LORD FAIRFAX HEALTH DISTRICT

Serving the Counties of Clarke, Frederick, Page, Shenandoah, Warren and the City of Winchester

2012 Communicable Disease Report

Dear Colleague:

Welcome to the second annual Communicable Disease Report from the Lord Fairfax Health District (LFHD). District employees investigate hundreds of reports of suspected communicable diseases each year. This report presents the results of those investigations and highlights the reportable diseases that most affected the LFHD in 2012.

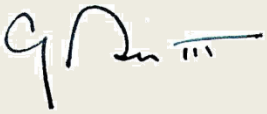
In addition to communicable disease data, the report also describes the communicable disease services provided by the Health Department and offers practical guidance for clinicians that we believe will help mitigate the future impact of these diseases.

I would like to thank all community partners including healthcare providers, infection control practitioners, laboratorians, and public safety personnel who report cases to the Lord Fairfax Health District. In addition, I want to acknowledge the hard work and dedication of the LFHD employees who investigate and control communicable disease, sexually transmitted infection, and tuberculosis.

I especially wish to acknowledge and thank Patricia Bair. As the LFHD Epidemiologist, Ms Bair was responsible for each of the two editions of this report. Ms Bair has advanced and is now the Regional Epidemiologist for this part of Virginia. I congratulate her on her promotion and thank her for her hard work with the Lord Fairfax Health District.

I also wish to welcome aboard Ms Casey Kelley who is our new District Epidemiologist. She is available to assist each of you with any communicable disease issue and can be reached by phone 540-722-3470, x143 or by email at casey.kelley@vdh.virginia.gov.

Sincerely,
Charles J. Devine, III, MD



Director, Lord Fairfax Health District

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2012 LFHD Population Estimates*

Clarke County	14,276
Frederick County	80,118
Page County	24,215
Shenandoah County	42,812
Warren County	38,077
Winchester City	27,208
TOTAL	**226,706**

*Weldon Cooper Center for Public Service: http://www.coopercenter.org/demographics/virginia-population-estimates

Communicable Disease Summary

In 2012, the LFHD investigated 1,277 reports of communicable disease. Table 1 provides a summary of the diseases investigated.

Table 1: Reported cases of selected communicable diseases Lord Fairfax Health District 2008-2012*

Disease	2008	2009	2010	2011	2012[α]	5-Year Average
Anaplasma phagocytophilum infection	0	0	8	4	4	3.2
Campylobacteriosis	49	39	47	45	45	45.0
Chlamydia trachomatis infection	500	452	403	574	783	542.4
Cryptosporidiosis	5	7	4	6	2	4.8
E. coli infection, shiga toxin-producing	11	3	11	8	8	8.2
Ehrlichia chaffeensis infection	1	0	2	4	5	2.4
Giardiasis	9	6	17	7	7	9.2
Gonorrhea	68	49	46	43	84	58.0
Haemophilus influenzae, invasive	4	4	5	6	4	4.6
Hepatitis A, acute	1		1	2	4	1.6
Hepatitis B, acute	4	6	9	3	3	5.0
Hepatitis C, acute	0	0	2	2	9	2.6
HIV	10	10	4	11	5	8.0
Lead, elevated levels	4	11	8	6	14	8.6
Legionellosis	2	0	4	5	6	3.4
Lyme disease	132	46	185	121	140	124.8
Malaria	3	0	0	3	1	1.4
Meningococcal disease (*Neisseria meningitidis*)	2	0	1	1	0	0.8
Pertussis	2	3	1	9	26	8.2
Salmonellosis	47	42	40	25	38	38.4
Shigellosis	9	6	7	5	1	5.6
Spotted Fever Rickettsiosis (including RMSF)	6	4	12	10	9	8.2
Staphylococcus aureus infection, invasive (MRSA)	29	22	21	25	36	26.6
Streptococcus pneumoniae, invasive (age < 5)	1	1	4	1	1	1.6
Streptococcus, Group A, invasive	9	6	3	8	8	6.8
Syphilis - early stage	2	0	0	2	0	0.8
Toxic-shock syndrome, streptococcal	0	0	1	1	1	0.6
Tuberculosis	1	0	0	1	2	0.8
Varicella (Chickenpox)	31	89	44	45	26	47.0
Vibriosis, non-cholera	0	1	1	2	1	1.0
West Nile infection, neuroinvasive	0	0	0	0	3	0.6
West Nile infection, non-neuroinvasive	0	0	0	0	1	0.2
Total	**942**	**807**	**891**	**985**	**1277**	**980.4**

