessions Puerto Rico 8 Other (specify): _____ 9 Unk

RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____

City: _____

State/Country: _____

FACILITY SETTING (check one):
1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one):
01 Physician, HMO 31 Hospital, Inpatient
99 Other (specify): _____

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 305 of the Public Health Service Act, 42 USC 242b and 242c). 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/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a report 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(b) of the Public Health Service Act (42 USC 242m).

V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
Sex with male	1	0	9
Sex with female	1	0	9
Injected nonprescription drugs	1	0	9
Received clotting factor for hemophilia/coagulation disorder	1	0	9
Specify 1 Factor VIII 2 Factor IX 8 Other (specify): _____			
HETEROSEXUAL relations with any of the following:	1	0	9
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First Mo. Yr. _____ Last Mo. Yr. _____			
Received transplant of tissue/organs or artificial insemination	1	0	9
Worked in a health-care or clinical laboratory setting	1	0	9
(specify occupation): _____			

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE Mo. Yr.
HIV-1 EIA	1	0	9	9	Mo. Yr. _____
HIV-1/HIV-2 combination EIA	1	0	9	9	Mo. Yr. _____
HIV-1 Western blot/IFA	1	0	8	9	Mo. Yr. _____
Other HIV antibody test (specify): _____	1	0	8	9	Mo. Yr. _____

2. POSITIVE HIV DETECTION TEST: (Record earliest test)

Mo. Yr. _____

□ culture □ antigen □ PCR, DNA or RNA probe

• Other (specify): _____

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Mo. Yr. _____

Test type* _____ COPIES/mL _____

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS

	Mo.	Yr.
CD4 Count _____ cells/μL	Mo. Yr. _____	Mo. Yr. _____
CD4 Percent _____ %	Mo. Yr. _____	Mo. Yr. _____
First <200 μL or <14%	Mo. Yr. _____	Mo. Yr. _____
CD4 Count _____ cells/μL	Mo. Yr. _____	Mo. Yr. _____
CD4 Percent _____ %	Mo. Yr. _____	Mo. Yr. _____

• Date of last documented negative HIV test (specify type): _____ Mo. Yr. _____

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes No Unk. 1 0 9

If yes, provide date of documentation by physician: _____ Mo. Yr. _____

Att. D 1 of 4

STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: (_____)
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT - Patient identifier information is not transmitted to CDC! -

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients <13 years of age at time of diagnosis)



DATE FORM COMPLETED:
Mo. Day Yr.
[][] [][] [][]

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

SOUNDINDEX CODE: [][][][]	REPORT STATUS: <input type="checkbox"/> 1 New Report <input type="checkbox"/> 2 Update	REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____	State Patient No.: [][][][][][][][]
	REPORT SOURCE: [][]		City/County Patient No.: [][][][][][][][]

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) <input type="checkbox"/> 3 Perinatally HIV Exposed <input type="checkbox"/> 4 Confirmed HIV Infection (not AIDS)		<input type="checkbox"/> 5 AIDS <input type="checkbox"/> 6 Seroreverter	DATE OF LAST MEDICAL EVALUATION: Mo. Yr. [][] [][]
DATE OF BIRTH: Mo. Day Yr. [][] [][] [][]	AGE AT DIAGNOSIS: Years Months HIV Infection (not AIDS) [][] [][] AIDS [][] [][]	CURRENT STATUS: <input type="checkbox"/> 1 Alive <input type="checkbox"/> 2 Dead <input type="checkbox"/> 3 Unk.	DATE OF DEATH: Mo. Day Yr. [][] [][] [][]
Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9	SEX: <input type="checkbox"/> 1 Male <input type="checkbox"/> 2 Female	ETHNICITY: (select one) <input type="checkbox"/> 1 Hispanic <input type="checkbox"/> 2 Not Hispanic or Latino <input type="checkbox"/> 3 Unk.	RACE: (select one or more) <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Unk.
RESIDENCE AT DIAGNOSIS: City: _____ County: _____ State/Country: _____ Zip Code: [][][][][][]		STATE/TERRITORY OF DEATH: _____ DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr. [][] [][]	

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/Country: _____

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO 31 Hospital, Inpatient 98 Other (specify): _____

V. PATIENT/MATERNAL HISTORY (Respond to ALL categories)

Child's biologic mother's HIV Infection Status: (check one)
 1 Refused HIV testing 2 Known to be uninfected after this child's birth 9 HIV status unknown

