Oldham County Health Department
2017

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
From the Desk of

Madonna Ringswald, D.O.
Public Health Medical Director

Dear Community Partner,

The Oldham County Health Department is pleased to extend this resource guide for all healthcare providers as part of our continuing efforts to enhance community disease surveillance through improved reporting and timely patient follow up.

The primary goal of this project is to collect information required for clinical and laboratory confirmation of infectious diseases and conditions. This information has been provided in one convenient handbook and we hope that you will find this tool valuable for your facility. The health department would also appreciate any suggestions for improvement or insight you may have regarding the topics covered in the guide.

The Reportable Conditions Resource Guide is a product of the Oldham County Epi Rapid Response Team, whose members are available as an additional resource.

Teresa Gamsky, RN, Public Health Director
Meagan Hurst, MPH, CHES, Epidemiologist, MRC Coordinator
Charlie Ward, RS, Environmental Health
Heather Richardson, RN, BSN, Communicable Disease Nurse
Leanne Kommer, MSM, CHES, Health Education Specialist, Preparedness Coordinator

Please contact these members of the health department if they can be of assistance in any manner. Oldham County Health Department strives to have a strong community with healthy citizens and we look forward to working with you to make this happen.

Healthy People...Strong Community,

Madonna Ringswald, D.O.

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2017

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Reportable Conditions Contact Information

To contact Oldham County Health Department regarding a reportable disease or condition, you may call (502)-222-3516. Extensions for members of the Epi Rapid Response Team are listed below:

Teresa Gamsky, Director....ext. 152
Meagan Hurst, Local Epidemiologist....ext. 136
Heather Richardson, Infectious Disease Nurse....ext. 129
Charlie Ward, Environmentalist....ext. 134
Leanne Kommer, Health Educator....ext. 128
Rachel Pitto, Regional Epidemiologist....ext. 135

To send reports (EPID200 Form\(^1\), Labs, Physician’s dictation, etc.) to the Epidemiologist, please use the following fax number:

502-222-8723

If this is an urgent matter, you may contact the Kentucky Department for Public Health at 1-888-973-7678. This is a 24 hour, seven day a week phone line provided for emergencies. To report a **Public Health EMERGENCY** within Oldham County, please contact the health department during regular business hours or the KDPM Emergency Hotline listed above. For after-hours emergencies, please contact Oldham County Dispatch *(502) 222-0111*.

**If your facility is interested in receiving updates made to this guide, please ensure that OCHD has a current Point of Contact for your office. Contact forms can be found in the back of the manual.**

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Reference Sheets
Community Disease Surveillance Resource Tables

Disease surveillance in the community is the responsibility of not only the local health department (LHD), but also of local providers and laboratories. In order to enhance disease surveillance in the community, the Oldham County Health Department would like to offer insight into the needs of the LHD, providers and laboratories to properly complete the reportable disease process. The information in the following section will attempt to accomplish this goal.

When the LHD receives reports of conditions from Kentucky providers or laboratories, further follow-up is usually required to determine whether or not the case meets the Centers for Disease Control and Prevention (CDC) clinical requirements for reporting. These requirements are set forth by the Council for State and Territorial Epidemiologist (CSTE) case definitions. In general, the case definitions included a case classification (identify cases as suspect, probable or confirmed status), clinical criteria and/or laboratory criteria. The following tables may be used as a resource to help explain our requests when investigating reports and as a guide for laboratory testing.

In order to utilize the information as intended, we have provided the following explanations:

1. KAR 902 02:020 (Kentucky Statutes and Regulations Section) requires a provider or laboratory to report diagnoses or laboratory results of notifiable conditions to the local health department (in which the client resides), or the state Department for Public Health (KDPH). In order to best serve the community, we request that you first contact the Oldham County Health Department. The telephone number included will allow you to reach a health department representative immediately. If the call is placed after hours, it is suggested that contact be made with the emergency line provided by KDPH. If the situation does not warrant telephone contact, the OCHD fax number and mailing address provided will allow you to meet the regulations requirement.

2. The table is divided into three segments based on the timeline Kentucky has established for reporting the diseases for which surveillance is required. The first section includes conditions that should be reported within 24 hours. This section is denoted by a red background. The second section contains all conditions that should be reported within 1 business day and is denoted by an orange background. Lastly, the third section includes conditions that should be reported within 5 business days and is denoted by a green background.

3. Laboratory tests required for case classifications are included in the second column. The results of the tests included in this column (and only these tests) are what public health needs to fulfill the CDC’s requirement. Often, if a required lab is not completed, a case is not
included as a part of Kentucky’s disease surveillance. If possible, when laboratory tests are ordered to diagnose a patient **PLEASE** order the tests found in this column.

**Note:** For enteric pathogens, please submit an isolate to KDPH, Division of Laboratory Services (DLS) and a completed Lab Form 219**

4. The third and final column, titled “Comments”, include several pieces of information. Suggestions for exclusion from public contact, available immunizations and other information may be listed for some of the conditions. **Most importantly however, comments that describe the documentation that the LHD requires to make case determinations are included in this column. In most cases, lab results alone are not sufficient to fulfill the case definition and further follow up is required to determine symptomology and diagnoses.** These comments should act as a guide for what type of information should be gathered and then faxed when reporting a notifiable condition. If the LHD receives all necessary documentation when a report is made, the surveillance system becomes much more efficient. This can also allow for more time to be devoted to patients. When reporting, please try to send all relevant documentation as stated by this chart.

   **Below is an example comment included and how to utilize the information**

**Comment:** “Clinical presentation and laboratory confirmation is required for case determination”

**Interpretation:** Lab results and symptoms are needed for case classification

**Action:** Complete a KY Reportable Disease Form (EPID 200). Be sure to include information in all relevant fields and fax to the Oldham County Health Department along with any lab results.
**Reportable Conditions**

**The following diseases should be reported to both Oldham County Health Department and Kentucky Department of Public Health**

<table>
<thead>
<tr>
<th>Report within 24 hours</th>
<th>Report within one (1) business day</th>
<th>Report within five (5) business days</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Anthrax</td>
<td>• Cholera</td>
<td>• Babesiosis</td>
</tr>
<tr>
<td>• Botulism</td>
<td>• Cryptosporidiosis</td>
<td>• Chancroid</td>
</tr>
<tr>
<td>• Brucellosis (multiple cases, temporally or spatially clustered)</td>
<td>• Dengue virus infections</td>
<td>• Chlamydia trachomatis infection</td>
</tr>
<tr>
<td>• Diphtheria</td>
<td>• Escherichia coli O157:H7</td>
<td>• Coccidioidomycosis</td>
</tr>
<tr>
<td>• Hepatitis A, acute</td>
<td>• Foodborne disease outbreak</td>
<td>• Creutzfeldt-Jakob disease</td>
</tr>
<tr>
<td>• Measles</td>
<td>• Haemophilus influenza invasive disease</td>
<td>• Ehrlichiosis/Anaplasmosis</td>
</tr>
<tr>
<td>• Meningococcal infections</td>
<td>• Hansen’s disease (leprosy)</td>
<td>• Gonorrhea</td>
</tr>
<tr>
<td></td>
<td>• Hantavirus infections</td>
<td>• Granuloma inguinale</td>
</tr>
<tr>
<td></td>
<td>• Hemolytic uremic syndrome (HUS), post-diarrheal</td>
<td>• Hepatitis C, acute</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B, acute</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B infection in a pregnant woman</td>
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</tr>
<tr>
<td></td>
<td>• Hepatitis B infection in an infant or a child aged five years or less</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Newborns born to Hepatitis B positive mothers at the time of delivery</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Influenza-associated mortality in a pregnant woman</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Influenza-associated pediatric mortality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Listeriosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Mumps</td>
<td>• Lyme Disease</td>
</tr>
<tr>
<td></td>
<td>• Norovirus outbreak</td>
<td>• Lymphogranuloma venereum</td>
</tr>
<tr>
<td></td>
<td>• Pertussis</td>
<td>• Malaria</td>
</tr>
<tr>
<td></td>
<td>• Pesticide-related illness, acute</td>
<td>• Spotted Fever Rickettsiosis (Rocky Mountain Spotted Fever)</td>
</tr>
<tr>
<td></td>
<td>• Psittacosis</td>
<td>• Syphilis (other than primary, secondary, early latent, or congenital)</td>
</tr>
<tr>
<td></td>
<td>• Q fever</td>
<td>• Toxoplasmosis</td>
</tr>
<tr>
<td></td>
<td>• Rubella, congenital syndrome</td>
<td>• Trichinellosis (Trichinosis)</td>
</tr>
<tr>
<td></td>
<td>• Salmonellosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shiga toxin-producing E. coli (STEC)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Shigellosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Streptococcal toxic-shock syndrome</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Streptococcus pneumoniae, invasive disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tetanus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Toxic-shock syndrome (other than Streptococcal)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Typhoid fever</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tuberculosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Vibriosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Waterborne disease outbreak</td>
<td></td>
</tr>
</tbody>
</table>

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### Notification of the following diseases shall be considered urgent and shall be made within twenty-four (24) hours:

- Anthrax;
- Botulism;
- Brucellosis (multiple cases, temporally or spatially clustered);
- Diphtheria;
- Hepatitis A, acute;
- Measles;
- Meningococcal infections;
- Novel Influenza A virus infections;
- Plague;
- Poliomyelitis;
- Rabies, animal;
- Rabies, human;
- Rubella;
- Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease;
- Smallpox;
- Tularemia;
- Varicella;
- Viral hemorrhagic fevers due to:
  - (a) Crimean-Congo Hemorrhagic Fever virus;
  - (b) Ebola virus;
  - (c) Lassa virus;
  - (d) Ljupata virus;
  - (e) Marburg virus; or
  - (f) New world arenaviruses including:
    - 1. Guanarito virus;
    - 2. Junin virus;
    - 3. Machupo virus;
    - 4. Sabia virus.
- Yellow fever;

### Notification of the following diseases or conditions shall be considered priority and shall be made within one (1) business day:

- Arboviral diseases, neuroinvasive and non-neuroinvasive, including:
  - (a) California encephalitis virus;
  - 2. Jamestown Canyon virus;
  - 3. Keystone virus;
  - 4. La Crosse virus;
  - 5. Snowshoe hare virus; and
  - 6. Trivittatus viruses;
- (b) Chikungunya virus disease;
- (c) Eastern equine encephalitis virus disease;
- (d) Powassan virus disease;
- (e) St. Louis encephalitis virus disease;
- (f) Venezuelan equine encephalitis disease;
- (g) West Nile virus disease;
- (h) Western equine encephalitis virus disease; and
  - (i) Zika virus disease or infection or the birth of a child to a mother who was Zika-positive or Zika-inconclusive during any stage of pregnancy or during the periconceptional period;
- Brucellosis (cases not temporally or spatially clustered);
- Campylobacteriosis;
- Carbon monoxide poisoning;
- Cholera;
- Cryptosporidiosis;
- Dengue virus infections; *Escherichia coli* 0157:H7;
- Foodborne disease outbreak;
- *Haemophilus influenzae* invasive disease;
- Hansen’s disease (leprosy);
- Hantavirus infection, non-Hantavirus pulmonary syndrome;
- Hantavirus pulmonary syndrome (HPS); Hemolytic uremic syndrome (HUS);
- post-diarrheal Hepatitis B, acute;
- Hepatitis B infection in a pregnant woman;
- Hepatitis B infection in an infant or a child aged five (5) years or less;
- Newborns born to Hepatitis B positive mothers at the time of delivery;
- Influenza-associated mortality;
- Listeriosis;
- Mumps;
- Norovirus outbreak;
- Pertussis;
- Pesticide-related illness, acute;
- Pertussis;
- Q fever;
- Rabies post exposure prophylaxis;
- Rubella, congenital syndrome;
- Salmonellosis;
- Shiga toxin-producing *E. coli* (STEC);
- Shigellosis;
- Streptococcal toxic-shock syndrome;
- Streptococcus pneumoniae, invasive disease;
- Tetanus;
- Toxic shock syndrome (other than Streptococcal);
- Tuberculosis;
- Typhoid fever;
- Vibriosis;
- Waterborne disease outbreak;
- Congenital syphilis;
- Syphilis – primary, secondary, or early latent;
- Syphilis;
- Chancroid;
- *Chlamydia trachomatis* infection;
- Gonorrhea;
- Granuloma inguinale;
- Lymphogranuloma venereum; or
- Syphilis, other than primary, secondary, early latent, or congenital.

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### Submission of Clinical Isolates, or if Not Available, the Direct Specimen

<table>
<thead>
<tr>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botulism;</td>
</tr>
<tr>
<td>Brucellosis;</td>
</tr>
<tr>
<td>Campylobacteriosis;</td>
</tr>
<tr>
<td>Cholera and diseases caused by other <em>Vibrio</em> species;</td>
</tr>
<tr>
<td>Diphtheria;</td>
</tr>
<tr>
<td><em>Escherichia coli</em> O157:H7;</td>
</tr>
<tr>
<td>Hemolytic Uremic Syndrome (HUS) – Post Diarrheal;</td>
</tr>
<tr>
<td>Listeriosis;</td>
</tr>
<tr>
<td>Measles;</td>
</tr>
<tr>
<td>Meningococcal infections;</td>
</tr>
<tr>
<td>Rabies animal;</td>
</tr>
<tr>
<td>Rubella;</td>
</tr>
<tr>
<td>Salmonellosis;</td>
</tr>
<tr>
<td>Shigatoxin-producing <em>E. coli</em> (STEC);</td>
</tr>
<tr>
<td>Shigellosis;</td>
</tr>
<tr>
<td>Tuberculosis;</td>
</tr>
<tr>
<td>Tularemia; and</td>
</tr>
<tr>
<td>Typhoid Fever.</td>
</tr>
</tbody>
</table>

### Routine Notification within Five (5) Business Days, by Electronic Laboratory Reporting, Beginning October 1, 2016

<table>
<thead>
<tr>
<th>Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cyclosporiasis;</td>
</tr>
<tr>
<td>Giardiasis;</td>
</tr>
<tr>
<td>Hepatitis B laboratory test results whether reported as positive or negative:</td>
</tr>
<tr>
<td>1. Include the serum bilirubin levels taken within ten (10) days of the test of a patient who has tested positive; or</td>
</tr>
<tr>
<td>2. Include the serum alanine aminotransferase levels taken within ten (10) days of the test of a patient who tested positive;</td>
</tr>
<tr>
<td>Hepatitis C laboratory test results whether reported as positive or negative:</td>
</tr>
<tr>
<td>1. Include the serum bilirubin levels taken within ten (10) days of the test of a patient who has tested positive; or</td>
</tr>
<tr>
<td>2. Include the serum alanine aminotransferase levels taken within ten (10) days of the test of a patient who tested positive; and</td>
</tr>
<tr>
<td>Varicella laboratory test results reported as positive for:</td>
</tr>
<tr>
<td>1. Isolation of varicella virus from a clinical specimen;</td>
</tr>
<tr>
<td>2. Varicella antigen detected by direct fluorescent antibody test;</td>
</tr>
<tr>
<td>3. Varicella-specific nucleic acid detected by polymerase chain reaction (PCR); or</td>
</tr>
<tr>
<td>4. A significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by a standard serologic assay.</td>
</tr>
</tbody>
</table>

(Reports made pursuant to this section [of 902 KAR 2:020] shall include a diagnosis)

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### Multi-drug Resistant Organisms

1. Vancomycin-intermediate *Staphylococcus aureus* (VISA);
2. Vancomycin-resistant *Staphylococcus aureus* (VRSA);
3. Methicillin-resistant *Staphylococcus aureus* (MRSA); or
4. Vancomycin-resistant *Enterococcus* species (VRE);
5. *Clostridium difficile* (C. difficile);
6. Carbapenem-resistant Enterobacteriaceae (CRE);
7. Cephalosporin-resistant *Klebsiella*;
8. Extended-spectrum beta-lactamase Gram negative organisms (ESBL);
9. Multidrug-resistant – *Acinetobacter*;
10. Multidrug-resistant *Pseudomonas*;

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Laboratory Criteria and Public Health Recommendations for Reportable Conditions

Report to the Oldham County Health Department using the EPID200 Form
1786 Commerce Pkwy LaGrange, Kentucky 40031
Phone: 502-222-3516
Fax: 502-222-8723