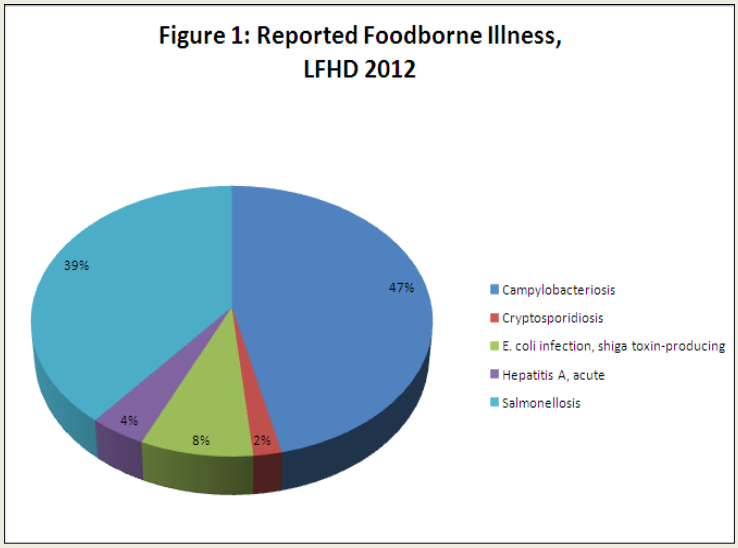
*All communicable disease data are primary surveillance data from the Lord Fairfax Health District and the Virginia Department of Health

[α]2012 data are provisional

Foodborne Illness

The Centers for Disease Control and Prevention (CDC) estimates that 1 in 6 Americans (or 48 million people) gets sick, 128,000 are hospitalized, and 3,000 die of foodborne diseases each year.[1] The Foodborne Diseases Active Surveillance Network (FoodNet) is a collaborative program established in July 1995 between the CDC, 10 state health departments, the U.S. Department of Agriculture's Food Safety and Inspection Service (USDA-FSIS), and the Food and Drug Administration (FDA). FoodNet conducts surveillance for *Campylobacter, Cryptosporidium, Cyclospora, Listeria, Salmonella,* Shiga toxin-producing *Escherichia coli* (STEC) O157 and non-O157, *Shigella, Vibrio*, and *Yersinia* infections diagnosed by laboratory testing of samples from patients.

Figure 1 shows the percentages of reported FoodNet agents by etiology in the LFHD in 2012. As noted, *Campylobacter* was the most commonly identified agent, followed by *Salmonella.*



The CDC states that everyone can do the following to prevent foodborne illness:

- Wash hands, cutting boards, utensils, and countertops.
- Keep raw meat, poultry, and seafood separate from ready-to-eat foods.
- Use a food thermometer to ensure that foods are cooked to a safe internal temperature: 145°F for whole meats, 160°F for ground meats, and 165°F for all poultry.
- Keep your refrigerator below 40°F and refrigerate food that will spoil.
- Don't prepare food for others if you have diarrhea or vomiting.
- Report suspected illness from food to your local health department.

For Healthcare Providers

- If a foodborne illness is suspected, conduct confirmatory testing whenever possible. In VA, all positive isolates from stool specimens are forwarded by local laboratories to the state laboratory (DCLS) for confirmatory testing. The LFHD and the state of VA use this information to identify outbreaks of foodborne illness.

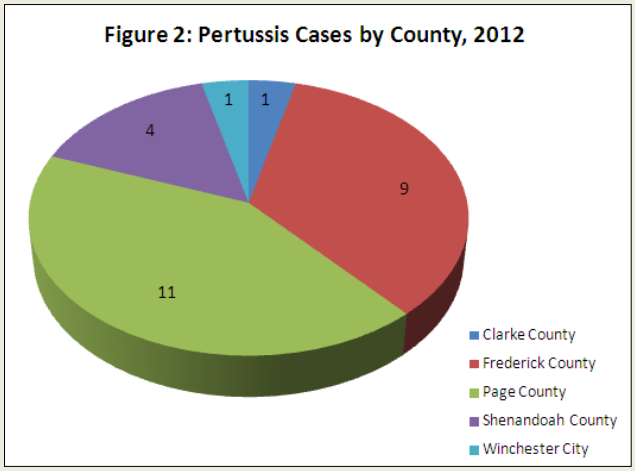
Lord Fairfax Health District Services

- LFHD will conduct an investigation for each reported case of a foodborne illness. During the investigation, LFHD will provide prevention information, identify potential sources of infection, and recommend control measure to prevent further disease transmission.
- The LFHD will also inspect facilities, including restaurants, when indicated during an investigation.