Diagnosed with HIV Infection/AIDS:
 3 Before this child's pregnancy 5 At time of delivery 7 After the child's birth
 4 During this child's pregnancy 6 Before child's birth, exact period unknown 8 HIV-infected, unknown when diagnosed

Date of mother's first positive HIV confirmatory test: Mo. Yr. [][] [][]

Mother was counseled about HIV testing during this pregnancy, labor or delivery? Yes No Unk.
 1 0 9

After 1977, this child's biologic mother had:	Yes	No	Unk.
• Injected nonprescription drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• HETEROSEXUAL relations with:			
- Intravenous/injection drug user	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
- Bisexual male	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
- Male with hemophilia/coagulation disorder	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
- Transfusion recipient with documented HIV infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
- Transplant recipient with documented HIV infection	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
- Male with AIDS or documented HIV infection, risk not specified	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transfusion of blood/blood components (other than clotting factor)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transplant of tissue/organs or artificial insemination	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

Before the diagnosis of HIV Infection/AIDS, this child had:	Yes	No	Unk.
• Received clotting factor for hemophilia/coagulation disorder (specify <input type="checkbox"/> 1 Factor VIII (Hemophilia A) <input type="checkbox"/> 2 Factor IX (Hemophilia B) disorder): <input type="checkbox"/> 0 Other (specify): _____	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Received transfusion of blood/blood components (other than clotting factor)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
First: Mo. Yr. [][] [][] Last: Mo. Yr. [][] [][]			
• Received transplant of tissue/organs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Sexual contact with a male	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Sexual contact with a female	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Injected nonprescription drugs	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9
• Other (Alert State/City NIR Coordinator)	<input type="checkbox"/> 1	<input type="checkbox"/> 0	<input type="checkbox"/> 9

VI. STATE/LOCAL USE ONLY

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

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo. Yr.
• HIV-1 EIA	1	0	-	9	
• HIV-1 EIA	1	0	-	9	
• HIV-1/HIV-2 combination EIA	1	0	-	9	
• HIV-1/HIV-2 combination EIA	1	0	-	9	
• HIV-1 Western blot/IFA	1	0	8	9	
• HIV-1 Western blot/IFA	1	0	8	9	
• Other HIV antibody test (specify): _____	1	0	8	9	

2. HIV DETECTION TESTS: (Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE Mo. Yr.
• HIV culture	1	0	9	
• HIV culture	1	0	9	
• HIV antigen test	1	0	9	
• HIV antigen test	1	0	9	
• HIV DNA PCR	1	0	9	
• HIV DNA PCR	1	0	9	
• HIV RNA PCR	1	0	9	
• HIV RNA PCR	1	0	9	
• Other, specify _____	1	0	9	

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable)

Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other

Test type*	Detectable Yes No	Copies/ml	Test Date Mo. Yr.
	1 0		

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

• CD4 Count		cells/L	Mo. Yr.
• CD4 Count		cells/L	Mo. Yr.
• CD4 Percent		%	Mo. Yr.
• CD4 Percent		%	Mo. Yr.

5. If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition? Yes No Unk. 1 0 9

6. If laboratory tests were not documented, is patient confirmed by a physician as: Yes No Unk. 1 0 9

- HIV-infected
- Not HIV-infected

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Det. Pres.	Initial Date Mo. Yr.	AIDS INDICATOR DISEASES	Initial Diagnosis Det. Pres.	Initial Date Mo. Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1 NA		Kaposi's sarcoma	1 2	
Candidiasis, bronchi, trachea, or lungs	1 NA		Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1 2	
Candidiasis, esophageal	1 2		Lymphoma, Burkitt's (or equivalent term)	1 NA	
Coccidioidomycosis, disseminated or extrapulmonary	1 NA		Lymphoma, immunoblastic (or equivalent term)	1 NA	
Cryptococcosis, extrapulmonary	1 NA		Lymphoma, primary in brain	1 NA	
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1 NA		Mycobacterium avium complex or M.kansasii, disseminated or extrapulmonary	1 2	
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1 NA		M. tuberculosis, disseminated or extrapulmonary*	1 2	
Cytomegalovirus retinitis (with loss of vision)	1 2		Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1 2	
HIV encephalopathy	1 NA		Pneumocystis carinii pneumonia	1 2	
Herpes simplex: chronic ulcer(s) (>1 mo. duration) or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1 NA		Progressive multifocal leukoencephalopathy	1 NA	
Histoplasmosis, disseminated or extrapulmonary	1 NA		Toxoplasmosis of brain, onset at >1 mo. of age	1 2	
Isosporiasis, chronic intestinal (>1 mo. duration)	1 NA		Wasting syndrome due to HIV	1 NA	