<table>
<thead>
<tr>
<th>Reportable Condition</th>
<th>Laboratory Criteria for Case Criteria</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthrax</td>
<td><strong>Confirmed:</strong></td>
<td>Reporting Criteria: Clinical diagnosis or clinical suspicion of anthrax</td>
</tr>
<tr>
<td></td>
<td>• Culture and identification of <em>B. anthracis</em> from clinical specimens by the Laboratory Response Network (LRN)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstration of <em>B. anthracis</em> antigens in tissues by immunohistochemical staining using both <em>B. anthracis</em> cell wall and capsule monoclonal antibodies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence of a four-fold rise in antibodies to protective antigen in paired convalescent sera using CDC quantitative anti-PA immunoglobulin G (IgG) ELISA testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Documented anthrax environmental exposure AND evidence of <em>B. anthracis</em> DNA (for example, by LRN-validated polymerase chain reaction) in clinical specimens collected from a normally sterile site (such as blood or CSF) or lesion of other affected tissue (skin, pulmonary, reticuloendothelial or gastrointestinal</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Probable:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Epidemiological link to a documented anthrax environmental exposure.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence of <em>B. anthracis</em> DNA (for example, by LRN-validated</td>
<td></td>
</tr>
</tbody>
</table>
| Anthrax | polymerase chain reaction-PCR-in clinical specimens collected from a normally sterile site (such as blood or cerebrospinal fluid [CSF]) or a lesion of other affected tissue (skin, pulmonary, reticuloendothelial, or gastrointestinal)  
- Positive result on testing of clinical serum specimens using the QuickELISA (enzyme-linked immunosorbent assay) Anthrax-PA (protective antigen) kit  
- Detection of Lethal Factor (LF) in clinical serum specimens by LF mass spectrometry  
- Positive result on testing of culture from clinical specimens with the RedLine Alert test |
|---|---|
| Botulism | Botulism, Foodborne:  
- Detection of botulinum toxin in serum, stool or patients food OR isolation of *Clostridium botulinum* from stool  
| Botulism, Infant:  
- Detection of botulinum toxin in stool or serum, OR isolation of *Clostridium botulinum* from stool  
- A clinically compatible case that is laboratory-confirmed, occurring in a child aged less than 1 year  
| Botulism, Other:  
- Detection of botulinum toxin in clinical specimen OR isolation of *Clostridium botulinum* from clinical specimen  
| Botulism, Wound:  
- Detection of botulinum toxin in serum, OR isolation of *Clostridium botulinum* from wound  
| Classification of cases may require one of the following:  
- Clinical presentation  
- Laboratory confirmation  
- Epidemiologic evidence |
| Brunellosis | **Definitive:**  
| • Culture and identification of *Brucella* spp. From clinical specimens  
| • Evidence of a fourfold or greater rise in *Brucella* antibody titer between acute- and convalescent-phase serum specimens obtained greater than or equal to 2 weeks apart  
| **Presumptive:**  
| • *Brucella* total antibody titer of greater than or equal to 160 by standard tube agglutination test (SAT) or *Brucella* microagglutination test (BMAT) in one or more serum specimens obtained after onset of symptoms  
| • Detection of *Brucella* DNA in a clinical specimen by PCR assay | Classification of cases may require one of the following:  
| • Clinical presentation  
| • Laboratory confirmation  
| Epidemiologic evidence |  

| Diphtheria | **Confirmed:**  
| • An upper respiratory tract illness with an adherent membrane of the nose, pharynx, tonsils, or larynx, and any of the following:  
| • Isolation of *Corynebacterium diphtheria* from the nose or throat OR  
| • Histopathologic diagnosis of diphtheria OR  
| • Epidemiologic linkage to a laboratory-confirmed case of diphtheria | Classification of cases may require one of the following:  
| • Clinical presentation  
| • Laboratory confirmation  
| Epidemiologic evidence |  

| Hepatitis A, acute | **Confirmed:**  
| • Immunoglobulin M (IgM) antibody to hepatitis A virus (anti-HAV) positive | Classification of cases may require one of the |  

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<table>
<thead>
<tr>
<th>Condition</th>
<th>Confirmed:</th>
<th>Classification of cases may require one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis A, acute</td>
<td>- Clinical presentation</td>
<td>• Clinical presentation</td>
</tr>
<tr>
<td></td>
<td>- Laboratory confirmation</td>
<td>• Laboratory confirmation</td>
</tr>
<tr>
<td></td>
<td>- Epidemiologic evidence</td>
<td>• Epidemiologic evidence</td>
</tr>
<tr>
<td>Measles</td>
<td><strong>Confirmed:</strong></td>
<td><strong>Classification of cases may require one of the following:</strong></td>
</tr>
<tr>
<td></td>
<td>• Isolation of measles virus from a clinical specimen</td>
<td>• Clinical presentation</td>
</tr>
<tr>
<td></td>
<td>• Detection of measles-virus specific nucleic acid from a clinical</td>
<td>• Laboratory confirmation</td>
</tr>
<tr>
<td></td>
<td>specimen using PCR</td>
<td>• Epidemiologic evidence</td>
</tr>
<tr>
<td></td>
<td>• IgG seroconversion or a significant rise in measles immunoglobulin</td>
<td><strong>Classification of cases may require one of the following:</strong></td>
</tr>
<tr>
<td></td>
<td>G antibody using any evaluated and validated method</td>
<td>• Clinical presentation</td>
</tr>
<tr>
<td></td>
<td>• Positive serologic test for measles immunoglobulin M antibody</td>
<td>• Laboratory confirmation</td>
</tr>
<tr>
<td></td>
<td>• Direct epidemiologic linkage to a case confirmed by one of the</td>
<td>• Epidemiologic evidence</td>
</tr>
<tr>
<td></td>
<td>methods above***</td>
<td><strong>Classification of cases may require one of the following:</strong></td>
</tr>
<tr>
<td>Meningococcal Infection</td>
<td><strong>Confirmed:</strong></td>
<td>• Clinical presentation</td>
</tr>
<tr>
<td></td>
<td>• Detection of <em>N. meningitidis</em>-specific nucleic acid in a specimen</td>
<td>• Laboratory confirmation</td>
</tr>
<tr>
<td></td>
<td>obtained from a normally sterile body site (e.g., blood or CSF)</td>
<td>• Epidemiologic evidence</td>
</tr>
</tbody>
</table>

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| Meningococcal Infection | using a validated PCR assay  
- Isolation of *N. meningitidis* from a normally sterile side (e.g., blood or CSF, or less commonly, synovial, pleural, or pericardial fluid) or from purpuric lesions  
**Probable:**  
- Detection of *N. meningitidis* antigen in formalin-fixed tissue by immunohistochemistry (IHC) or in CDF by latex agglutination  
**Suspected:**  
- Clinical purpura fulminans in the absence of a positive blood culture or gram-negative diplococci, not yet identified, isolated from a normally sterile body site (e.g., blood or CSF) | following:  
- Laboratory confirmation  
- Epidemiologic evidence |
<p>| Novel Influenza A Virus | A human case of infection with an influenza A virus subtype that is different from currently circulating human influenza H1 and H3 viruses. Novel subtypes include, but are not limited to, H2, H5, H7, and H9 subtypes. Influenza H1 and H3 subtypes originating from a non-human species or from genetic reassortment between animal and human viruses are also novel subtypes. Novel subtypes will be detected with methods available for detection of currently circulating human influenza viruses at state public health laboratories (e.g., real-time reverse transcriptase polymerase chain reaction [RT-PCR]). Confirmation that influenza A virus represents a novel virus will be performed by CDC’s influenza laboratory. Once a novel virus has been identified by CDC, confirmation may be made by public health laboratories following CDC-approved protocols for that specific virus, or by laboratories using an FDA-authorized test specific for detection |</p>
<table>
<thead>
<tr>
<th>Novel Influenza A Virus</th>
<th>of that novel influenza virus. sterile body site (e.g., blood, CSF)</th>
<th></th>
</tr>
</thead>
</table>
| **Plague**              | **Confirmatory:**  
  - Isolation of *Y. pestis* from a clinical specimen **OR** fourfold or greater change in serum antibody titer to *Y. pestis* F1 antigen  
  **Presumptive:**  
  - Elevated serum antibody titer(s) to *Yersinia pestis* fraction 1 (F1) antigen (without documented fourfold or greater change) in a patient with no history of plague vaccination **OR** detection of F1 antigen in a clinical specimen by fluorescent assay | Reporting Criteria: Clinical diagnosis initially; laboratory confirmation required to meet case definition. |
| **Poliomyelitis**       | **Paralytic:**  
  - No laboratory criteria identified by CDC  
  **Non-paralytic:**  
  - Any person without symptoms of paralytic poliomyelitis in whom a poliovirus isolate was identified in an appropriate clinical specimen, with confirmatory typing and sequencing performed by the CDC Poliovirus Laboratory, as needed |  |
| **Rabies, Animal**      | **Confirmed:**  
  - A positive direct fluorescent antibody test (preferably performed on central nervous system tissue)  
  - Isolation of rabies virus (in cell culture or in a laboratory animal) |  |
| **Rabies, Human**       | - Detection of Lyssavirus antigens in a clinical specimen (preferably the brain or the nerves surrounding hair follicles in the nape of the neck) by direct fluorescent antibody test **OR**  
  - Isolation (in cell culture or in a laboratory animal) of a Lyssavirus | Reporting Criteria: Clinical diagnosis initially; laboratory confirmation |
| Rabies, Human | from saliva or central nervous system tissue OR  
|              | • Identification of Lyssavirus specific antibody (i.e., by indirect fluorescent antibody (IFA) test or complete rabies virus neutralization at 1-5 dilution) in the serum of an unvaccinated person OR  
|              | • Detection of Lyssavirus viral RNA (using reverse transcriptase-polymerase chain reaction [RT-PCR]) in saliva, CSF or tissue | required to meet case definition. |

| Rubella       | Confirmed:  
|              | • Isolation of rubella virus OR  
|              | • Detection of rubella-virus specific nucleic acid by PCR OR  
|              | • IgG seroconversion or a significant rise between acute and convalescent phase titers in serum rubella IgG antibody level by any standard serologic assay  
|              | • Positive serologic test for rubella immunoglobulin M (IgM) antibody | Classification of cases may require one of the following:  
|              | • Clinical presentation  
|              | • Laboratory confirmation  
|              | • Epidemiologic evidence  
|              | Children should be kept home from school and daycare for 7 days following the onset of rash |

| Severe Acute Respiratory Syndrome-associated | Tests to detect SARS-CoV are being refined and their performance characteristics assessed; therefore, criteria for laboratory diagnosis of SARS-CoV are changing. The following are general criteria for |

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<table>
<thead>
<tr>
<th>Disease</th>
<th>Laboratory Confirmation Criteria</th>
<th>Reporting Criteria</th>
</tr>
</thead>
</table>
| **Coronavirus (SARS-CoV)** | - Detection of serum antibody to SARS-CoV by a test validated by CDC (e.g., enzyme immunoassay), OR  
- Isolation in cell culture of SARS-CoV from a clinical specimen OR  
- Detection of SARS-CoV RNA by a RT-PCR test validated by CDC and with subsequent confirmation in a reference laboratory (e.g., CDC) | Clinical diagnosis initially; laboratory confirmation required to meet case definition. |
| **Smallpox** | - PCR identification of variola DNA in a clinical specimen OR  
- Isolation of smallpox (variola) virus from a clinical specimen (Level D laboratory only; confirmed by variola PCR) | |
| **Tularemia** | **Confirmatory:**  
- Isolation of *F. tularensis* in a clinical specimen OR  
- Fourfold or greater change in serum antibody titer to *F. tularensis* antigen  
**Presumptive:**  
- Elevated serum antibody titer(s) to *Francisella tularensis* antigen (without documented fourfold or greater change) in a patient with no history of tularemia vaccination OR  
- Detection of *F. tularensis* in a clinical specimen by fluorescent assay | Clinical diagnosis initially; laboratory confirmation required to meet case definition. |
| **Yellow Fever** | - Fourfold or greater rise in yellow fever antibody titer in a patient who has no history of recent yellow fever vaccination and cross-reaction to other flaviviruses have been excluded OR  
- Demonstration of yellow fever virus, antigen, or genome in | Clinical diagnosis initially; laboratory confirmation |
<table>
<thead>
<tr>
<th><strong>Yellow Fever</strong></th>
<th>tissue, blood, or other body fluid</th>
<th>required to meet case definition.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Varicella</strong></td>
<td><strong>Probable:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An acute illness with:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Diffuse (generalized) maculo-papulovesicular rash, <strong>AND</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lack of laboratory confirmation, <strong>AND</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Lack of epidemiologic linkage to another probable or confirmed case.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Confirmed:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>An acute illness with diffuse (generalized) maculo-papulovesicular rash, <strong>AND</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Epidemiologic linkage to another probable or confirmed case, <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Isolation of varicella virus from a clinical specimen, <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Varicella antigen detected by direct fluorescent antibody test, <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Varicella-specific nucleic acid detected by polymerase chain reaction (PCR), <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by any standard serologic assay</td>
<td></td>
</tr>
<tr>
<td><strong>Viral Hemorrhagic Fevers</strong></td>
<td>One or more of the following laboratory findings:</td>
<td></td>
</tr>
<tr>
<td><em>Crimean-Congo Hemorrhagic Fever virus, Ebola virus, Lassa</em></td>
<td>• Detection of viral hemorrhagic fever (VHF) viral antigens in blood by enzyme-linked Immunosorbent Assay (ELISA) antigen detection</td>
<td></td>
</tr>
</tbody>
</table>

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New World Arenaviruses

<table>
<thead>
<tr>
<th>virus, Lujo virus, Marburg virus, Guanarito virus, Junin virus, Machupo virus, Sabia virus</th>
</tr>
</thead>
<tbody>
<tr>
<td>- VHF viral isolation in cell culture for blood or tissues</td>
</tr>
<tr>
<td>- Detection of VHF-specific genetic sequence by RT-PCR from blood or tissues</td>
</tr>
<tr>
<td>- Detection of VHF viral antigens in tissues by immunohistochemistry</td>
</tr>
</tbody>
</table>

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## Laboratory Criteria and Public Health Recommendations for Reportable Conditions

--- REPORT WITHIN ONE (1) BUSINESS DAY ---

Report to the Oldham County Health Department using the EPID200 Form
1786 Commerce Pkwy LaGrange, Kentucky 40031
Phone: 502-222-3516
Fax: 502-222-8723

<table>
<thead>
<tr>
<th>Reportable Condition</th>
<th>Laboratory Criteria for Case Criteria</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Arboviral diseases, neuroinvasive and non-neuroinvasive, including:                | • Isolation of virus from, or demonstration of specific viral antigen or nucleic acid in tissue, blood, CSF or other body fluid OR
• Four-fold or greater change in virus-specific quantitative antibody titers in paired sera OR
• Virus-specific IgM antibodies in serum with confirmatory virus-specific neutralizing antibodies in the same or a later specimen, OR
• Virus-specific IgM antibodies in CSF or specimen                                   | Reporting Criteria: Clinical diagnosis initially; laboratory confirmation required to meet case definition. |

| California serogroup virus diseases, including diseases caused by: California encephalitis virus, Jamestown Canyon virus, Keystone Virus, La Crosse virus, Snowshoe hare virus, Trivittatus viruses, Chikungunya virus disease, Eastern equine encephalitis virus disease, |

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<table>
<thead>
<tr>
<th>Disease</th>
<th>Definitive:</th>
<th>Classification of cases may require one of the following:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Powassan virus disease, Venezuelan equine encephalitis disease, West Nile virus disease, Western equine encephalitis virus disease</td>
<td>• Culture and identification of <em>Brucella</em> spp. from clinical specimens</td>
<td>• Clinical presentation</td>
</tr>
<tr>
<td></td>
<td>• Evidence of a fourfold or greater rise in <em>Brucella</em> antibody titer</td>
<td>• Laboratory confirmation</td>
</tr>
<tr>
<td></td>
<td>between acute- and convalescent- phase serum specimens obtained</td>
<td>Epidemiologic evidence</td>
</tr>
<tr>
<td></td>
<td>greater than or equal to 2 weeks apart.</td>
<td></td>
</tr>
<tr>
<td>Brucellosis (cases not temporally or spatially clustered)</td>
<td><strong>Presumptive:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <em>Brucella</em> total antibody titer of greater than or equal to 160 by</td>
<td></td>
</tr>
<tr>
<td></td>
<td>standard tube agglutination test (SAT) or <em>Brucella</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>microagglutination test (BMAT) in one or more serum specimens obtained</td>
<td></td>
</tr>
<tr>
<td></td>
<td>after onset of symptoms</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detection of <em>Brucella</em> DNA in a clinical specimen by PCR assay</td>
<td></td>
</tr>
<tr>
<td>Campylobacteriosis</td>
<td><strong>Confirmed:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Isolation of <em>Campylobacter</em> spp. from a clinical specimen</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Probable:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detection of <em>Campylobacter</em> in a clinical specimen using a culture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>independent diagnostic test (CIDT)</td>
<td></td>
</tr>
</tbody>
</table>
| **Cholera** | • Isolation of toxigenic (i.e., cholera toxin-producing) *Vibrio cholerae* O1 or O139 from stool or vomitus **OR**  
• Serologic evidence of recent infection |
| **Cryptosporidiosis** | **Confirmed:**  
Evidence of *Cryptosporidium* organisms or DNA in stool, intestinal fluid, tissue samples, biopsy specimens or other biological sample by certain laboratory methods with a high positive predictive value (PPV).  
- Direct fluorescent antibody (DFA) test  
- PCR  
- Enzyme immunoassay (EIA)  
- Light microscopy of stained specimen  
**Probable:**  
The detection of *Cryptosporidium* antigen by a screening test method, such as immunochromatographic card/rapid card test; or a laboratory test of unknown method. |
| **Dengue** | **Confirmatory:**  
- Detection of DENV nucleic acid in serum, plasma blood, CSF or other body fluid or tissue by validated RT-PCR **OR**  
- Detection of DENV antigens in tissue by a validated immunofluorescence or immunohistochemistry assay **OR**  
- Detection in serum or plasma of DENV NS1 antigen by a validated immunoassay **OR**  
- Cell culture isolation of DENV from a serum, plasma or CSF specimen **OR** |

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### Dengue

- Detection of IgM anti-DENV by validated immunoassay in a serum specimen or CSF in a person living in a dengue endemic or non-endemic area of the United States without evidence of other Flavavirus transmission (e.g., WNV, SLEV, or recent vaccination against a Flavavirus (e.g., YFV, JEV)) OR
- Detection of IgM anti-DENV in a serum specimen or CSF by validated immunoassay in a traveler returning from a dengue endemic area without ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV) OR
- IgM anti-DENV seroconversion or greater than or equal to 4 fold rise in titer by a validated immunoassay in serum specimens collected more than two weeks apart and confirmed by a neutralization test (e.g., plaque reduction neutralization test) with a greater than 4-fold higher end point titer as compared to other flaviviruses tested