[1]CDC. Vital Signs: Incidence and Trends of Infection with Pathogens Transmitted Commonly Through Food --- Foodborne Diseases Active Surveillance Network, 10 U.S. Sites, 1996-2010. MMWR June 10, 2011 / 60(22);749-755

Pertussis

Pertussis, or whooping cough, is an acute infectious disease caused by the bacterium *Bordetella pertussis* and despite the availability of vaccine, the incidence has been gradually increasing since the early 1980s[2]. While the reasons for this increase are not fully understood, multiple factors have likely contributed to the increase including waning immunity from childhood pertussis vaccines, increased recognition of the disease, and better diagnostic testing and increased reporting[3].



From 2001-2004 the LFHD saw an average of 1-3 cases of pertussis reported each year. In 2005 the number of reported cases peaked at 30, and then returned to 1-3 baseline until 2012. In 2012, there were a total of 26 cases, with 11 of those being in Page County (Figure 2).

There were no pertussis outbreaks reported in LFHD in 2012.

Vaccination

The Advisory Committee on Immunization Practices (ACIP) recommends a four-dose primary series of DTaP, administered at 2, 4, 6 and 15–18 months of age, followed by a fifth booster dose given at 4–6 years. In 2005 and 2006, the ACIP recommended the replacement of a single Td booster with a dose of Tdap for adolescents (ages 11–18) and adults (ages 19–64) who have not previously received Tdap. In 2010, ACIP expanded Tdap recommendations to include adults aged 65 years and older who anticipate close contact with an infant and who have not previously received the vaccine. In 2011, ACIP recommended that all healthcare personnel who have not yet received a dose of Tdap, regardless of age, should be vaccinated[3].

For Healthcare Providers

- Promote vaccination by ensuring that patients are fully vaccinated against pertussis according to the Advisory Committee Immunization Practices (ACIP) Guidelines.
- Ensure that you and ALL staff are immunized with Tdap
- Report suspected cases of pertussis to the Lord Fairfax Health District Health Department as soon as the case is suspected. This allows the LFHD to follow up on cases, to identify high-risk contact, and to recommend prophylaxis to those that need it to protect them from the disease.

Lord Fairfax Health District Services

- LFHD offers free Tdap vaccine to those 19 years of age and older, and per school requirements.

[2]CDC. Epidemiology and Prevention of Vaccine-Preventable Diseases. The Pink Book: Course Textbook - 12th Edition Second Printing (May 2012)

[3]CDC. Chapter 10: Pertussis. Manual for the Surveillance of Vaccine-Preventable Diseases (5th Edition, 2011)

Rabies

Wild animals continue to account for more than 90% of reported cases of rabies in the U.S., with raccoons beings the most frequently reported rabid animal species, followed by skunks, bats, fox, and other wild animals[4]. The number of reported rabid domestic animals has decreased among all domestic species except cats. The number of reported human rabies cases averages two to three per year in the United States[4]. Virginia has had two human rabies cases in the last decade: 2009 involved an imported case after contact with a dog in India; 2003 exposure is unknown, but it was confirmed to be a raccoon variant of the disease.

- LFHD received reports of 708 animal bites in 2012. Of those, about 9% received post-exposure prophylaxis (PEP). Most of these cases did not result in PEP being administered because: 1) the biting animal was domestic and could be observed for 10 days to rule out the possibility of rabies transmission, or 2) were wild or feral and were captured, euthanized, and tested.

Table 1: Pre and Post Exposure Prophylaxis, LFHD 2012

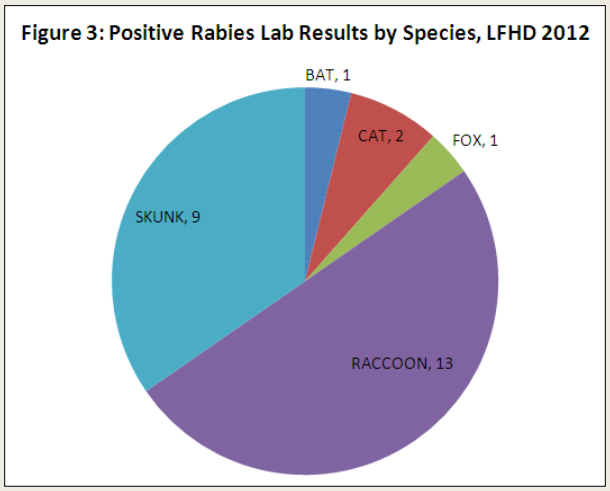
	Post-Exposure	Pre-Exposure	Bites Reported
Clarke	10	5	40
Frederick/Winchester	29	7	305
Page	5	0	79
Shenandoah	8	1	109
Warren	14	11	175
LFHD Totals	66	24	708