Det. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis? 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr. RVCT CASE NO.: _____

IX. BIRTH HISTORY (for PERINATAL cases only)

ATT: V
3 of 4

Birth history was available for this child: Yes No Unk. *If No or Unknown, proceed to Section X.*

HOSPITAL AT BIRTH:
Hospital: _____ City: _____ State: _____ Country: _____

RESIDENCE AT BIRTH:
City: _____ County: _____ State/Country: _____ Zip Code: _____

BIRTHWEIGHT: (enter lbs/oz OR grams) <input type="text"/> lbs. <input type="text"/> oz. <input type="text"/> grams	BIRTH: Type: <input type="checkbox"/> 1 Single <input type="checkbox"/> 2 Twin <input type="checkbox"/> 3 >2 <input type="checkbox"/> 9 Unk. Delivery: <input type="checkbox"/> 1 Vaginal <input type="checkbox"/> 2 Elective Caesarean <input type="checkbox"/> 3 Non-elective Caesarean <input type="checkbox"/> 4 Caesarean, unk. type <input type="checkbox"/> 9 Unk. Birth Defects: <input type="checkbox"/> 1 Yes <input type="checkbox"/> 0 No <input type="checkbox"/> 8 Unk. Specify type(s): _____ Code: _____	NEONATAL STATUS: <input type="checkbox"/> 1 Full term <input type="checkbox"/> 2 Premature Weeks <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>99 = Unk.</small>	PRENATAL CARE: mos. Month of pregnancy prenatal care began: <input type="text"/> <input type="text"/> <small>99 = Unk. 00 = Not 98</small> Total number of prenatal care visits: <input type="text"/> <input type="text"/> <small>99 = Unk. 00 = Not 98</small>
	• Did mother receive zidovudine (ZDV, AZT) during pregnancy? Released Yes No Unk. <input type="checkbox"/> 8 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? Weeks: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <small>99 = Unk.</small>	• Did mother receive zidovudine (ZDV, AZT) during labor/delivery? Released Yes No Unk. <input type="checkbox"/> 8 <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 • Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 8	• Did mother receive any other Anti-retroviral medication during pregnancy? Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 If yes, specify: _____ • Did mother receive any other Anti-retroviral medication during labor/delivery? Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 If yes, specify: _____

Maternal Date of Birth: Mo. Day Yr.
 Maternal Sounding: _____
 Maternal State Patient No. _____

Birthplace of Biologic Mother:
 1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____
 8 Other (specify): _____ 9 Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

• Neonatal zidovudine (ZDV, AZT) for HIV prevention: Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 DATE STARTED: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>	• Anti-retroviral therapy for HIV treatment: Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 DATE STARTED: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>
• Other neonatal anti-retroviral medication for HIV prevention: Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 DATE STARTED: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>	• PCP prophylaxis: Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 9 DATE STARTED: Mo. <input type="text"/> Day <input type="text"/> Yr. <input type="text"/>

If yes, specify: _____

Was child breastfed? Yes No Unk. <input type="checkbox"/> 1 <input type="checkbox"/> 0 <input type="checkbox"/> 8	This child has been enrolled at: Clinical Trial: <input type="checkbox"/> 1 NIH-sponsored <input type="checkbox"/> 2 Other <input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unk. Clinic: <input type="checkbox"/> 1 HRSA-sponsored <input type="checkbox"/> 2 Other <input type="checkbox"/> 3 None <input type="checkbox"/> 9 Unk.	This child's medical treatment is primarily reimbursed by: <input type="checkbox"/> 1 Medicaid <input type="checkbox"/> 4 Other Public Funding <input type="checkbox"/> 2 Private insurance/HMO <input type="checkbox"/> 7 Clinical trial/government program <input type="checkbox"/> 3 No coverage <input type="checkbox"/> 9 Unk.
---	--	---

This child's primary caretaker is:
 1 Biologic parent(s) 2 Other relative 3 Foster/Adoptive parent, relative 4 Foster/Adoptive parent, unrelated 7 Social service agency 8 Other (specify in Section XI.) 9 Unk.

XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 305 of the Public Health Service Act, 42 USC 242b and 242j). 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/AIDS. Information in CDC's HIV/AIDS 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).

Public reporting burden of this collection of information is estimated to average 10 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, NE D-24, Atlanta, GA 30333, ATTN: PRA (0040-0000). Do not send the completed form to this address.