#### Probable:

- Detection of IgM anti-DENV by validated immunoassay in a serum specimen or CSF in a person living in a dengue endemic or non-endemic area of the United States with evidence of other flavivirus transmission (e.g., WNV, SLEV) or recent vaccination against a flavivirus (e.g., YFV, JEV)
- Detection of IgM anti-DENV in a serum specimen or CSF by validated immunoassay in a traveler returning from a dengue endemic area without ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV)
<table>
<thead>
<tr>
<th>Disease</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dengue</td>
<td>endemic area with ongoing transmission of another flavivirus (e.g., WNV, JEV, YFV), clinical evidence of co-infection with one of these flaviviruses, or recent vaccination against a flavivirus (e.g., YFV, JEV)</td>
</tr>
<tr>
<td><strong>Suspected:</strong></td>
<td>- The absence of IgM anti-DENV by validated immunoassay in a serum or CSF specimen collected &lt;5 days after illness onset and in which molecular diagnostic testing was not performed in a patient with an epidemiologic linkage.</td>
</tr>
<tr>
<td><strong>Escherichia coli O157:H7</strong></td>
<td>- Isolation of <em>Escherichia coli</em> O157:H7 from a specimen <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>- Isolation of Shiga toxin-producing <em>E. coli</em> O157:NM from a clinical specimen</td>
</tr>
<tr>
<td><strong>Foodborne Outbreak Diseases</strong></td>
<td>- Diagnostic laboratory criteria depend upon the etiologic agent.</td>
</tr>
<tr>
<td><strong>Haemophilus Influenza Invasive Disease</strong></td>
<td>- Detection of <em>Haemophilus influenza</em> type B antigen in CSF  <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>- Detection of <em>Haemophilus influenzae</em>-specific nucleic acid in a specimen obtained from a normally sterile body site (e.g., Blood or CSF) using a validated PCR assay  <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>- Isolation of <em>Haemophilus influenzae</em> from a normally sterile body site (e.g., CSF, blood, joint fluid, pleural fluid, pericardial fluid)</td>
</tr>
<tr>
<td><strong>Hansen’s Disease (Leprosy)</strong></td>
<td><strong>Confirmed:</strong></td>
</tr>
<tr>
<td></td>
<td>- Demonstration of acid fast bacilli in skin or dermal nerve from a biopsy of a skin lesion using Fite stain, without growth of</td>
</tr>
<tr>
<td>Disease/Diagnosis</td>
<td>Diagnostic Criteria</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Hansen’s Disease (Leprosy)**                                                  | - mycobacteria on conventional media (if done) OR  
  - Identification of noncaseating granulomas with peripheral nerve involvement, without growth of mycobacterium conventional media (if done)                                                                                   |
| **Hantavirus Infection**                                                        | - Detection of hantavirus-specific immunoglobulin M or rising tiers of hantavirus-specific immunoglobulin G, OR  
  - Detection of hantavirus-specific ribonucleic acid in clinical specimens, OR  
  - Detection of hantavirus antigen by immunohistochemistry in lung biopsy or autopsy tissues |
| **Hemolytic uremic syndrome (HUS), Post-diarrheal**                              | The following are both present at some time during the illness:  
  - Anemia (acute onset) with microangiopathic changes (i.e., schistocytes, burr cells, or helmet cells) on a peripheral blood smear, AND  
  - Renal injury (acute onset) evidenced by either hematuria, proteinuria, or elevated creatinine level (i.e., greater than or equal to 1.0 mg/dL in a child aged less than 13 years or greater than or equal to 1.5 mg/dL in a person aged greater than or equal to 13 years, or greater than or equal to 50% increase over baseline) |
| **Hepatitis B, acute**                                                          | - HBsAg positive, AND  
  - Immunoglobulin M (IgM) antibody to hepatitis B core antigen (IgM anti-HBc) positive (if done)                                                                                                               |
| **Hepatitis B infection in a pregnant woman**                                   | - Hepatitis B surface antigen (HBsAg) positive                                                                                                                                          |
| **Hepatitis B infection in an infant or child aged five years or less** | • Hepatitis B surface antigen (HBsAg) positive and quantitative antibody to hepatitis B surface antigen (quantitative anti-HBs) at 9-18 months of age and one to two months after the last dose of the hepatitis B vaccine series. |
| **Newborns born to Hepatitis B positive mothers at the time of delivery** | • Hepatitis B surface antigen (HBsAg) positive mother |
| **Influenza-associated pediatric mortality or mortality in a pregnant woman** | Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens, and include identification of influenza A or B virus infections by a positive result by at least one of the following:  
• Influenza virus isolation in tissue cell culture from respiratory specimens  
• RT-PCR testing of respiratory specimens  
• Immunofluorescent antibody staining (direct or indirect) of respiratory specimens  
• Rapid influenza diagnostic testing of respiratory specimens  
• Immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens  
• Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera |
### List of Notifications

<table>
<thead>
<tr>
<th><strong>Listeriosis</strong></th>
</tr>
</thead>
</table>
| • Isolation of *L. monocytogenes* from a normally sterile site (e.g., blood or CSF) or less commonly joint, pleural or pericardial fluid  
  • In the setting of miscarriage or stillbirth, isolation of *L. monocytogenes* from a placental or fetal tissue. |

| **Mumps** | **Confirmed:**  
| --- | 
| • A positive mumps laboratory confirmation for mumps virus with RT-PCR or culture in a patient with an acute illness characterized by any of the following:  
  • Acute parotitis or other salivary gland swelling, lasting at least 2 days  
  • Aseptic meningitis  
  • Encephalitis  
  • Hearing loss  
  • Orchitis  
  • Oophoritis  
  • Mastitis  
  • Pancreatitis |

<table>
<thead>
<tr>
<th><strong>Norovirus Outbreak</strong></th>
</tr>
</thead>
</table>
| • RT-PCR is the most widely used diagnostic assay for detecting norovirus. Stool specimens collected during acute illness (within 48-72 hours after symptom onset) is preferred.  
  • EIAs for detecting norovirus in stool samples are available. EIAs are currently not sensitive enough (<50%) for diagnosing individual cases. |

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| Pertussis | Isolation of *B. pertussis* from a clinical specimen  
Positive PCR for pertussis | Clinical presentation and laboratory confirmation required for case determination  
Confirmed cases should be excluded from public contact until they have completed 5 days of the recommended course of antimicrobial therapy\(^2\)  
If no treatment is provided to patient, individual should be excluded from public contact until three weeks after the onset of cough\(^2\) | Antimicrobial |

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<table>
<thead>
<tr>
<th>Pertussis</th>
<th>Therapy recommended for pertussis include: Azithromycin, Erythromycin, Clarithromycin and TMP-SMX. SEROLOGY CANNOT BE USED TO IDENTIFY CASES OF PERTUSSIS Vaccination with TDAP should be recommended to all cases and contacts.</th>
</tr>
</thead>
</table>
| Pesticide-related Illness and Injury, acute | If available, the following laboratory data can confirm exposure to a pesticide:  
- Biological tests for the presence of, or toxic response to, the pesticide and/or its metabolite (in blood, urine, etc.)  
- Measurement of the pesticide and/or its metabolite(s) in the biological specimen  
- Measurement of a biochemical response to the pesticide in a biological specimen (e.g., cholinesterase levels) |

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### Pesticide-related Illness and Injury, acute
- Environmental tests for the pesticide (e.g., foliage residue, analysis of suspected liquid)
- Pesticide detection on clothing or equipment used by the case subject

### Psittacosis
- Isolation of *Chlamydia psittaci* from respiratory specimens (e.g., sputum, pleural fluid, or tissue) or blood OR
- Fourfold or greater increase in antibody (IgG) against *C. psittaci* by complement fixation (CF) or microimmunofluorescence (MIF) between paired acute- and convalescent phase serum specimens obtained at least 2-4 weeks apart OR
- Supportive serology (e.g., *C. psittaci* titer (IgM) or greater than or equal to 32 in at least one serum specimen obtained after onset of symptoms) OR
- Detection of *C. psittaci* DNA in a respiratory specimen (e.g., sputum, pleural fluid or tissue) via amplification of a specific target by PRC assay.

### Q Fever
**Laboratory Confirmed:**
- Serological evidence of a fourfold change in IgG-specific antibody titer to *C. burnetii* phase II antigen by IFA between paired serum samples. (CDC suggests one taken during the first week of illness and a second 3-6 weeks later, antibody titers to Phase I antigen may be elevated or rise as well)
- Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by PCR assay
- Demonstration of *C. burnetii* in a clinical specimen by IHC.

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| Q Fever | Isolation of *C. burnetii* from a clinical specimen by culture.  
**Laboratory supportive:**  
- Has a single supportive IFA IgG titer of >1:128 to Phase II antigen (Phase I titers may be elevated as well)  
- Has serologic evidence of elevated Phase II IgG or IgM antibody reactive with *C. burnetii* antigen by ELISA, dot-ELISA or latex agglutination. Note: For acute testing, CDC uses in-house IFA IgG testing (cutoff of ≥ 1:128), preferring simultaneous testing of paired specimens, and does not use IgM results for routine diagnostic testing.  
**Chronic Cases:**  
- Serological evidence of IgG antibody to *C. burnetii* Phase I antigen of ≥ 1:800 by IFA (while Phase II IgG titer will be elevated as well, Phase I titer is higher than the Phase II titer)  
- Detection of *C. burnetii* DNA in a clinical specimen via amplification of a specific target by PCR assay  
- Demonstration of *C. burnetii* DNA in a clinical specimen by IHC  
- Isolation of *C. burnetii* from a clinical specimen by culture  
*Note: Has an antibody titer to *C. burnetii* Phase I IgG antigen of ≥ 1:128 and <1:800 |
| --- |
| Rubella, congenital syndrome | **Confirmed:** An infant with at least one symptom that is clinically consistent with congenital rubella syndrome AND laboratory evidence of congenital rubella infection as demonstrated by:  
Classification of cases may require one of the following:  
- Clinical |
### Rubella, congenital syndrome

- Isolation of rubella virus **OR**
- Detection of rubella-specific IgM antibody **OR**
- Infant rubella antibody level that persists at a higher level and for a longer period than expected from passive transfer of maternal antibody (i.e., rubella titer that does not drop at the expected rate of a twofold dilution per month) **OR**
- A specimen that is PCR positive for rubella virus

Children with congenital rubella should be considered contagious until they are at least 1 year of age, unless nasopharyngeal and urine culture results repeatedly are negative for rubella virus.

### Salmonella

<table>
<thead>
<tr>
<th><strong>Confirmed:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Isolation of <em>Salmonella</em> from a clinical specimen</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Suspect:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Detection of <em>Salmonella</em> from a clinical specimen using a non-culture based method</td>
</tr>
</tbody>
</table>
### Shiga toxin-producing *Escherichia coli*

**Laboratory Confirmed:**
- Isolation of STEC from a clinical specimen. *E. coli O157:H7 isolates that produce the H7 antigen may be assumed to be Shiga toxin-producing. For all other *E. coli* isolates, Shiga toxin production or the presence of Shiga toxin genes must be determined to be considered STEC.
- Both asymptomatic infection and infections at the sites other than the gastrointestinal tract, if laboratory confirmed, are considered confirmed cases that should be reported.

**Supportive laboratory results:**
- A case with isolation of *E. coli O157:H7* from a clinical specimen, without confirmation of H antigen or Shiga toxin production.
- Identification of an elevated antibody titer to a known STEC serotype from a clinically compatible case.
- Identification of Shiga toxin in a specimen from a clinically compatible case without the isolation of STEC.

### Shigellosis

**Confirmed:**
- Isolation of *Shigella* from a clinical specimen

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<table>
<thead>
<tr>
<th>Shigelliosis</th>
<th>Suspect:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Detection of <em>Shigella</em> from a clinical specimen using a non-culture based method</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Streptococcal toxic-shock syndrome</th>
<th>Isolation of group A <em>Streptococcus</em></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Streptococcus pneumonia, invasive disease</th>
<th>Isolation of <em>S. pneumoniae</em> from a normally sterile body site (e.g., blood, CSF, or, less commonly, joint, pleural or pericardial fluid)</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Syphilis (primary, secondary, early latent or congenital)</th>
<th>Primary:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Demonstration of <em>T. pallidum</em> in clinical specimens by darkfield microscopy, or by PCR or equivalent direct molecular methods.</td>
<td></td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Syphilis (primary, secondary, early latent or congenital)</th>
<th>Secondary:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- A reactive VDRL in CSF <strong>AND</strong> either:</td>
</tr>
<tr>
<td></td>
<td>- 1.) A reactive treponemal serologic test for syphilis (e.g., FTA-ABS, TP-PA, EIA, CIA or equivalent serologic methods) <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>- 2.) A reactive nontreponemal serologic test for syphilis (VDRL, RPR or equivalent serologic method).</td>
</tr>
<tr>
<td></td>
<td><strong>Early Latent:</strong></td>
</tr>
<tr>
<td></td>
<td>- A reactive nontreponemal test (e.g., VDRL, RPR, or equivalent serologic test <strong>AND</strong> a reactive treponemal test (e.g., FTA-ABS, TP-PA, EIA, CIA or equivalent serologic methods), <strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>- A current nontreponemal test titer demonstrating fourfold or greater increase from the last nontreponemal test titer.</td>
</tr>
<tr>
<td></td>
<td><strong>AND</strong> evidence of having acquired the infection within the previous 12 months based on one or more of the following:</td>
</tr>
<tr>
<td></td>
<td>- Documented seroconversion or fourfold or greater increase in titer of a nontreponemal test during the previous 12 months</td>
</tr>
<tr>
<td></td>
<td>- Documented seroconversion of a treponemal test during the previous 12 months</td>
</tr>
<tr>
<td></td>
<td>- A history of symptoms consistent with primary or secondary syphilis during the previous 12 months</td>
</tr>
<tr>
<td></td>
<td>- A history of sexual exposure to a partner within the previous 12 months who had primary, secondary, or early latent syphilis documented independently as duration &lt;12 months)</td>
</tr>
</tbody>
</table>
### Syphilis (primary, secondary, early latent or congenital)

- Only sexual contact was within the last 12 months (sexual debut)

**Congenital:**
- Demonstration of *Treponema pallidum* by:
  - Darkfield microscopy of lesions, body fluids or neonatal nasal discharge OR
  - PCR or other equivalent direct molecular methods of lesions, neonatal nasal discharge, placenta, umbilical cord or autopsy material OR
  - IHC or special stains (e.g., silver staining) of specimens from lesions, placenta, umbilical cord or autopsy material.

### Tetanus

No laboratory criteria identified

### Toxic-shock syndrome (other than streptococcal)

Negative results on the following tests, if obtained:
- Blood or CSF cultures (blood culture may be positive for *Staphylococcus aureus*)
- Negative serologies for Rocky Mountain Spotted Fever, Leptospirosis or Measles

Clinical criteria and laboratory results required for case identification.

### Tuberculosis

- Isolation of *M. tuberculosis* from a clinical specimen OR
- Demonstration of *M. tuberculosis* complex from a clinical specimen by a nucleic acid amplification test OR
- Demonstration of acid-fast bacilli in a clinical specimen when a culture has not been or cannot be obtained or is falsely negative or contaminated.

### Typhoid Fever

- Isolation of serotype *Typhi* from blood, stool or other clinical specimen.