Post-Exposure - Number of people reported to the local health department who received rabies post-exposure treatment (either the full series or the 2 injections given to exposed individuals who had previous rabies vaccinations)

Pre-Exposure - Number of people reported to the local health department who received rabies pre-exposure vaccinations (either the initial 3 injection series or the 1 injection booster).

Bites Reported - Number of humans reported to the local health department with animal bites.

Figure 3: Positive Rabies Lab Results by Species, LFHD 2012



- In 2012, LFHD tested 127 animals for rabies.
- As noted in Figure 3, raccoons and skunks were the primary carriers of rabies in the district (51.9% and 29.6% respectively).

For Healthcare Providers

- All exposures should be reported immediately to your local health department. After-hours call number: 540-665-8611
- Not all individuals exposed to a potentially rabid animal will need PEP. If the animal is located, PEP should be delayed pending the outcome of testing or confinement.
- When anatomically feasible, the full dose of RIG should be infiltrated into and around the wound.
- PEP administration should be reported to LFHD using the VDH Morbidity Report.
- Call us and we will provide advice and assistance in testing or confining the offending animal.

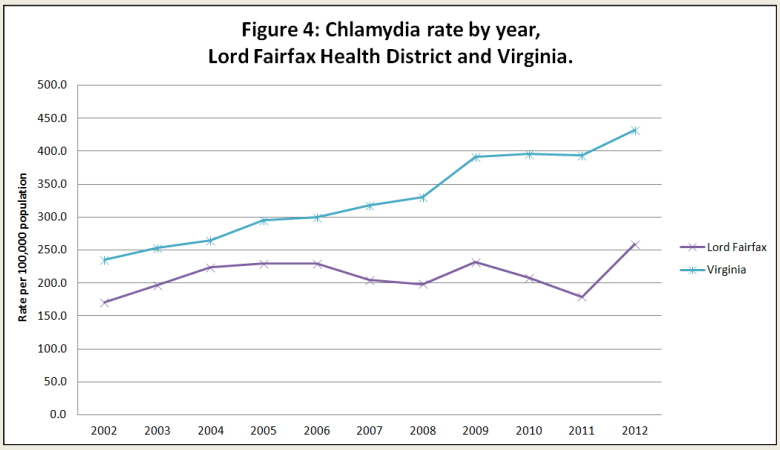
Rabies Exposure Definition

Any bite, scratch, or other situation where saliva or central nervous system tissue or CSF from a potentially rabid animal enters a fresh, open wound or contacts a mucous membrane by entering the eye, mouth, or nose.

[4]CDC. Rabies Surveillance Data in the United States. http://www.cdc.gov/rabies/location/usa/surveillance/index.html

Chlamydia

C. trachomatis infection is the most commonly reported notifiable disease in the United States. It is among the most prevalent of all STDs, and since 1994, has comprised the largest proportion of all STDs reported to CDC[5]. The increase in reported chlamydial infections during the last 20 years reflects the expansion of chlamydia screening activities, the use of increasingly sensitive diagnostic tests, an increased emphasis on case reporting from providers and laboratories, and improvements in the information systems used for reporting. However, many women who are at risk are still not being tested—reflecting, in part, the lack of awareness among some health care providers and the limited resources available to support these screenings.



- Although the chlamydia incidence rate in LFHD has slightly increased over the last decade, it still remains well below the rate for the rest of Virginia[6] (Figure 4).

For Healthcare Providers

- The CDC recommends that all sexually active women aged ≤25 years and older women with risk factors should receive annual screening for chlamydia.
- Screening of sexually active men should be considered in areas with a high prevalence of chlamydia.
- Sexual partners of those diagnosed with chlamydia should be seen for evaluation, testing and treatment. If the partner is not enrolled in your practice, please refer them to their private physician or to their local health department.

Lord Fairfax Health District Services

- Testing and treatment services for chlamydia are free at one of the five local health departments in the LFHD.
- Please call the local health department for hours and appointments. A list of contact numbers is included at the end of this report.