Att. V
4 of 4

XI. COMMENTS (continued)

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Nebraska Health and Human Services System
Department of Regulation and Licensure
Antimicrobial Resistance Surveillance Monthly Report



Att. E

Name of Hospital/Laboratory:		
Address:		
Phone #:	Fax #:	E-mail address:
Reported by (please indicate name and official designation of person reporting): <input type="checkbox"/> Laboratory supervisor _____ <input type="checkbox"/> Other _____		
Surveillance period: Month (1 st to last day)		Year
Reported for county/region:		
Date submitted report: (mm/dd/yyyy)		

Please complete the following tables (include isolates from all body sites).

1) *Streptococcus pneumoniae*, penicillin-intermediate and penicillin-resistant

NCCLS interpretive standards:
 Resistant: MIC \geq 2.0 μ g/mL
 Intermediate: MIC = 0.12-1.0 μ g/mL
 Susceptible: MIC \leq 0.06 μ g/mL

	No. of isolates
Penicillin-resistant <i>S. pneumoniae</i>	
Penicillin-intermediate <i>S. pneumoniae</i>	
Total <i>S. pneumoniae</i> tested for susceptibility to penicillin	

2) *Enterococcus* spp., vancomycin-resistant (VRE) and vancomycin-intermediate

NCCLS interpretive standards:
 Resistant: MIC \geq 32 μ g/mL and/or resistant by disk diffusion
 Intermediate: MIC = 8-16 μ g/mL
 Susceptible: MIC \leq 4 μ g/mL

	No. of isolates
VRE	
Vancomycin-intermediate <i>Enterococcus</i> spp.	
Total <i>Enterococcus</i> spp. tested for susceptibility to vancomycin	

3) *Staphylococcus aureus*, methicillin-resistant (MRSA)

NCCLS interpretive standards to oxacillin:
 Resistant: MIC \geq 4 μ g/mL and/or resistant by disk diffusion
 Susceptible: MIC \leq 2 μ g/mL

	No. of isolates
MRSA	
Total <i>S. aureus</i> tested for susceptibility to oxacillin	

4) *S. aureus*, vancomycin-intermediate/resistant (VISA/VRSA)*

NCCLS interpretive standards:
 Intermediate/Resistant: MIC $>$ 4 μ g/mL
 Susceptible: MIC \leq 4 μ g/mL

	No. of isolates
VISA/VRSA	

* Report immediately

**EMERGENCY SERVICES PROVIDER (ESP) OR PUBLIC SAFETY
OFFICIAL (PSO) SIGNIFICANT EXPOSURE REPORT FORM**

(to be completed by ESP/PSO at the time of the exposure --

See Neb. Rev. Stat. Sections 71-507 to 71-513 for a description for use of this form)



Name: _____ Work Phone: _____
Address: _____ Home Phone: _____

Provider Agency: _____
Provider Address: _____
City, State, Zip: _____
Supervisor: _____ Work Phone: _____
Responsible Person: _____ Work Phone: _____

Designated Physician: _____ Work Phone: _____
Address: _____ Home Phone: _____
City, State, Zip: _____ Other Phone: _____

SOURCE OF EXPOSURE

Date of Incident: _____ Time of Incident: _____ am / pm Location: _____
Reference Number to Incident (such as Dispatch Number, NARSIS Number, Investigation, Etc.): _____

Name of Source Patient or Individual: _____ Age: _____ Sex: Male Female
Address: _____ Home Phone: _____
City, State, Zip: _____ Other Phone: _____
Other identification (e.g. operators permit number, vehicle license plates, etc.): _____

Receiving Facility of Source Patient or Individual (e.g., hospital, funeral establishment, etc.): _____
Address: _____
City, State, Zip: _____ Phone: _____

Patient's Attending Physician: _____ Work Phone: _____
Address: _____ Home Phone: _____
City, State, Zip: _____

Known Infectious Disease: _____

Describe the Significant Exposure: _____

Describe any action taken in response to the exposure to remove the contamination (e.g. handwashing): _____

What Personal Protective Equipment and Procedures were you using at the time of the exposure (e.g., gloves, eye protection, clothing): _____

Any other information related to the incident: _____

List witnesses to the exposure: _____

Signature _____ Date _____

WHITE to Health Care or Alternate Receiving Facility; YELLOW to ESP Designated Physician; PINK to ESP/PSO Provider Agency; GOLD to ESP/PSO Provider