Classification of cases may require one of...
| Typhoid Fever | the following:  
|              | • Clinical presentation  
|              | • Laboratory confirmation  
|              | • Epidemiologic evidence  
|              | Exclude patient from food handling and patient care until at least 3 negative cultures taken at least 24 hours apart and at least 48 hours after any antibiotic, and not earlier than one month after onset.  
|              | If any of these cultures are positive, repeat cultures at intervals of one month until at least 3 consecutive negative |
| Typhoid Fever | Cultures are obtained. 
Household and close contacts should be excluded from food handling occupations until at least 2 negative fecal and urine cultures, taken at least 24 hours apart, are obtained. |
| --- | --- |
| Vibriosis | • Isolation of a species of the family *Vibrionaceae* (other than toxigenic *Vibrio cholerae* O1 or O139, which are reportable as cholera) from a clinical specimen. 
Classification of cases may require one of the following: 
- Clinical presentation 
- Laboratory confirmation 
- Epidemiologic evidence |
| Waterborne Disease Outbreak | • Depends upon etiologic agent |
Laboratory Criteria and Public Health Recommendations for Reportable Conditions

REPORT WITHIN FIVE (5) BUSINESS DAYS

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Report to the Oldham County Health Department using the EPID200 Form
1786 Commerce Pkwy LaGrange, Kentucky 40031
Phone: 502-222-3516
Fax: 502-222-8723

<table>
<thead>
<tr>
<th>Reportable Condition</th>
<th>Laboratory Criteria for Case Criteria¹</th>
<th>Recommendations²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babesiosis</td>
<td>Laboratory Confirmatory:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Identification of intraerythrocytic <em>Babesia</em> organisms by light microscopy in a Giemsa, Wright, or Wright-Giemsa-stained blood smear <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detection of <em>Babesia microti</em> DNA in a whole blood specimen by PRC <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Detection of <em>Babesia</em> spp. genomic sequences in a whole blood specimen by a nucleic acid amplification, <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Isolation of <em>Babesia</em> organisms from a whole blood specimen by animal inoculation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Laboratory Supportive:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstration of <em>Babesia microti</em> IFA total immunoglobulin (Ig) or IgG antibody titer of greater than or equal to 1:256 (or 1:64 in epidemiologically linked blood donors or recipients, <strong>OR</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Demonstration of <em>Babesia microti</em> immunoblot IgG positive result, <strong>OR</strong></td>
<td></td>
</tr>
</tbody>
</table>

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| Babesiosis                                      | • Demonstration of a *Babesia divergens* IFA total Ig or IgG antibody titer of greater than or equal to 1:256, **OR**  
|                                               | • Demonstration of a *Babesia duncani* IFA total Ig or IgG antibody titer of greater than or equal to 1:512 |  |
| Chancroid                                      | • Isolation of *Haemophilus ducreyi* from a clinical specimen | Complete and submit EPID 200 and laboratory results |
| *Chlamydia trachomatis Infection*              | • Isolation of *C. trachomatis* by culture, **OR**  
|                                               | • Demonstration of *C. trachomatis* in a clinical specimen by detection of antigen or nucleic acid | Complete and submit EPID 200 and laboratory results |
| Coccidioidomycosis                            | A confirmed case must meet at least one of the following laboratory criteria for diagnosis:  
|                                               | • Cultural, histopathologic or molecular evidence of presence of *Coccidioides* species, **OR**  
|                                               | • Positive serologic test for coccidioidal antibodies in serum, CSF or other body fluids by:  
|                                               |   • Detection of coccidioidal IgM by EIA, latex agglutination or tube precipitin, **OR**  
|                                               |   • Detection of coccidioidal IgG by immunodiffusion, EIA or complement fixation, **OR**  
|                                               |   • Coccidioidal skin-test conversion from negative to positive after onset of clinical signs and symptoms |  |
| Creutzfeldt-Jakob Disease                     | The diagnosis of human prion disease can be made with certainty only by neuropathologic examination of affected brain tissue, |  |

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<table>
<thead>
<tr>
<th>Creutzfeldt-Jakob Disease</th>
<th>through biopsy or autopsy. In most patients with classic CJD, a characteristic 1-cycle to 2-cycles per second triphasic short-wave discharge on electroencephalographic tracing is regarded as indicative of CJD. A protein assay that detects the 14-3-3 protein in CSF has been reported to be reasonably sensitive, although not specific, as a marker for CJD. Measurement of the tau protein level in addition to the detection of 14-3-3 protein in the CSF has been reported to increase the specificity of CSF testing. No validated blood test is available, but a prototype test for CJD that captures, enriches and detects disease-associated prior protein from whole blood using stainless steel power is being investigated. Because no unique nucleic acid has been detected in prions causing TSEs, genome amplification studies such as PCR are not possible. State-of-the-art diagnostic testing, including assays 14-3-3 and tau proteins in CSF, PRNP gene sequencing, Western blot analysis to identify and characterize PrP&lt;sup&gt;TSE&lt;/sup&gt;, and histologic processing of brain tissues with expert neuropathologic consultation are offered by the National Prion Disease Pathology Surveillance Center.</th>
</tr>
</thead>
</table>
| Ehrlichiosis and Anaplasmosis | **Confirmed:**  
- Serological evidence of a fourfold change in IgG-specific antibody titer to *E. chaffeensis* antigen by IFA between paired serum samples (one taken in first week of illness and a second 2-4 weeks later), OR |
| | Clinical presentation and laboratory confirmation required for case determination. |
### Ehrlichiosis and Anaplasmosis

- Detection of *E. chaffeensis* in a clinical specimen via amplification of a specific target by PCR assay, **OR**
- Demonstration of ehrlichial antigen in a biopsy or autopsy sample by IHC methods, **OR**
- Isolation of *E. chaffeensis* from a clinical specimen in cell culture

**Supportive:**
- Serological evidence of elevated IgG or IgM antibody reactive with *E. chaffeensis* antigen by indirect IFA, ELISA, dot-ELISA or assays in other formats (CDC uses an IFA IgG cutoff of ≥1:64 and does not use IgM test results independently as diagnostic support criteria), **OR**
- Identification of morulae in the cytoplasm of monocytes or macrophages by microscopic examination

**Ehrlichia ewingii Infection:**
- Because the organism has never been cultured, antigens are not available. Thus, *E. ewingii* infections may only be diagnosed by molecular detection methods. *E. ewingii* DNA detected in a clinical specimen via amplification of a specific target by PCR assay.

### Gonorrhea

- Observation of gram-negative intracellular diplococci in a urethral smear obtained from a male or an endocervical smear obtained from a female, **OR**
- Isolation of typical gram-negative, oxidase-positive diplococci by culture (presumptive *Neisseria gonorrhoeae*) from a

Complete and submit EPID 200 and laboratory results.
Gonorrhea | clinical specimen, OR
- Demonstration of *N. gonorrhoeae* in a clinical specimen by detection of antigen or nucleic acid

Granuloma inguinale | Demonstration of intracytoplasmic Donovan bodies in Wright or Giemsa-stained smears or biopsies of granulation tissue.

Hepatitis C, Acute | A positive test for antibodies to Hepatitis C virus (anti-HCV)
- Hepatitis C virus detection test:
  - Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative or genotype testing), OR
  - A positive test indicating presence of Hepatitis C viral antigen(s) (HCV antigen)

Hepatitis C Infection in a Pregnant Woman | A positive test for antibodies to Hepatitis C virus (anti-HCV)
- Hepatitis C virus detection test:
  - Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative or genotype testing), OR
  - A positive test indicating presence of Hepatitis C viral antigen(s) (HCV antigen)

Hepatitis C Infection in an Infant or a Child | A positive test for antibodies to Hepatitis C virus (anti-HCV)
- Hepatitis C virus detection test:

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| Aged Five Years or Less | • Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative or genotype testing), OR  
• A positive test indicating presence of Hepatitis C viral antigen(s) (HCV antigen) | presentation, liver function test results and laboratory confirmation.  
Report to the local health department (LHD) on the EPID 394 form. |
| Newborns Born to Hepatitis C Positive Mothers at the Time of Delivery | • A positive test for antibodies to Hepatitis C virus (anti-HCV)  
• Hepatitis C virus detection test:  
  • Nucleic acid test (NAT) for HCV RNA positive (including qualitative, quantitative or genotype testing) OR  
• A positive test indicating presence of Hepatitis C viral antigen(s) (HCV antigen) | Case identification requires clinical presentation, liver function test results and laboratory confirmation.  
Report to the local health department (LHD) on the EPID 394 form. |
| Histoplasmosis | • Isolation of *H. capsulatum* from culture of bone marrow, sputum or lesions  
• Histological demonstration of intracellular yeast cells from bone marrow or tissue biopsy  
• Detection of *H. capsulatum* polysaccharide antigen in urine | Clinical presentation and/or laboratory confirmation required for case definition. |

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| **Histoplasmosis** or serum | • Rise in CF titers to either histoplasmin or yeast-phase antigen | Reports of HIV/AIDS cases occurring in Jefferson, Henry, Oldham, Bullitt Spencer, Shelby and Trimble counties should be reported:  
• By phone: 502-574-6574  
• By mail: Louisville Metro Health Department  
  Attn: Fay Davis  
  400 East Gray St. Rm 137  
  Louisville, KY 40202  
  Report by phone or mail. When mailing, please place case forms inside of two (2) sealed envelopes, both marked |

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<table>
<thead>
<tr>
<th>HIV/AIDS</th>
<th>CONFIDENTIAL.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case report forms are available from: <a href="http://chfs.ky.gov/dph/epi/hivaids/surveillance.htm">http://chfs.ky.gov/dph/epi/hivaids/surveillance.htm</a> or by calling: 1-866-510-0008</td>
<td></td>
</tr>
<tr>
<td>All cases of HIV infections/AIDS are reportable to a separate surveillance system in accordance with KRS 211.180(1)b. To obtain report forms, contact the HIV/AIDS branch at 502-564-6539</td>
<td></td>
</tr>
<tr>
<td>DO NOT REPORT HIV/AIDS CASES ON EPID200 FORM</td>
<td></td>
</tr>
</tbody>
</table>

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## HIV/AIDS

<table>
<thead>
<tr>
<th>Lead Poisoning</th>
<th>Lead Poisoning</th>
<th>Complete and submit EPID 200 and laboratory results.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood lead concentration of ≥ 5 µg/dL in one venous blood specimen, or two capillary blood specimens, drawn within 12 weeks or each other, both with elevated lead concentration</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Legionellosis

**Confirmed:**
- Isolation of any *Legionella* organism from respiratory secretions, lung tissue, pleural fluid or other normally sterile fluid
- Detection of *Legionella pneumophila* serogroup 1 antigen in urine using validates reagents
- Seroconversion: fourfold or greater rise in specific serum antibody titer to *Legionella pneumophila* serogroup 1 using validated reagents

**Suspected**
- By seroconversion: fourfold or greater rise in antibody titer to specific species or serogroups of *Legionella* other than *L. pneumophila* serogroup 1 (e.g., *L. micdadei, L. pneumophila* serogroup 6)
- By seroconversion: fourfold or greater rise in antibody titer to multiple species of *Legionella* using pooled antigen and validated reagents
- By the detection of specific *Legionella* antigen or staining of the organism in respiratory secretions, lung tissue or pleural fluid

Clinical presentation and laboratory confirmation required for case classification.
| **Legionellosis** | fluid by direct fluorescent antibody (DFA) staining, IHC or other similar method, using validated reagents  
- By detection of *Legionella* species by a validated nucleic acid assay |  |
| **Lyme Disease** | For the purposes of surveillance, the definition of a qualified laboratory assay is:  
- Positive culture for *B. burgdorferi*, OR  
- Two-tier testing interpreted using established criteria, where:  
  - Positive IgM is sufficient only when ≤ 30 days from symptoms onset  
  - Positive IgG is sufficient at any point during illness  
  - Single-tier IgG immunoblot seropositivity using established criteria  
  - CSF antibody positive for *B. burgdorferi* by EIA or IFA, when the titer is higher than it was in serum. | Clinical presentation (specifically *Erythema migrans*), laboratory confirmation, and/or exposure are required for case classification. Lyme disease reports will not be considered cases if the medical provider specifically states this is not a case of Lyme disease, or the only symptom listed is “tick bite” or “insect bite”. |
| **Lymphogranuloma venereum** | • Isolation of *Chlamydia trachomatis* serotype L1, L2 or L3 from clinical specimen, OR  
• Demonstration by immunofluorescence of inclusion bodies in | Complete and submit EPID 200 and laboratory results. |

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<table>
<thead>
<tr>
<th>Disease</th>
<th>Diagnosis</th>
<th>Laboratory Confirmed Case:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lymphogranuloma venereum</td>
<td>Leukocytes of an inguinal lymph node (bubo) aspirate, OR Positive microimmunofluorescent serologic test for a lymphogranuloma venereum strain of <em>C. trachomatis</em> (in clinically compatible case)</td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>Detection of circulating malaria-specific antigens using rapid diagnostic test (RDT)</td>
<td>Clinical presentation not needed for case definition</td>
</tr>
<tr>
<td></td>
<td>Detection of species specific parasite DNA in a sample of peripheral blood using a PCR test</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detection of malaria parasites in thick or thin peripheral blood films</td>
<td></td>
</tr>
<tr>
<td>Spotted Fever</td>
<td>The organism in the acute case of illness is best detected by PCR and IHC methods in skin biopsy specimens, and occasionally by PCR in appropriate whole blood specimens taken during the first week of illness, prior to antibiotic treatment. Serology can also be employed for detection, however an antibody response may not be detectable in initial samples, and paired acute and convalescent samples are essential for confirmation.</td>
<td>Laboratory confirmation and/or clinical presentation required for case classification.</td>
</tr>
<tr>
<td>Rickettsiosis (Rocky Mountain Spotted Fever)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Laboratory Confirmed Case:</td>
<td>Serological evidence of a fourfold change in IgG-specific antibody titer reactive with <em>Rickettsia rickettsii</em> or other spotted fever group antigen by IFA between paired serum specimens (one taken in the first week of illness and a second 2-4 weeks later)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Detection of <em>R. rickettsii</em> or other spotted fever group DNA in</td>
<td></td>
</tr>
</tbody>
</table>
| **Spotted Fever Rickettsiosis (Rocky Mountain Spotted Fever)** | a clinical specimen via amplification of a specific target by PCR assay  
- Demonstration of spotted fever group antigen in a biopsy or autopsy specimen by IHC  
- Isolation of *R. rickettsii* or other spotted fever group rickettsia from clinical specimen in cell culture |  |
| **Syphilis (other than primary, secondary, early latent or congenital)** | Late with clinical manifestations (including late benign syphilis and cardiovascular syphilis)  
- Demonstration of *T. pallidum* in late lesions by special stains (although organisms are rarely visualized in late lesions), or equivalent methods, or by PCR or equivalent direct molecular methods  
**Neurosyphilis:**  
- A reactive VDRL in CSF AND either a reactive treponemal serologic test for syphilis (e.g., FTA-ABS, TP-PA, EIA, CIA or equivalent serologic methods OR a reactive nontreponemal serologic test for syphilis (VDRL, RPR or equivalent serologic method) | Neurosyphilis can apply to all stages of infection of syphilis.  
If the patient has neurologic manifestations of syphilis, the case should be reported with the appropriate stage of infection and neurologic manifestations should be noted in the case report. If no other stage is appropriate, the case should be staged as “late, with |
<table>
<thead>
<tr>
<th><strong>Syphilis (other than primary, secondary, early latent or congenital)</strong></th>
<th></th>
<th><strong>clinical manifestations”. Complete and submit EPID 200 and laboratory results</strong></th>
</tr>
</thead>
</table>
|  | • Demonstration of *Toxoplasma gondii* in body tissues or fluids  
• Significant change in antibody titer on paired specimen serology  
• In infants, demonstration of specific IgM or increasing titers in sequential sera is conclusive evidence of congenital infection |  | Clinical presentation and laboratory confirmation required for case determination. |

<table>
<thead>
<tr>
<th><strong>Toxoplasmosis</strong></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
|  | • Demonstration of *Toxoplasma gondii* in body tissues or fluids  
• Significant change in antibody titer on paired specimen serology  
• In infants, demonstration of specific IgM or increasing titers in sequential sera is conclusive evidence of congenital infection |  |  |

| **Trichinellosis (trichinosis)** | **Human Specimens:**  
• Demonstration of Trichinella larvae in tissue obtained by biopsy, **OR**  
• Positive serologic test for Trichinella  
**Food Specimens:**  
• Demonstrations of Trichinella larvae in the food item (probable) |  |  |

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*a* Data included in table adapted from 2012 Nationally Notifiable Diseases and Conditions and Current Case Definitions and the Kentucky Department for Public Health Reportable Disease Desk Reference<sup>2,3</sup>  
*b* Red Book recommendations for vaccination, outbreak measures, and control measures<sup>4,5,6</sup>  
*c* Information available on the National Notifiable Diseases Surveillance System website<sup>7</sup>
Healthcare Provider Guidelines
For
Foodborne and Waterborne Outbreaks

While outbreak investigations are typically guided by the local health department, they are usually initiated by the emergency medical community. Early and effective recognition of outbreaks in Oldham County is the key to the health and well-being of Oldham County residents. In order to improve the actions taken by public health and the medical community, the Oldham County Health Department has identified two areas of improvement.

1. Recognition of an outbreak depends on the way in which an outbreak is defined. The Kentucky Department for Public Health defines an outbreak in the following ways:
   a. 2 or more individuals who are experiencing a similar illness after ingesting a common food or a different food in a common place.
   b. 2 or more individuals who are experiencing a similar illness after having contact with the same drinking source or recreational water source.
   c. A situation when the number of observed cases exceeds the number of expected cases.\(^{(18)}\)

Using those three definitions, KAR 902 02:020 (Kentucky Statutes and Regulations Section) requires that you report your suspicions to the Oldham County Health Department or the Kentucky Department for Public Health immediately. Therefore, please contact the Oldham County Health Department by telephone as soon as you suspect an outbreak. Please ask to speak with the Local Epidemiologist. The Epidemiologist will give you further information to help guide you in gathering the appropriate forms/labs/etc.

2. Specimen collection has been a source of difficulty in past outbreak investigations. In order to conclusively determine the causative organism or agent, samples from the suspected source must be matched to the specimens collected from the suspected cases. Historically, specimens have been unavailable and the causative organism or agent goes unexplained. For that reason, please collect all relevant clinical specimens from your patients (if available) and contact the Oldham County Health Department to make arrangements to have food or water samples collected. Contact the health department through the main line: 502-222-3516 to be directed to the appropriate individual to facilitate in sample collection.

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
Foodborne Outbreak Guidelines

Case Definition: A foodborne disease outbreak is defined as two (2) or more persons experiencing a similar illness after ingestion of a common food or different food in a common place. If a foodborne disease outbreak is suspected, follow these steps:

1. **Inquire whether there are other ill persons.**
2. **Immediately contact Oldham County Health Department.**
   a. Contact information: (502) 222-3516 ext. 136
   b. Contact the Kentucky Department for Public Health (KDPH) Hotline (1-888-9-REPORT)
   c. If notifying the Oldham County Health Department or Kentucky Department for Public Health, please have the following information available:
      i. Brief description of situation
      ii. Contact Information (names, phone number, address, etc.)
      iii. Demographics of patient (age, sex, etc.)
      iv. Date and time of symptom onset
      v. Description of symptoms
      vi. Hospitalization status
      vii. Other available information (knowledge of other ill persons, food sources, etc.)
      viii. Name of physician (if different than reporter), address, telephone number
   d. The 24-hour Division of Epidemiology and Health Planning Emergency Hotline:
      i. 1-888-9-REPORT or 1-888-973-7678
3. **Collect clinical samples for laboratory analysis.**
   a. **If NOROVIRUS is suspected:** The KDPH Division of Laboratory Services will accept seven to ten clinical specimens for norovirus testing.
      i. Collection and packing procedures for norovirus are found in the Appendix.
      ii. Lab Form 275 must be completed and submitted to DLS for each specimen collected
         1. Lab Form 275 is also found in the Appendix
   b. If other enteric pathogens are suspected, a private lab will need to be utilized for testing
      i. If present, isolates may need to be sent to DLS for additional testing using Lab Form 219. Please contact the Oldham County Health Department if you have questions.
      ii. During business hours, please contact the Oldham County Health Department using the main line telephone number: 502-222-3516 ext. 136

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
4. The local health department will arrange to collect samples if a food source is suspected of containing infectious disease pathogens.
   a. Other resources for specific food sample collection procedures can be found in the Appendix. Information can also be found on page... of the Foodborne/Waterborne Outbreak Investigation Manual.
      i. Lab form 504 (Copy found in Appendix)
   b. If the suspected food item(s) are still available for consumption, individuals should be instructed not to ingest or discard the food, but keep it in the refrigerator for sample collection.
   c. Notify the Oldham County Health Department to arrange food specimen collection and analysis, or if clarification is needed regarding water sample collection
      i. Contact information: 502-222-3516 ext. 134
**Waterborne Outbreak Guidelines**

Case Definition: A waterborne disease outbreak is defined as two (2) or more persons who experience a similar illness after having contact with the same source of drinking or recreational water. If a potential exposure to waterborne diseases causing pathogens, follow these steps:

1. **Inquire whether there are other ill persons.**
2. **Immediately contact the Oldham County Health Department.**
   a. Contact information: (502) 222-3516 ext. 136
   b. Contact the Kentucky Department for Public Health (KDPH) Hotline (1-888-9-REPORT)
   c. If notifying the Oldham County Health Department or Kentucky Department for Public Health, please have the following information available:
      i. Brief description of situation
      ii. Contact Information (names, phone number, address, etc.)
      iii. Demographics of patient (age, sex, etc.)
      iv. Date and time of symptom onset
      v. Description of symptoms
      vi. Hospitalization status
      vii. Other available information (knowledge of other ill persons, food sources, etc.)
      viii. Name of physician (if different than reporter), address, telephone number
   d. The 24-hour Division of Epidemiology and Health Planning Emergency Hotline:
      i. 1-888-9-REPORT or 1-888-973-7678

3. **Collect clinical samples for laboratory analysis.**
   a. The KDPH Division of Laboratory Services will accept seven to ten clinical specimens for norovirus testing.
   b. Specimen testing for other enteric pathogens should be sent to a private lab.

4. **The local health department will arrange to collect samples if a water source is suspected of containing infectious disease pathogens.**
   a. Notify the Oldham County Health Department to arrange water specimen collection and analysis, or if clarification is needed regarding water sample collection
      i. Contact information: 502-222-3516 ext. 131
   b. Other resources for specific water sample collection procedures can be found in the Appendix.
      i. Lab form 507 must be completed and submitted to DLS for each sample.
         1. Lab Form 507 may be found in the Appendix.
   c. Samples must arrive in the lab within **30 hours** of collection.

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
d. If chain of custody precautions are required, the sample needs to be iced and transported to the nearest certified lab within **6 hours** of collection.

e. Further information regarding sample collection/testing of water samples may be directed to the Division of Laboratory Services (DLS) at 502-564-4446.
Collaboration between the medical provider and the environmentalists housed within the Oldham County Health Department assures appropriate and timely follow-up and investigations for patients who are identified with Latent Tuberculosis Infection (LTBI) or Active Tuberculosis Disease. The following pages provide information to aid Clinicians in screening those higher risk clients.

All cases of TB are required to be reported to the local Health Department within one (1) business day.

Per 902 KAR 2:020, a pharmacist shall give notice if two (2) or more of the following medications used for the initial treatment of active tuberculosis are dispensed to an inpatient in a health facility or to an ambulatory patient in a health facility or a pharmacy: Rifampin or Rifabutin, Pyrazinamide, or Ethambutol.

It is standard procedure of the Oldham County Health Department to repeat any suspected positive PPD reading, if the test was not administered and read by a nurse within the local health department.

Lab form 207, used for clinical specimen submissions, has been included in the Appendix for your reference.

To reference guidelines for Tuberculosis and the evaluation of immigrants and refugees, please visit the Core Clinical Services Page through CHFS and choose between the two TB links. The link to the CHFS website can be found in the Appendix, Section I.
PROCEDURE FOR
THE MANTOUX TUBERCULIN SKIN TEST

Tuberculin skin testing is the standard method of identifying persons infected with tuberculosis. The intradermal Mantoux tuberculin skin test (TST)—not a multiple puncture test—should be used to determine if tuberculosis infection has occurred.

The Mantoux TST is performed by the intradermal injection of 0.1 mL of PPD tuberculin containing 5 TU (tuberculin units) into either the volar (flexor) or dorsal surface of the forearm (the volar area preferred). The injection should be made about 4 inches below the elbow, with a disposable tuberculin syringe, just beneath the surface of the skin, with the needle bevel facing upward, to produce a discrete, pale elevation of the skin (a wheal) 6 mm. to 10 mm. in diameter. A one-quarter- to one-half-inch, 27- gauge needle should be used.

A TST can be administered to individuals of any age who are at increased risk for acquiring LTBI or active TB disease, even to newborn infants.

Standard precautions pertaining to blood exposure and prevention of needle stick injuries should be employed.

The Mantoux TST should be read 48 to 72 hours after the injection. However, if the patient fails to show up for the scheduled reading, positive reactions may still be measurable up to one week after testing. If, however, the delayed reading after 72 hours is negative, any reaction may have waned, and the TST will need to be repeated immediately and read within 48 to 72 hours. The TST reading should be based on measurement of induration, not erythema, using a Mantoux skin test ruler. The diameter of induration should be measured transversely to the long axis of the forearm and recorded in millimeters. Record no induration as zero (0) millimeters.

A negative TST result does not exclude LTBI or active TB disease.

Measure TSTs Transversely

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
CLASSIFYING THE TUBERCULIN SKIN TEST REACTION

<table>
<thead>
<tr>
<th>5 or More Millimeters</th>
<th>10 or More Millimeters</th>
<th>15 or More Millimeters</th>
</tr>
</thead>
<tbody>
<tr>
<td>≥ 5 mm is classified as positive in:</td>
<td>≥ 10 mm is classified as positive in:</td>
<td>≥ 15 mm is classified as positive in:</td>
</tr>
<tr>
<td>- HIV-positive persons</td>
<td>- People who have come to the U.S. within the last 5 years from areas of the world where TB is common *</td>
<td>- Persons with no known risk factors for TB</td>
</tr>
<tr>
<td>- Recent contacts of a case with active TB disease</td>
<td>- Injection drug users</td>
<td>- Targeted skin testing programs should only be conducted among high-risk groups</td>
</tr>
<tr>
<td>- People who have previously had active TB disease</td>
<td>- People who live or work in high-risk congregate settings</td>
<td></td>
</tr>
<tr>
<td>- Persons with fibrotic changes on chest radiograph consistent with old healed TB</td>
<td>- Mycobacteriology laboratory personnel</td>
<td></td>
</tr>
<tr>
<td>- Patients with organ transplants and other immunosuppressed patients (including patients taking a prolonged course of oral or intravenous corticosteroids or tumor necrosis factor alpha (TNF-alpha) antagonists)</td>
<td>- Children younger than 4 years</td>
<td></td>
</tr>
<tr>
<td>- Persons with clinical conditions that place them at high-risk for TB (silicosis, diabetes mellitus, severe kidney disease, certain types of cancer, and certain intestinal conditions)</td>
<td>- Infants, children, and adolescents exposed to adults in high-risk categories**</td>
<td></td>
</tr>
</tbody>
</table>

A tuberculin skin test conversion is defined as an increase of ≥ 10 mm of induration within a 2-year period, regardless of age.

ATS Diagnostic Standards and Classification of Tuberculosis in Adults and Children. Am. J. Respir. Care Med., 4/00

* ATS, Diagnostic Standards and Classification of Tuberculosis in Adults and Children.

**According to Red Book, 2012, ≥10 mm induration is considered positive for children with increased exposure to adults who are HIV-infected, homeless, users of illicit drugs, residents of nursing homes, incarcerated or migrant farm workers.

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Collaboration between the Medical Provider and the Lead Case Manager, located within the Oldham County Health Department, assures appropriate and timely follow-up and investigations for patients who are identified with elevated blood lead levels (EBBL’s). Any level of lead in the blood is considered abnormal. Refer to your EPSDT policy for preventive screens/reimbursement.

Please contact the Oldham County Health Department with any elevated blood lead level > 0 µg/dL, including prenatal clients, and include lab results when faxing information to the health department.

Blood Lead Specimen Guidelines:

Contamination errors are common in trace metal analysis, so precautions must be taken to eliminate or reduce them. All staff obtaining blood lead specimens should view CDC’s Blood Lead Collection Guidelines at: http://www.cdc.gov/nchec/lead/training/blood_lead_samples.htm. All staff obtaining blood lead specimens must be familiar with their analyzing labs’ requirements on blood lead specimen collection.

Blood Specimen Collection Guidelines can also be found at: www.putthelidonlead.org

On the following pages you will find the verbal lead exposure risk assessment. Additional copies of each of these forms will be provided in the Appendix. To reference the guidelines for blood lead screening and management for EBLL, please visit the Core Clinical Services Page through CHFS and click “Lead”. The link to the website can be found in the Appendix, Section I.
VERBAL LEAD EXPOSURE RISK ASSESSMENT

WHAT IS LEAD?

Lead is a common element that can harm our bodies. The body cannot distinguish lead from the other minerals that we need like calcium and iron, and it is absorbed into our bloodstream if it is breathed in or swallowed. Once absorbed into our bloodstream, lead is then deposited into our brain and bones where it can cause serious damage. Children and pregnant women are at the greatest risk for lead poisoning!

AM I AT RISK FOR LEAD EXPOSURE?

☐ Do you live in or visit a building built before 1978, with peeling/chipping paint or with ongoing renovation (dust)?

**FACT:** Lead can be found in the paint in homes built before 1978. The paint can flake and peel resulting in dust contaminated with lead. Also, plumbing pipes and fixtures made with lead can contaminate the water that is used for drinking and cooking.

☐ Does your home have plumbing with lead pipes or copper with lead solder joints?

☐ Do you or a family member (who visits, you visit, or lives with you) work in an occupation (job) or participate in a hobby that may contain lead? Examples include but not limited to:

<table>
<thead>
<tr>
<th>Auto mechanics/bodywork</th>
<th>Plumbing</th>
<th>Smelting Metals/Scrap yards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Farm/Migrant Farm Work</td>
<td>Blowing Glass</td>
<td>Recycling centers</td>
</tr>
<tr>
<td>Furniture Refinishing</td>
<td>Gardening</td>
<td>Metal Sculpting</td>
</tr>
<tr>
<td>Renovation Work</td>
<td>Painting</td>
<td>Stained Glass</td>
</tr>
<tr>
<td>Painting Roads</td>
<td>Printing</td>
<td>Car/Boat repair</td>
</tr>
<tr>
<td>Metal Work/Welding</td>
<td>Casting Aluminum</td>
<td>Firing Ranges</td>
</tr>
<tr>
<td>Plastics manufacturing</td>
<td>Ceramic Making</td>
<td>Firearms/Firing Range</td>
</tr>
<tr>
<td>Radiator Repair</td>
<td>Electronic soldering</td>
<td>Burning renovation materials</td>
</tr>
<tr>
<td>Making Bullets/Sinkers/lead toys</td>
<td>High Construction Area</td>
<td>Battery Recycling/Smelting</td>
</tr>
<tr>
<td>Home Repairs/Remodeling</td>
<td>Bridge Repair/Painting</td>
<td>Jewelry Making/Repair</td>
</tr>
</tbody>
</table>

**FACT:** Some jobs and hobbies expose people to lead. Sometimes products made outside of the United States can contain lead such as vinyl mini-blinds, glazes for dishes, cosmetics, foods and toys.

☐ Do you have someone close such as a child, sibling, housemate, or playmate or close contact (at work/home/church/school) that has been or is being treated or monitored for lead poisoning? (blood level at or above 15µg/dL)?

☐ Do you live near a heavily traveled major highway where soil/dust may be contaminated with lead?

**FACT:** Soil around your home could be contaminated by past leaded gasoline fallout and lead based insecticides, and could be on or in your soil, or in cisterns/wells for many years following contamination. This soil can get on your child’s hands and also be absorbed from the soil in fast growing plants such as kale, spinach, and other garden vegetables.

☐ Do you chew on crayons, pottery, paint chips or any painted surfaces, or eat dirt?

☐ Do you use folk remedies or use old painted pottery to store food that may possibly contain lead? (see next page for list of known folk remedies)

ACH-25a (Patient Copy) Rev. 1/12

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
Known Folk Remedies Containing Lead

Azarcon: aka Ruedo, Corol, maria luiso, Alarcon, Ligo- used for intestinal illness
Greta: a yellow powder used for intestinal illness.

Dominican Republic
Litargirio: yellow peach powder used as a deodorant, foot fungicide, treatment for burns and wound healing

Hmong Community
Pay-loo-ah- a red powder given for rash or fever.

Asian
Ghasard: a brown powder given as an aid to digestion.

Sindoor: a powder applied to face or scalp during ceremonies, mistakenly used as food

Bala Goli: a round, flat, black bean dissolved in ”gripe water” and used for stomach ache.

Kandu: a red powder used to treat stomach ache.

Kajal: eye cosmetic when used can be ingested if on hands

Surma: eye cosmetic when used can be ingested if on hands

Arab American
Kohl: aka Alkohl: a powder used both as a cosmetic eye make-up and applied to skin infections and the navel of a newborn child.

Africa and Middle East
Kajal: eye cosmetic when used can be ingested if on hands

Surma: eye cosmetic when used can be ingested if on hands

WHAT ARE THE POSSIBLE RISKS OF LEAD EXPOSURE IN PREGNANCY?

• Increase chance of miscarriage, low birth weight, premature birth, stillbirth
• May cause learning and behavior problems for the baby/child
• May cause birth defects

WHAT ARE THE SIGNS OF LEAD POISONING?

• Many times symptoms are not present!
• May include headaches, mood changes, tiredness, anemia (low blood), or nausea (These are also commonly seen in normal pregnancies)

OTHER POSSIBLE WAYS TO AVOID LEAD EXPOSURE

• Avoid chipping or peeling paint and do NOT sand or scrape paint
• Replace plastic mini-blinds if made in China, Taiwan, or Mexico
• Do not eat or drink out of lead glazed ceramic dishes
• Be aware of “folk remedies” that may contain lead (Azarcon, Greta, Pay Looah)
• Always wash fruit and vegetables thoroughly before eating
• Wear gloves when gardening or otherwise working in the soil
• Wash your hands frequently, especially before eating or drinking
• Avoid hobbies that may increase your lead exposure
• If someone in your household works around lead, be sure they shower and change clothes before coming home and do not wash contaminated work clothes with the family’s laundry.

If you work in an area where you may be exposed to lead, talk to your supervisor about decreasing your exposure while you are pregnant.

Check with your health care provider for blood testing if you or your children are at risk for lead exposure.
Verbal Lead Risk Assessment

To be completed at every preventative visit for:
- Children ages 9-72 months
- Positive Pregnancy Test or Initial Prenatal Visit

Please Place this copy in Patient Chart:
Place Label here

Parent/Guardian: ___________________________ Date of Initial Assessment: ________________

The following situations may create lead exposure. It is imperative to evaluate the possible risks in a child’s environment and a prenatal patient’s risks. Check any questions that may be answered yes.

Verbal Risk Assessment Questionnaire

1. Does the patient live in or visit a building built before 1978, with peeling/chipping paint or with ongoing renovation (dust)?
2. Does the patient’s home have plumbing with lead pipes or copper with lead solder joints?
3. Does the patient have someone close such as a child, sibling, housemate, or playmate or close contact (at work/home/church/school) that has been or being treated or monitored for lead poisoning? (Blood level at or above 15µg/dL)?
4. Is the patient exposed to or have a family member (who visits the child visits or lives with patient) that works in an occupation (job) or participate in a hobby that may contain lead? (Examples include but not limited to: work with lead batteries; firing ranges; chemicals or chemical preparations; construction of bridges, tunnels and elevated highways, etc.)
5. Does the patient live near a heavily traveled major highway where soil/dust may be contaminated with lead?
6. Does the patient chew on crayons, pottery, paint chips or any painted surfaces, or eat dirt?
7. Do you use folk remedies or use old painted pottery to store food that may possibly contain lead?

☐ ACH-25a Reviewed and Given to Patient
☐ No risks identified.
☐ Risk(s) identified from list: 1 2 3 4 5 6 7

☐ Action taken for risk: _____________________________

 Provider Signature _____________________________ Date ________________

☐ ACH-25a Reviewed and Given to Patient
☐ No risks identified.
☐ Risk(s) identified from list: 1 2 3 4 5 6 7

☐ Action taken for risk: _____________________________

 Provider Signature _____________________________ Date ________________

A CH-25b (Keep in Medical Record) Rev. 1/12

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
ANIMAL BITE REPORTING PROCEDURES

In accordance with KRS 258.065, Physicians are to report a person bitten by a dog, cat, ferret, or other animal to the local health department within twelve (12) hours after his first professional attendance.

During the patient’s appointment, it is also necessary to collect as much information as possible concerning the animal. To do so, please reference the Animal Bite Reporting Form provided in the Appendix section of the reportable conditions binder. A copy of the Animal Bite Reporting Form is also included for your reference and use.

1. Completely fill out the Animal Quarantine Information (copies may be found in Appendix)
2. Fax the form to the Oldham County Health Department: 502-222-8723
   a. Forms only need to be faxed to the health department, phone notification of an animal bite is not necessary.
   b. If a client presents with a bite from a STRAY animal (dog or cat), take the information as stated above and FAX to the health department.
   c. If a client presents with a bite from a WILD animal (skunk, raccoon, etc.) and the animal is NOT available for examination, ensure the CLIENT calls the health department for Rabies post-exposure prophylaxis (PEP) procedures.

On the following pages, you will find a copy of the Animal Bite Reporting Form and a diagram created by the Kentucky Department for Public Health depicting the rationale used for administering Rabies PEP. For further information on Rabies and Rabies PEP, please visit the Core Clinical Services Page through CHFS and click “Rabies”. The link to the website can be found in the Appendix, Section I.
## Animal Bite Reporting Form

<table>
<thead>
<tr>
<th>Person Bitten</th>
<th>Age</th>
<th>Date Bitten</th>
</tr>
</thead>
</table>

**Victim**

**Home Address**

**Directions to Home**

**Daytime Telephone**

**Evening Telephone**

**Parent or Guardian**

**Owner**

**Owner of Animal**

**Owner Address**

**Directions to Home**

**Daytime Telephone**

**Evening Telephone**

**Animal**

- Dog
- Cat
- Ferret
- Skunk
- Raccoon
- Bat
- Other

- Pet
- Stray
- Wild
- Male
- Female
- Short Hair
- Long Hair

**Animal's Name**

**Breed**

**Color or Markings**

**Vaccination Date**

**I.D. #**

**Veterinarian**

**Other Comments**

**Form Completed by:**

**Name**

**Date Reported**

**Institution/Agency/ Provider Reporting**

**Tel**

Fax form to LOCAL HEALTH DEPT. in COUNTY where animal bite occurred.

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
ANIMAL BITE EXPOSURE PEP RATIONALE\textsuperscript{15, 16}

RABIES POST-EXPOSURE PROPHYLAXIS (PEP) PROTOCOL FOR PEOPLE EXPOSED TO ANIMALS

Data adapted from: Division of Epidemiology and Health Planning Rabies Program. Rabies Post-Exposure Prophylaxis (PEP) Protocol for People Exposed to Animals. Frankfort, KY: Department for Public Health.

Figure 3: Kentucky Department for Public Health Rabies Post-Exposure Prophylaxis (PEP) Protocol for People Exposed to Animals\textsuperscript{15, 16, 17}

Please call your local health department environmentalist for investigation, more information and quarantine requirements. All animal bites should be reported to the local health department within 12 hours of the treatment.

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
Section 2. Notification Standards.

(1) Health Professionals and Facilities. A health professional and a health facility shall give notification if:
   (a) The health professional makes a probable diagnosis of a disease specified in Section 3, 5, 6, 7, 8, 10, 13, 14, 15, or 16 of this administrative regulation; and
   (b) The diagnosis is supported by:
      1. Clinical or laboratory criteria; and
      2. Case classifications published by the Centers for Disease Control and Prevention at www.cdc.gov/nndss; or
      2. A health professional’s medical opinion that the disease is present.

(2) A single report by a health facility of a condition diagnosed by a test result from the health facility’s laboratory shall constitute notification on behalf of the health facility and its laboratory.

(3) A health facility may designate an individual to report on behalf of the health facility’s laboratory, pharmacy, and the health facility's other clinical entities.

(4) Notification shall be given to the local health department serving the jurisdiction in which the patient resides.

(5) If the local health department cannot be reached, notification shall be given to the Kentucky Department for Public Health.

(6) The reporting health professional shall furnish:
   (a) Information required in Section 4(16) of this administrative regulation; and
   (b) Clinical, epidemiologic, and laboratory information pertinent to the disease including sources of specimens submitted for laboratory testing.

(7) Medical Laboratories. Upon a laboratory test result which indicates infection with an agent associated with one or more of the diseases or conditions specified in Section 3, 5, 6, 7, 8, 10, 13, 14, 15, or 16 of this administrative regulation, the laboratory shall report the result to the local health department serving the county in which the patient resides.

(8) If the local health department cannot be reached, notification shall be given to the Kentucky Department for Public Health.

(9) The reporting laboratory shall furnish the information required in Section 4(16) of this administrative regulation.

(10) National Reference Laboratories. Upon a test result performed by a national reference laboratory which indicates infection with an agent associated with one or more of the diseases or conditions specified in Section 3, 5, 6, 7, 8, 10, 13, 14, 15, or 16 of this administrative regulation, the director of a medical laboratory, a health facility, or the health professional that referred the test to the national reference laboratory shall ensure that the result is reported by the national reference laboratory to the local health department serving the jurisdiction in which the patient resides.

(11) If the local health department cannot be reached, notification shall be given to the Kentucky Department for Public Health.

(12) The report shall include the information required by Section 4(16) of this administrative regulation.
Section 3. Submission of Specimens to the Kentucky Department for Public Health Division of Laboratory Services.

(1) A medical laboratory and a national reference laboratory in receipt of diagnostic specimens originating from the Commonwealth of Kentucky shall send specimens or clinical isolates for diseases outlined in subsection (5) of this section to the Division of Laboratory Services for primary or confirmatory testing and related studies.

(2) A medical laboratory or national reference laboratory using non-culture techniques to identify bacterial agents of diarrheal disease, such as enzyme immunoassays (EIAs) or molecular assays, shall attempt isolation of the etiologic agent identified. Clinical isolates shall be submitted to the Division of Laboratory Services.

(3) If the culture attempts do not produce a clinical isolate, the direct specimen, submitted in the appropriate preservative, shall be sent to the Division of Laboratory Services. A submitting laboratory shall provide the name of the etiologic agent detected by the non-culture technique at the time of specimen submission.

(4) A medical laboratory performing this test shall continue to follow the state’s requirement for the submission of appropriate materials to the state public health laboratory.

(5) A medical or national reference laboratory shall submit clinical isolates or, if not available, the direct specimen from the following diseases to the Division of Laboratory Services:

- (a) Botulism;
- (b) Brucellosis;
- (c) Campylobacteriosis;
- (d) Cholera and diseases caused by other Vibrio species;
- (e) Diphtheria;
- (f) Escherichia coli O157:H7;
- (g) Hemolytic Uremic Syndrome (HUS) – Post Diarrheal;
- (h) Listeriosis;
- (i) Measles;
- (j) Meningococcal infections;
- (k) Rabies animal;
- (l) Rubella;
- (m) Salmonellosis;
- (n) Shiga toxin-producing E. coli (STEC);
- (o) Shigellosis;
- (p) Tuberculosis;
- (q) Tularemia; and
- (r) Typhoid fever.

Section 4. Reporting Classifications and Methods.

(1) Immediate reporting. A report required by Section 10(1) and (2) of this administrative regulation to be made immediately shall be:

- (a) Made by telephone to the local health department serving the county in which the patient resides; and
- (b) Followed up by electronic or fax submission to the local health department serving the county in which the patient resides within one (1) business day.

(2) Upon receipt of a report for a disease requiring immediate reporting, the local health department shall:

- (a) Notify the Kentucky Department for Public Health by telephone; and
- (b) Assist the department in carrying out a public health response.

(3) Weekend, evening, or holiday immediate notification. If local health department personnel cannot be contacted directly, notification shall be made by telephone using an emergency number provided by the local health department or the Kentucky Department for Public Health.

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
(4) For the protection of patient confidentiality, a report using the emergency number shall include:
   (a) The name of the condition being reported; and
   (b) A telephone number that can be used by the department to contact the reporting health professional or health facility.

(5) Urgent Reporting. A report made within twenty-four (24) hours as required by Section 5 of this administrative regulation shall be:
   (a) Submitted electronically, by fax, or by telephone to the local health department serving the county in which the patient resides; and
   (b) If submitted by telephone, followed up by electronic or fax submission to the local health department serving the county in which the patient resides within one (1) business day.

(6) Upon receipt of a report for a disease requiring urgent reporting, the local health department shall:
   (a) Notify the Kentucky Department for Public Health; and
   (b) Assist the department in carrying out a public health response.

(7) Weekend, evening, or holiday urgent notification. If local health department personnel cannot be contacted directly, notification shall be made by telephone using an emergency number provided by the local health department or the Kentucky Department for Public Health.

(8) For the protection of patient confidentiality, notification using the emergency number shall include:
   (a) The name of the condition being reported; and
   (b) A telephone number that can be used by the department to contact the reporting health professional or health facility.

(9) Priority Reporting. A report made within one (1) business day as required by Sections 6, 14(4), and 15 of this administrative regulation shall be:
   (a) Submitted electronically, by fax, or by telephone to the local health department serving the county in which the patient resides; and
   (b) If submitted by telephone, followed up by electronic or fax submission of a report to the local health department serving the county in which the patient resides within one (1) business day.

(10) Upon receipt of a report for a disease requiring priority reporting, a local health department shall:
    (a) Investigate the report and carry out public health protection measures; and
    (b) Notify the Kentucky Department for Public Health of the case by electronic or fax submission within one (1) business day.

(11) The reporting health department may seek assistance in carrying out public health measures from the Kentucky Department for Public Health.

(12) Routine Reporting. A report made within five (5) business days, as required by Sections 7, 8, 9, 11(1), 13, 14(7), and 17 of this administrative regulation, shall be made electronically, by fax, or by mail to the local health department serving the county in which the patient resides.

(13) Upon receipt of a report of a disease or condition requiring routine reporting, a local health department shall:
    (a) Make a record of the report;
    (b) Answer inquiries or render assistance regarding the report if requested by the reporting entity; and
    (c) Forward the report to the Kentucky Department for Public Health by electronic or fax submission of a report, or in writing within five (5) business days.

(14) General Reporting. A report made within three (3) months, as required by Section 16 of this administrative regulation, shall be made electronically, by fax, or by mail.

(15) A report submitted by fax or by mail shall be made using one (1) of the following reporting forms:
    (a) EPID 200, Kentucky Reportable Disease Form;
    (b) EPID 250, Kentucky Reportable MDRO Form, until electronic reporting is available pursuant to Section 9(1) of this administrative regulation;

   To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
(c) EPID 394, Kentucky Reportable Disease Form, Hepatitis Infection in Pregnant Women or Child (aged five (5) years or less);
(d) EPID 399, Perinatal Hepatitis B Prevention Form for Infants;
(e) Adult HIV/AIDS Confidential Case Report form; or
(f) Pediatric HIV/AIDS Confidential Case Report form.

(16) Information to be reported. Except as provided in subsections (3) and (7) of this section, a report required by this administrative regulation shall include:
   (a) Patient name;
   (b) Date of birth;
   (c) Gender;
   (d) Race;
   (e) Ethnicity;
   (f) Patient address;
   (g) County of residence;
   (h) Patient telephone number;
   (i) Name of the reporting medical provider or facility;
   (j) Address of the reporting medical provider or facility; and
   (k) Telephone number of the reporting medical provider or facility.

(17) A reporting health professional shall furnish the information listed in subsection (16) of this section and Section 2(6)(b) of this administrative regulation.

Section 5. Notifiable Infectious Conditions Requiring Urgent Notification.
Notification of the following diseases shall be considered urgent and shall be made within twenty-four (24) hours:
(1) Anthrax;
(2) Botulism;
(3) Brucellosis (multiple cases, temporally or spatially clustered);
(4) Diphtheria;
(5) Hepatitis A, acute;
(6) Measles;
(7) Meningococcal infections;
(8) Novel influenza A virus infections;
(9) Plague;
(10) Poliomyelitis;
(11) Rabies, animal;
(12) Rabies, human;
(13) Rubella;
(14) Severe Acute Respiratory Syndrome-associated Coronavirus (SARS-CoV) disease;
(15) Smallpox;
(16) Tularemia;
(17) Varicella;
(18) Viral hemorrhagic fevers due to:
   (a) Crimean-Congo Hemorrhagic Fever virus;
   (b) Ebola virus;
   (c) Lassa virus;
   (d) Lujo virus;
   (e) Marburg virus; or

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(f) New world arenaviruses including:
   1. Guanarito virus;
   2. Junin virus;
   3. Machupo virus; and
   4. Sabia virus; and

(19) Yellow fever.


Notification of the following diseases or conditions shall be considered priority and shall be made within one (1) business day:

(1) Arboviral diseases, neuroinvasive and non-neuroinvasive, including:
   (a) California serogroup virus diseases, including diseases caused by:
      1. California encephalitis virus;
      2. Jamestown Canyon virus;
      3. Keystone virus;
      4. La Crosse virus;
      5. Snowshoe hare virus; and
      6. Trivittatus viruses;
      (b) Chikungunya virus disease;
      (c) Eastern equine encephalitis virus disease;
      (d) Powassan virus disease;
      (e) St. Louis encephalitis virus disease;
      (f) Venezuelan equine encephalitis disease;
      (g) West Nile virus disease;
      (h) Western equine encephalitis virus disease; and
      (i) Zika virus disease or infection or the birth of a child to a mother who was Zika-positive or Zika-inconclusive during any stage of pregnancy or during the periconceptional period;

(2) Brucellosis (cases not temporally or spatially clustered);

(3) Campylobacteriosis;

(4) Carbon monoxide poisoning;

(5) Cholera;

(6) Cryptosporidiosis;

(7) Dengue virus infections;

(8) Escherichia coli O157:H7;

(9) Foodborne disease outbreak;

(10) Haemophilus influenzae invasive disease;

(11) Hansen's disease (leprosy);

(12) Hantavirus infection, non-Hantavirus pulmonary syndrome;

(13) Hantavirus pulmonary syndrome (HPS);

(14) Hemolytic uremic syndrome (HUS), post-diarrheal;

(15) Hepatitis B, acute;

(16) Hepatitis B infection in a pregnant woman;

(17) Hepatitis B infection in an infant or a child aged five (5) years or less;

(18) Newborns born to Hepatitis B positive mothers at the time of delivery;

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(19) Influenza-associated mortality;
(20) Leptospirosis;
(21) Listeriosis;
(22) Mumps;
(23) Norovirus outbreak;
(24) Pertussis;
(25) Pesticide-related illness, acute;
(26) Psittacosis;
(27) Q fever;
(28) Rubella, congenital syndrome;
(29) Salmonellosis;
(30) Shiga toxin-producing E. coli (STEC);
(31) Shigellosis;
(32) Streptococcal toxic-shock syndrome;
(33) Streptococcus pneumoniae, invasive disease;
(34) Tetanus;
(35) Toxic-shock syndrome (other than Streptococcal);
(36) Tuberculosis;
(37) Typhoid fever;
(38) Vibriosis; and
(39) Waterborne disease outbreak.

Section 7. Notifiable Infectious Conditions and Notifiable Non-Infectious Conditions Requiring Routine Notification.
Notification of the following diseases shall be considered routine and shall be made within five (5) business days:
(1) Babesiosis;
(2) Coccidioidomycosis;
(3) Creutzfeldt-Jakob disease;
(4) Ehrlichiosis/Anaplasmosis;
(5) Hepatitis C, acute;
(6) Hepatitis C infection in a pregnant woman;
(7) Hepatitis C infection in an infant or a child aged five (5) years or less;
(8) Newborns born to Hepatitis C positive mothers at the time of delivery;
(9) Histoplasmosis;
(10) Lead poisoning;
(11) Legionellosis;
(12) Lyme Disease;
(13) Malaria;
(14) Spotted Fever Rickettsiosis (Rocky Mountain Spotted Fever);
(15) Toxoplasmosis; and
(16) Trichinellosis (Trichinosis).
Section 8. Notifiable Infectious Conditions Requiring Routine Notification by Electronic Laboratory Reporting.
(1) Beginning October 1, 2016, notification of the following diseases shall be considered routine and shall be electronically reported to the Kentucky Department for Public Health through the Kentucky Health Information Exchange within five (5) business days:
   (a) Cyclosporiasis;
   (b) Giardiasis;
   (c) Hepatitis B laboratory test results whether reported as positive or negative:
      1. Include the serum bilirubin levels taken within ten (10) days of the test of a patient who has tested positive; or
      2. Include the serum alanine aminotransferase levels taken within ten (10) days of the test of a patient who tested positive;
   (d) Hepatitis C laboratory test results whether reported as positive or negative:
      1. Include the serum bilirubin levels taken within ten (10) days of the test of a patient who has tested positive; or
      2. Include the serum alanine aminotransferase levels taken within ten (10) days of the test of a patient who tested positive;
   (e) Varicella laboratory test results reported as positive for:
      1. Isolation of varicella virus from a clinical specimen;
      2. Varicella antigen detected by direct fluorescent antibody test;
      3. Varicella-specific nucleic acid detected by polymerase chain reaction (PCR); or
      4. A significant rise in serum anti-varicella immunoglobulin G (IgG) antibody level by a standard serologic assay.
(2) Reports made pursuant to this section shall include a diagnosis.

Section 9. Multi-Drug Resistant Organisms and Other Organisms Requiring Routine Notification by Electronic Laboratory Reporting.
(1) Beginning October 1, 2016, notification of the following diseases shall be considered routine and shall be electronically reported to the Kentucky Department for Public Health through the Kentucky Health Information Exchange within five (5) business days:
   (a) Vancomycin-intermediate Staphylococcus aureus (VISA), which includes S. aureus cultured from any specimen that the results show a minimum inhibitory concentration (MIC) of 4-8 mg/mL per standard laboratory methods;
   (b) Vancomycin-resistant Staphylococcus aureus (VRSA), which includes S. aureus cultured from any specimen that the results show a minimum inhibitory concentration (MIC) of greater than or equal to 16 mg/mL per standard laboratory methods;
   (c) Methicillin-resistant Staphylococcus aureus (MRSA), which includes S. aureus cultured from any specimen that tests oxacillin-resistant, cefoxitin-resistant, or methicillin-resistant by standard susceptibility testing methods, or by a laboratory test that is FDA-approved for MRSA detection from isolated colonies. These methods may also include a positive result by any FDA-approved test for MRSA detection;
   (d) Vancomycin-resistant Enterococcus species (VRE), only those identified to the species level, that are resistant to Vancomycin by standard susceptibility testing methods or by results from any FDA-approved test for VRE detection from specific specimen sources;
   (e) Clostridium difficile (C. difficile) identified from a positive laboratory test result for a C. difficile toxin A or B (includes molecular assays (PCR) or toxin assays) or a toxin-producing organism detected by culture or other laboratory means performed on a stool sample;

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(f) Carbapenem-resistant Enterobacteriaceae (CRE), which includes Escherichia coli, Klebsiella oxytoca, Klebsiella pneumonia, or Enterobacter species testing resistant to imipenem, meropenem, doripenem, or ertapenem by standard susceptibility testing methods or by production of carbapenemase by an isolate demonstrated by using a recognized test;

(g) Cephalosporin-resistant Klebsiella, which includes Klebsiella oxytoca, Klebsiella pneumonia, or a Klebsiella species testing non-susceptible (resistant or intermediate) to ceftazidime, cefotaxime, ceftiraxone, or cefepime;

(h) Extended–spectrum beta-lactamase Gram negative organisms (ESBL) Enterobacteriaceae species non-susceptible (resistant or intermediate) to ceftazidime, cefepime, ceftiraxone, or cefotaxime;

(i) Multidrug-resistant – Acinetobacter - Non-susceptibility (resistant or intermediate) to at least one (1) agent in at least three (3) antimicrobial classes of the following six (6) classes:
   1. Ampicillin-sulbactam;
   2. Cephalosporins (cefepime, ceftazidime);
   3. β-lactam-β-lactamase inhibitor combination (piperacillin, piperacillin-tazobactam);
   4. Carbapenems (imipenem, meropenem, doripenem);
   5. Fluoroquinolones (ciprofloxacin or levofloxacin); and
   6. Aminoglycosides (gentamicin, tobramycin, or amikacin); and

(j) Multidrug-resistant Pseudomonas - Non-susceptibility, resistant or intermediate, to at least one (1) agent in at least three (3) antimicrobial classes of the following five (5) classes:
   1. Cephalosporins (cefepime, ceftazidime);
   2. β-lactam-β-lactam β-lactamase inhibitor combination (piperacillin, piperacillin-tazobactam);
   3. Carbapenems (imipenem, meropenem, doripenem);
   4. Fluoroquinolones (ciprofloxacin or levofloxacin); and
   5. Aminoglycosides (gentamicin, tobramycin, or amikacin).

(2) The report of an organism under this section shall include the following:
   (a) Date of specimen collection;
   (b) Source of specimen;
   (c) Susceptibility pattern; and
   (d) Name of the ordering health professional.

(3) Upon a test result performed by a medical laboratory which indicates infection with an agent associated with one (1) or more of the diseases or conditions or a multi-drug resistant organism specified in this section, the director of the medical laboratory shall electronically report the result to the Kentucky Department for Public Health through the Kentucky Health Information Exchange within five (5) days.

(4) The report shall include a diagnosis.


(1) The following shall be reported immediately by telephone to the Kentucky Department for Public Health:
   (a) A suspected incidence of bioterrorism caused by a biological agent;
   (b) Submission of a specimen to the Kentucky Division of Laboratory Services for select agent identification or select agent confirmation testing; or
   (c) An outbreak of a disease or condition that resulted in multiple hospitalizations or death.

(2) An unexpected pattern of cases, suspected cases, or deaths which may indicate the following shall be reported immediately by telephone to the local health department in the county where the health professional is practicing or where the facility is located:
   (a) A newly-recognized infectious agent;

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(b) An outbreak;
(c) An emerging pathogen which may pose a danger to the health of the public;
(d) An epidemic; or
(e) A non-infectious chemical, biological, or radiological agent.

(3) A report of the following shall be considered priority and shall be reported to the local health department in the county where the health professional is practicing or where the facility is located within one (1) business day:
(a) Suspected Staphylococcal or other foodborne intoxication; or
(b) Salmonellosis or other foodborne or waterborne infection.

(4) The local health department shall:
(a) Investigate the outbreak or occurrence;
(b) Carry out public health protection measures to address the disease or condition involved; and
(c) Make medical and environmental recommendations to prevent future similar outbreaks or occurrences.

(5) The local health department may seek assistance from the Kentucky Department for Public Health.

Section 11. Laboratory Surveillance. (1) Medical or national reference laboratory results for the following shall be considered routine:
(a) Influenza virus isolates;
(b) PCR-positive test results for influenza virus; and
(c) DNA molecular assays for influenza virus.

(2) The report shall include specific laboratory information pertinent to the result.

(3) Upon request by the Kentucky Department for Public Health, a health facility laboratory or a medical laboratory shall report the number of clinical isolates and information regarding the antimicrobial resistance patterns of the clinical isolates at intervals no less frequently than three (3) months for the following:
(a) Staphylococcus aureus;
(b) Enterococcus species; or
(c) An organism specified in a request that includes a justification of its public health importance.

(1) A healthcare facility in Kentucky that participates in CMS reporting programs shall authorize the CDC to allow the Kentucky Department for Public Health to access health care-associated infection data reported to NHSN.
(2) The Kentucky Department for Public Health shall preserve patient confidentiality and shall not disclose to the public any patient-level data obtained from any health care facility.
(3) The Kentucky Department for Public Health may issue reports to the public regarding healthcare-associated infections in aggregate data form which:
(a) May identify individual health care facilities; and
(b) Shall comply with methodology developed by the CDC and CMS for national reporting of health care-associated infections.
(4) The Kentucky Department for Public Health may evaluate healthcare-associated infection data for accuracy and completeness.

Section 13. Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) Surveillance.
(1) A report of an HIV infection or AIDS diagnosis shall be considered routine and shall be reported within five (5) business days of diagnosis on one (1) of the following forms:
(a) Adult HIV/AIDS Confidential Case Report form; or
(b) Pediatric HIV/AIDS Confidential Case Report form.
(2) Health professionals and medical laboratories shall report:
(a) A positive test result for HIV infection including a result from:

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Section 14. Sexually Transmitted Disease (STD).
(1) Notification of a probable diagnosis of an STD as specified in subsection (4) or (7) of this section shall be made.
(2) The report shall provide the following information:

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(a) Pregnancy status; and
(b) Clinical, epidemiologic, laboratory, and treatment information pertinent to the disease.

(3) Upon a laboratory test result which indicates infection with an agent associated with one (1) or more of the
diseases or conditions specified in subsection (4) and (7) of this section, a medical laboratory shall report to the
Kentucky Department for Public Health information required by Section 4(16) of this administrative regulation.

(4) Sexually Transmitted Diseases Requiring Priority Notification. A report of the following shall be considered
priority and shall be made within one (1) business day:
(a) Congenital syphilis; or
(b) Syphilis - primary, secondary, or early latent.

(5) Upon receipt of a report for a disease or condition specified in subsection (4) of this section, a local health
department shall:
(a) Investigate the report;
(b) Carry out public health protection measures to address the disease or condition; and
(c) Forward the report to the Kentucky Department for Public Health within one (1) business day.

(6) The local health department may seek assistance from the Kentucky Department for Public Health.

(7) Sexually Transmitted Diseases Requiring Routine Notification. A report of the following shall be
considered routine and shall be made within five (5) business days:
(a) Chancroid;
(b) Chlamydia trachomatis infection;
(c) Gonorrhea;
(d) Granuloma inguinale;
(e) Lymphogranuloma venereum; or
(f) Syphilis, other than primary, secondary, early latent, or congenital.

(8) Upon receipt of a report for a disease or condition specified in subsection (7) of this section, a local health
department shall:
(a) Make a record of the report using Form EPID 200, Kentucky Reportable Disease Form;
(b) Forward the report to the Kentucky Department for Public Health within five (5) business days; and
(c) Render assistance if requested by the reporting entity or the Kentucky Department for Public Health.

Section 15. Tuberculosis.
(1) A pharmacist shall give notice if two (2) or more of the following medications used for the initial treatment of
active tuberculosis are dispensed to an inpatient in a health facility or to an ambulatory patient in a health facility
or a pharmacy:
   (a) Rifampin or rifabutin;
   (b) Isoniazid;
   (c) Pyrazinamide; and
   (d) Ethambutol.

(2) A report of tuberculosis shall be considered priority and shall be reported to the local health department
serving the county in which the patient resides.

(3) If the local health department cannot be reached, notification shall be given to the Kentucky Department for
Public Health.

(4) The report shall include:
   (a) Information required in Section 4(16) of this administrative regulation; and
   (b) Names of the medications dispensed.

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Department will update contact records bi-annually.
Section 16. Asbestosis, Coal Worker's Pneumoconiosis, and Silicosis.
(1) A health professional shall report a diagnosis of the following to the Kentucky Department for Public Health within three (3) months of diagnosis:
   (a) Asbestosis;
   (b) Coal worker's pneumoconiosis; or
   (c) Silicosis.
(2) A report required under this section shall include the following information regarding the patient:
   (a) Name;
   (b) Address;
   (c) Date of birth; and
   (d) County of residence.

Section 17. Reporting of Communicable Diseases in Animals.
(1) A diagnosis in an animal of a condition known to be communicable to humans, except for rabies, shall require routine notification.
(2) A veterinarian shall report the diagnosis within five (5) business days to the local health department serving the county in which the animal is located.
(3) If a laboratory test indicates infection of an animal with an agent associated with a condition known to be communicable to humans, the director of a medical laboratory shall report the result to the local health department serving the county in which the animal is located within five (5) business days.
(4) The local health department receiving the report shall:
   (a) Investigate the report;
   (b) Carry out public health protection measures for the control of communicable diseases; and
   (c) Forward the report to the Kentucky Department for Public Health within five (5) business days.
(5) The local health department may seek assistance from the Kentucky Department for Public Health.

Section 18. Kentucky Department for Public Health Advisory.
(1) If the Secretary of the Cabinet for Health and Family Services or the Commissioner of the Department for Public Health determines that a disease not presently listed in this administrative regulation requires reporting, the secretary or commissioner may issue a Kentucky Public Health Advisory.
(2) The Kentucky Public Health Advisory shall include:
   (a) Date and time the advisory is issued;
   (b) A unique number to identify the advisory;
   (c) Names for the disease or condition;
   (d) A description of the disease or condition;
   (e) Recommendations for health professionals, health facilities, and laboratories; and
   (f) Notification requirements including:
      1. The notification time interval;
      2. Methods for notification; and
      3. Forms to be completed and submitted with the notification.
(3) The duty to report by health professionals, health facilities, and laboratories pursuant to a Kentucky Public Health Advisory shall begin upon receipt of the advisory and shall remain in effect until the advisory is rescinded by order of the secretary or the commissioner.

Section 19. Incorporation by Reference.
(1) The following material is incorporated by reference:
   To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
(a) Form "EPID 200, Kentucky Reportable Disease Form", 6/2016;
(b) Form "EPID 250, Kentucky Reportable MDRO Form", 6/2014;
(c) Form "EPID 394, Kentucky Reportable Disease Form, Hepatitis Infection in Pregnant Women or Child (aged five years or less)", 9/2016;
(d) Form "EPID 399, Perinatal Hepatitis B Prevention Form for Infants", 4/2012;
(e) Form "Adult HIV Confidential Case Report Form", 3/2013; and

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Department for Public Health, 275 East Main Street, Frankfort, Kentucky 40621, Monday through Friday, 8 a.m. to 4:30 p.m. (CDS-2; 1 Ky.R. 187; eff. 12-11-1974; Am. 2 Ky.R. 464; eff. 4-14-1976; 11 Ky.R. 1518; 1786; eff. 6-4-1985; 16 Ky.R. 663; 1185; eff. 11-29-1989; 21 Ky.R. 128; eff. 8-17-1994; 23 Ky.R. 3119; 3597; 4131; eff. 6-16-1997; 27 Ky.R. 1099; 1489; eff. 12-21-2000; 29 Ky.R. 812; 1273; eff. 10-16-2002; 31 Ky.R. 873; eff. 1-4-2005; 41 Ky.R. 1213; 1674; eff. 2-26-2015; 43 Ky.R. 122, 568; eff, 11-16-2016.)

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211.902 Reports on persons with excess level of lead in blood -- Records of reports to be indexed and analyzed -- Information to local organizations.

(1) Every physician, nurse, hospital administrator, director of a clinical laboratory, or public health officer who receives information of the existence of any person found or suspected to have a two and three-tenths (2.3) micrograms per deciliter of whole blood level of lead in his or her blood shall report the information to the cabinet within seven (7) days and to the local or district health officer in approved electronic format as prescribed by administrative regulations promulgated by the cabinet in accordance with KRS Chapter 13A. The contents of the report shall include but not be limited to the following information:

(a) The full name and address of the person tested;
(b) The date of birth of such person;
(c) The type of specimen and the results of the appropriate laboratory tests made on such person; and
(d) Any other information about such person deemed necessary by the cabinet to carry out the provisions of this section.

Any physician, nurse, hospital administrator, director of clinical laboratory, public health officer, or allied health professional making such a report in good faith shall be immune from any civil or criminal liability that otherwise might be incurred from the making of such report.

(2) Notwithstanding the requirements of subsection (1) of this section, a clinical or research laboratory shall not be fined or otherwise disciplined for failure to report required information to the cabinet if the information was not provided by the medical professional obtaining the blood sample.

(3) The secretary shall maintain comprehensive records of all reports submitted pursuant to KRS 211.900 to 211.905 and 211.994. Records shall be analyzed and geographically indexed by county annually in order to determine the location of areas with a high incidence of elevated blood lead levels reported. The records and analysis shall be public record and provided annually by October 1 to the Governor, the General Assembly, the Legislative Research Commission, and the Lead Poisoning Prevention Advisory Committee; provided, however, that the name of any individual shall not be made public unless the secretary determines that such inclusion is necessary to protect the health and well-being of the affected individual.

(4) When an elevated blood lead level is reported to the cabinet, it shall inform such local boards of health, local health departments, and other persons and health organizations as deemed necessary.

Effective: July 12, 2012

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ANIMAL BITE STATUTES

KRS 258.065 Physicians to report persons bitten by dogs, cats, ferrets, and other animals -- Reporting when local health department is closed.

(1) Except as provided in subsection (2) of this section, every physician shall, within twelve (12) hours after his first professional attendance of a person bitten by a dog, cat, ferret, or other animal, report to the local health department the name, age, sex, and precise location of the person so bitten. If a child is bitten and no physician attends, the report shall be made by his parents or guardian. If an adult is bitten and no physician attends, he or the person caring for him shall make the report.

(2) If the local health department is closed when a physician, parent, guardian, or other adult attends to a bitten person, the physician, parent, guardian, or other adult shall report the incident on the next working day of the health department.

Effective: July 13, 2004
Note: 1980 Ky. Acts ch.396, sec.82 would have amended this section effective July 1, 1982. However, 1980 Ky. Acts ch.396 was repealed by 1982 Ky. Acts ch.141, sec.146, also effective July 1, 1982.
OLDHAM COUNTY HEALTH DEPARTMENT
CLINIC SERVICES

Below is a listing of services provided by the Oldham County Health Department. If your clients would like further information on any of these services, please call the health department at 502-222-3516.

Immunizations: Influenza (Flu), Shingles, Pneumococcal Polysaccharide, Pneumococcal Conjugate (PCV13), Tetanus, Diphtheria and Pertussis (Tdap), Tetanus and Diphtheria (Td), Polio, Measles, Mumps and Rubella (MMR), Meningococcal ACWY (MenACWY), Human Papillomavirus (HPV or Gardasil-9), Haemophilus Influenzae Type b (Hib), Hepatitis B, Hepatitis A, Diphtheria, Tetanus and Pertussis (DTaP), Chickenpox and Rotavirus

*Oldham County Health Department does not do off label vaccine administration. Any questions regarding this will be directed to one of our nurses

Family Planning: Meet with clinician to discuss birth control options best for the individual patient/annual well woman exams/pap smears/mammograms if indicated

Folic Acid Supplements: Counseling visit with a nurse on steps for a healthy pregnancy and patient provided with 400 mcg of folic to prevent birth defects

Preconception Counseling: Counseling visit with a clinician to talk about specifics related to a healthy pregnancy; topics include avoidance of substance abuse, smoking cessation, healthy diet, physical activity and early prenatal care

Pregnancy Testing

Prenatal (For people without insurance): For those that qualify the Oldham County Health Department can help to pay for services associated with prenatal care.

Children’s physical exams: Kindergarten and 6th grade physicals required for entry by school/preventive well child exams for children of all ages if qualifies

WIC Program (Supplemental food program for Women, Infants and Children): This program provides families that meet income guidelines and nutrition risk criteria with healthy foods and health education. Foods provided include milk, eggs, cereal, juice, fruit, vegetables, peanut butter and grains.

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Medical Nutrition Therapy (Nutrition Counseling): Individual nutrition counseling and assessment with a registered dietitian with or without referral.

Screening and treatment:

- Tuberculosis (TB skin test)
- Sexually Transmitted Diseases
- Lead (young children)
- HIV
- Cancer (Pap and Mammogram referrals)
- Hypertension
- Cholesterol
- Diabetes

Other services valuable to the community:

- Diabetes classes (2 kinds of classes available)
  - Diabetes Basics and Nutrition Basics: a basic 1 hour class on Diabetes general information and a 1 hours class on nutrition management of Diabetes
  - Diabetes Self-Management Education: 8 hour comprehensive curriculum that covers all aspects of Diabetes. Topics covered include monitoring, standards of care, meal planning, long-term and short-term complications, medications, exercise and disease process. Perfect for the newly diagnosed person.
- Smoking Cessation Classes: This class series is 13 weeks and participants are provided with their choice of either Nicorette gum or Nicotine patch to aid in smoking cessation. The group meets in a support group format and regular discussion time is provided. Classes are ongoing.

**Call for times and information**
ACKNOWLEDGEMENTS

The Oldham County Health Department would like to extend their deepest gratitude to the Bullitt County Health Department for their assistance and guidance in the development of this resource guide. It is the hope that with this tool, the clinicians and community partners of Oldham County in conjunction with Oldham County Health Department will build a strong and healthy community. The Oldham County Health Department would also like to acknowledge the diligent efforts of the state of Kentucky’s Department of Public Health in improving the health of all citizens and making a happier and healthier commonwealth.

Resources within this guide were developed from case definitions and recommendations made by the Centers for Disease Control and Prevention and the Council of State and Territorial Epidemiologists. It is with much gratitude that we thank these two organizations for their due diligence in preserving and improving the health of all Americans.
REFERENCES


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SECTION I: REFERENCE WEBSITES
Oldham County Health Department Website:
http://oldhamcountyhealthdepartment.org/

KRS-KAR Legislative Searching Service:
http://www.lrc.ky.gov/lrcsearch

E PID 200 (Revised):

Cabinet for Health and Family Services:
http://chfs.ky.gov/

Core Clinical Service Guide:
http://chfs.ky.gov/dph/ccsg.htm

National Notifiable Diseases Surveillance System (contains most up to date information on case definitions):
http://wwwn.cdc.gov/nndss/

CHFS Diseases and Conditions webpage (information on all of KY reportables):
http://chfs.ky.gov/dph/diseases/

CHFS Epi Rapid Response Team webpage (resources for ERRT teams/providers during outbreaks):
http://chfs.ky.gov/dph/epi/Epi/

Oldham County Emergency Management Services:
http://oldhamcountyems.com/

Oldham County Fiscal Court
http://www.oldhamcounty.net/

To receive updates to this manual, please ensure OCHD has a current Point of Contact for your office. The Health Department will update contact records bi-annually.
SECTION II: FORMS
INFLUENZA-ASSOCIATED MORTALITY REPORTING

EFFECTIVE NOVEMBER 16, 2016: Per 902 KAR 2:020 Section 6, it is mandatory that ALL Influenza-associated deaths be reported to the Kentucky Department for Public Health within one (1) business day.

Influenza-Associated Mortality Case Definition

Clinical Description

An influenza-associated death is defined for surveillance purposes as a death resulting from a clinically compatible illness that was confirmed to be influenza by an appropriate laboratory or rapid diagnostic test. There should be no period of complete recovery between the illness and death. Influenza-associated deaths in all persons should be reported.

A death should not be reported if:

1. There is no laboratory confirmation of influenza virus infection.
2. The influenza illness is followed by full recovery to baseline health status prior to death.
3. After review and consultation there is an alternative agreed upon cause of death.

Laboratory Criteria for Diagnosis

Laboratory testing for influenza virus infection may be done on pre- or post-mortem clinical specimens, and include identification of influenza A or B virus infections by a positive result by at least one of the following:

- Influenza virus isolation in tissue cell culture from respiratory specimens;
- Reverse-transcriptase polymerase chain reaction (RT-PCR) testing of respiratory specimens;
- Immunofluorescent antibody staining (direct or indirect) of respiratory specimens;
• Rapid influenza diagnostic testing of respiratory specimens;
• Immunohistochemical (IHC) staining for influenza viral antigens in respiratory tract tissue from autopsy specimens;
• Four-fold rise in influenza hemagglutination inhibition (HI) antibody titer in paired acute and convalescent sera*.

**Case Classification**

**Confirmed**

A death meeting the clinical definition that is laboratory confirmed.

Laboratory or rapid diagnostic test confirmation is required as part of the case definition; therefore, all reported deaths will be classified as confirmed.

**Comments**

*Serologic testing for influenza is available in a limited number of laboratories, and should only be considered as evidence of recent infection if a four-fold rise in influenza (HI) antibody titer is demonstrated in paired sera. Single serum samples are not interpretable.

**REFERENCES:**

HISTOPLASMOSIS

IDENTIFICATION

CLINICAL DESCRIPTION:

A systemic fungal infection of varying severity caused by Histoplasma capsulatum. Infection may be asymptomatic or take one of four clinical forms:

**Acute benign respiratory** - mild respiratory illness with general malaise, fever, chills, headache, myalgia, chest pains, nonproductive cough and scattered small calcifications of the lung.

**Acute disseminated** - debilitating fever, GI symptoms, bone marrow suppression, lymphadenopathy. Most frequent in children and immunosuppressed; fatal if not treated.

**Chronic pulmonary** - clinically and radiologically resembles chronic pulmonary tuberculosis with cavitations, usually in middle-aged and elderly persons with underlying emphysema.

**Chronic disseminated** - low-grade fever, weight loss, weakness, liver and spleen enlargement, mucosal ulcers, subacute course with slow progression; fatal if not treated.

LABORATORY CRITERIA FOR CONFIRMATION:

- Isolation of *H. capsulatum* from culture of bone marrow, sputum, or lesions, OR
- Histological demonstration of intracellular yeast cells from bone marrow or tissue biopsy, OR
- Detection of *H. capsulatum* polysaccharide antigen in urine or serum, OR
- Rise in CF titers to either histoplasmin or yeast-phase antigen.

COMMENT

Positive histoplasmin skin test IS NOT sufficient evidence.

REPORTING CRITERIA:

Signs/symptoms and/or laboratory confirmation

ACTIONS REQUIRED / PREVENTION MEASURES

KENTUCKY DISEASE SURVEILLANCE REQUIRES WITHIN ONE (1) BUSINESS DAY OF THE IDENTIFICATION OF A CASE OR SUSPECTED CASE REPORT TO THE LOCAL OR STATE HEALTH. If health department personnel cannot be contacted directly, notification shall be made by electronic submission or by telephone to the emergency number of the Division of Epidemiology and Health Planning: **1-888-973-7678**.

Dec/12
EPIDEMIOLOGY REPORTS REQUESTED:

- Electronically: KEUPS-NBS OR
- By Fax or Mail: Kentucky Reportable Disease Form – EPID 200 (Jan/03)

PUBLIC HEALTH INTERVENTION:

- Minimize exposure to dust in areas contaminated by bird droppings such as chicken or pigeon coops, bird or bat roosts and surrounding soil.
- Surfaces can be sprayed with water to reduce dust.
- Cleaning (using respiratory protection) and/or chemical decontamination requires specially trained personnel.

CONTACTS FOR CONSULTATION

DPH, COMMUNICABLE DISEASE BRANCH: 502-564-3261.
DPH, SURVEILLANCE AND HEALTH DATA BRANCH: 502-564-3418.
DPH, DIVISION OF LABORATORY SERVICES 502-564-4446.

RELATED REFERENCES


Kentucky Reportable Disease Form
Department for Public Health
Division of Epidemiology and Health Planning
275 East Main St., Mailstop HS2E-A
Frankfort, KY 40621-0001

Fax or Mail the Completed Form to the Local Health Department

<table>
<thead>
<tr>
<th>DEMOGRAPHIC DATA</th>
</tr>
</thead>
</table>
| Patient's Last Name | First | M.I. | Date of Birth | Age | Gender
|                   |       |     |               |     | □M □F □Unk. |
| Address           | City  | State | ZIP Code | County of Residence |
| Phone Number      | Patient ID Number | Ethnic Origin
|                   |       | □Hispanic □Non-Hispanic |
| Race              |       | □W □B □A/PI □Am. Ind. □Other |

<table>
<thead>
<tr>
<th>DISEASE INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease/Organism</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>List Symptoms/Comments</td>
</tr>
<tr>
<td>Hospitalized?</td>
</tr>
<tr>
<td>□Yes □No</td>
</tr>
<tr>
<td>Died?</td>
</tr>
<tr>
<td>□Yes □No □Unk.</td>
</tr>
<tr>
<td>Hospital Name:</td>
</tr>
<tr>
<td>School/Daycare Associated? □Yes □No</td>
</tr>
<tr>
<td>Name of School/Daycare:</td>
</tr>
<tr>
<td>Person or Agency Completing form:</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Address:</td>
</tr>
<tr>
<td>Phone:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LABORATORY INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ADDITIONAL INFORMATION FOR SEXUALLY TRANSMITTED DISEASES ONLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease:</td>
</tr>
<tr>
<td>□Syphilis</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

| Disease:           | Site: (Check all that apply) | Resistance: |
|                    | □Gonorrhea □Chlamydia □Chancroid | □Genital, uncomplicated □Ophthalmic |
|                    | □Pharyngeal □Anorectal | □PID/Acute □Tetracycline |
|                    | □Salpingitis | □Other |

<table>
<thead>
<tr>
<th>Date of Spec. Collection</th>
<th>Laboratory Name</th>
<th>Type of Test</th>
<th>Results</th>
<th>Treatment Date</th>
<th>Medication</th>
<th>Dose</th>
</tr>
</thead>
</table>

If syphilis, was previous treatment given for this infection? □Yes □No
If yes, give approximate date and place
**Kentucky Reportable MDRO Form**
**Department for Public Health**
**Division of Epidemiology and Health Planning**
275 East Main St., Mailstop HS2E-B
Frankfort, KY 40621-0001

**EPID 250 –MDRO**

**KDPH use only:**
**Record No:** ________________

### DEMOGRAPHIC DATA

<table>
<thead>
<tr>
<th>Patient’s Last Name</th>
<th>First</th>
<th>M.I.</th>
<th>Date of Birth</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td>/ /</td>
<td></td>
<td>M F Unk</td>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>County of Residence</th>
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<th>Phone Number</th>
<th>Patient ID Number</th>
<th>Ethnic Origin</th>
<th>Race</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>His. Non-His.</td>
<td>W B A/PI Am.Ind. Other</td>
</tr>
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### DISEASE INFORMATION

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<thead>
<tr>
<th>Organism name</th>
<th>Date of Onset</th>
<th>Date of Diagnosis</th>
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<table>
<thead>
<tr>
<th>MDRO type</th>
<th>Date of Onset</th>
<th>Date of Diagnosis</th>
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<td>/ /</td>
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<table>
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<tr>
<th>Hospitalized</th>
<th>Hospital Name</th>
<th>Admission Date</th>
<th>Date of Discharge</th>
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<tbody>
<tr>
<td>Yes</td>
<td></td>
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<table>
<thead>
<tr>
<th>Admitted from</th>
<th>Specify Name</th>
<th></th>
</tr>
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<tbody>
<tr>
<td>Home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other HC Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agency completing form</th>
<th>Attending Physician</th>
<th>Name</th>
</tr>
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<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
<td></td>
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<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
<th>Date of Report</th>
<th>Phone</th>
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<tbody>
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</table>

<table>
<thead>
<tr>
<th>Person Completing Form</th>
<th>Name</th>
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<tbody>
<tr>
<td>Name:</td>
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### LABORATORY INFORMATION

<table>
<thead>
<tr>
<th>Date of Test</th>
<th>Name or Type of Test</th>
<th>Name of Laboratory</th>
<th>Specimen Source</th>
<th>Results</th>
</tr>
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<tr>
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<table>
<thead>
<tr>
<th>Reason for Culture</th>
<th>Patient infected or colonized</th>
</tr>
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<tbody>
<tr>
<td>Clinical Surveillance</td>
<td>Infected Colonized</td>
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### DISPOSITION INFORMATION

<table>
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<tr>
<th>Status</th>
<th>Discharged to</th>
<th>Identify Receiving Facility</th>
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<tbody>
<tr>
<td>Expired</td>
<td>Home</td>
<td>LTC Facility Other HC Facility Other</td>
</tr>
<tr>
<td></td>
<td>Yes No Unk</td>
<td>Specify Name:</td>
</tr>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Was the receiving facility notified of the patient’s MDRO status:</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Yes No Unk</td>
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</table>

<table>
<thead>
<tr>
<th>Identifying Facility</th>
<th>Facility Type</th>
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</thead>
<tbody>
<tr>
<td>Name:</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone</th>
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<tbody>
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<table>
<thead>
<tr>
<th>Outbreak Associated</th>
<th>Outbreak reference number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes No</td>
<td></td>
</tr>
</tbody>
</table>
# Animal Bite Reporting Form

**Victim**

- Person Bitten
- Age
- Date Bitten
- Home Address
- Directions to Home
- Daytime Telephone
- Evening Telephone
- Parent or Guardian

**Owner**

- Owner of Animal
- Owner Address
- Directions to Home
- Daytime Telephone
- Evening Telephone

<table>
<thead>
<tr>
<th>Dog</th>
<th>Cat</th>
<th>Ferret</th>
<th>Skunk</th>
<th>Raccoon</th>
<th>Bat</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pet</td>
<td>Stray</td>
<td>Wild</td>
<td>Male</td>
<td>Female</td>
<td>Short Hair</td>
<td>Long Hair</td>
</tr>
</tbody>
</table>

- Animal’s Name
- Breed
- Color or Markings
- Vaccination Date
- I.D. #
- Veterinarian
- Other Comments

**Form Completed by:**

- Name
- Date Reported
- Institution/Agency/Provider Reporting
- Tel

Fax form to LOCAL HEALTH DEPT. in COUNTY where animal bite occurred.
# OLDHAM COUNTY HEALTH DEPARTMENT CONTACT FORM

<table>
<thead>
<tr>
<th>Facility Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Address</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Primary Phone</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Secondary Phone</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Fax</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Email 1</th>
</tr>
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<tbody>
<tr>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Email 2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Point of Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Email</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Phone</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Private Phone</th>
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</thead>
<tbody>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Available 24/7? (Y/N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tertiary Contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>A)</td>
</tr>
<tr>
<td>B)</td>
</tr>
<tr>
<td>C)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Information/Instructions/Comments:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

Please fax form to Oldham County Health Department: 502-222-8723.
<table>
<thead>
<tr>
<th>Type</th>
<th>Facility</th>
<th>Contact</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Norton Brownsboro</td>
<td>Alice Held</td>
<td>502-446-8796</td>
</tr>
<tr>
<td></td>
<td>Baptist East</td>
<td>---</td>
<td>502-897-8028</td>
</tr>
<tr>
<td></td>
<td>St Mary and Elizabeth</td>
<td>April</td>
<td>502-367-3364</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sam</td>
<td>502-361-6708</td>
</tr>
<tr>
<td></td>
<td>Jewish</td>
<td>Patricia Gould/Linda Ross</td>
<td>502-587-4870</td>
</tr>
<tr>
<td></td>
<td>University of Louisville</td>
<td>Crystal</td>
<td>502-217-1071</td>
</tr>
<tr>
<td></td>
<td>The Brook KMI</td>
<td>La’Tisha Washington</td>
<td>502-814-3726</td>
</tr>
<tr>
<td></td>
<td>Norton Suburban</td>
<td>Donna Miles</td>
<td>502-899-6528</td>
</tr>
<tr>
<td></td>
<td>Norton Audubon</td>
<td>IP Office</td>
<td>502-636-7320</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Lee French</td>
<td>502-636-8177</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cathy Pattengale</td>
<td>502-636-8990</td>
</tr>
<tr>
<td></td>
<td>VA</td>
<td>Rhonda</td>
<td>502-287-6441</td>
</tr>
<tr>
<td></td>
<td>Norton Downtown</td>
<td>---</td>
<td>502-629-8000</td>
</tr>
<tr>
<td></td>
<td>Kosair Children’s</td>
<td>Kelly Zink</td>
<td>502-629-6000</td>
</tr>
<tr>
<td></td>
<td>Hardin Memorial</td>
<td>Ruth Belflower</td>
<td>270-737-1212</td>
</tr>
<tr>
<td></td>
<td>Flaget (Bardstown)</td>
<td>Mary Newton</td>
<td>502-350-5054</td>
</tr>
<tr>
<td></td>
<td>Our Lady of Peace</td>
<td>Angela</td>
<td>502-479-4278</td>
</tr>
<tr>
<td>Lab</td>
<td>CPA</td>
<td>---</td>
<td>502-897-9594</td>
</tr>
</tbody>
</table>
Oldham County Health Department

Resource Guide Presentation Evaluation

Name:__________________________________________
Email Address:_____________________________________
Practice/Facility Name:_____________________________________
Practice Address:_____________________________________
Work Phone: ____________________ Fax Number:_____________________
Preferred Method of Contact:  [ ] Email  [ ] Fax

Please answer the following questions in reference to your activities and knowledge prior to this presentation.

When reporting notifiable conditions, who does your agency primarily report the disease to:
[ ] Oldham County Health Department  [ ] Kentucky Department of Public Health

When reporting notifiable conditions, how often did you utilize the “1-888-9-report” line?
[ ] Never  [ ] Rarely  [ ] Sometimes  [ ] Often  [ ] Always

Were you comfortable reporting notifiable conditions directly to the Oldham County Health Department?
[ ] Yes  [ ] No

Did you feel more comfortable contacting the Kentucky Department for Public Health regarding notifiable conditions?
[ ] Yes  [ ] No

Please answer the following questions with regard to your thoughts after the presentation:

Will the Reportable Conditions Guide make OCHD contact information more easily available?
[ ] Yes  [ ] No

Did the presentation add to your knowledge surrounding notifiable conditions?
[ ] Yes  [ ] No

Are you more likely to contact OCHD in the event that you diagnose a notifiable condition?
[ ] Yes  [ ] No

Do you feel like the Reportable Conditions Guide is a good resource for providers in the area?
[ ] Yes  [ ] No

Comments:________________________________________________________

________________________________________________________

Continue on back of page if more space is needed.