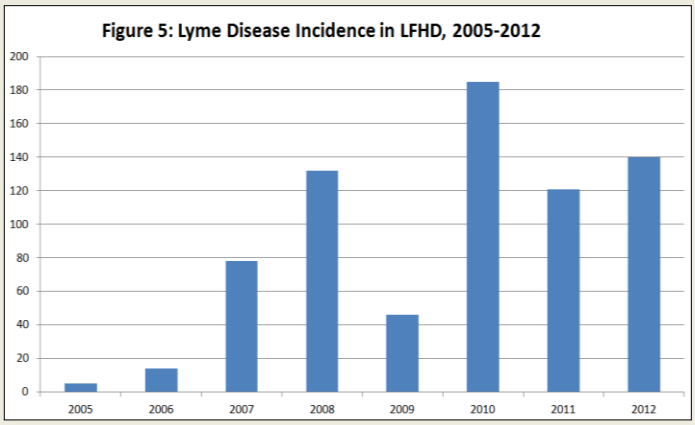
[5]CDC. 2010 Sexually Transmitted Diseases Surveillance. http://www.cdc.gov/std/stats10/chlamydia.htm
[6]Virginia Department of Health. HIV/AIDS, Sexually Transmitted Disease (STD), and Tuberculosis Data and Statistics. http://www.vdh.virginia.gov/epidemiology/DiseasePrevention/DAta/

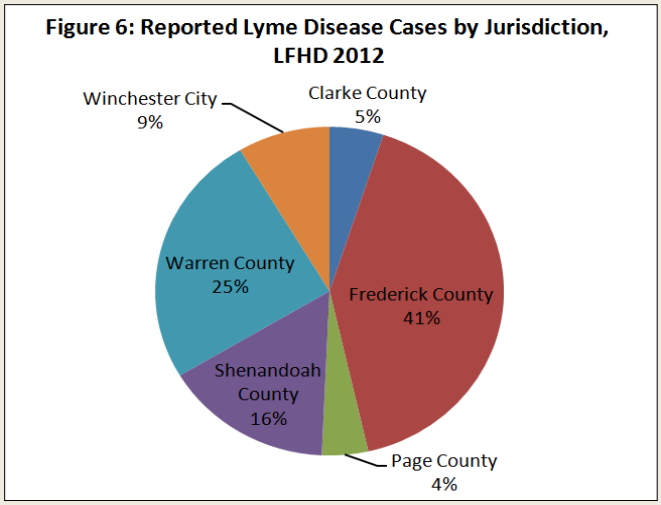
Lyme Disease

Lyme disease is the most commonly reported vectorborne illness in the United States--in 2011, it was the 6th most common Nationally Notifiable disease. However this disease does **not** occur nationwide and is concentrated heavily in the northeast and upper Midwest[7]. In 2011, 96% of Lyme disease cases were reported from 13 states, including VA.

- As noted in Figure 5, cases of Lyme Disease steadily increased from 2005, peaking at 185 cases in 2010. In 2012, the number of cases was 140.

- Lyme Disease cases are reported throughout the year in all jurisdictions within LFHD. In 2012, 41% of the cases were reported in Frederick County, followed by Warren County at 25% (Figure 6). All residents should be considered at risk for the disease.





- Although Lyme disease continues to be the most commonly reported tickborne disease in Virginia and in the LFHD, other tickborne diseases are also increasing in incidence.

- In 2012, there were 9 cases of RMSF, 5 cases of ehrlichiosis and 4 cases of anaplasmosis in the LFHD.

For Healthcare Providers

- Consider Lyme disease and other tickborne infections in any patient who presents with a febrile illness during the warm weather months. Most patients, when treated with antibiotics in the early stages, quickly recover.
- All cases of suspected Lyme Disease are to be reported to your local health department. Contact information is found at the end of this report.
- For surveillance purposes, the CDC Lyme Disease case definition requires clinical and laboratory evidence of infection (i.e., 2-tier testing with EIA and Westernblot).
- For serological testing, if blood is drawn within 30 days of infection:
  - Positive or equivocal **ELISA** (Enzyme Linked Immunoabsorbant Assay) (or IFA), **AND**;
  - Positive **Western Blot IgM** serology are sufficient to meet the case definition.
- If blood is drawn more than 30 days after infection:
  - Positive **Western Blot IgG** serology is necessary to meet the case definition.

[7]CDC. Lyme Disease Data. Found at: http://www.cdc.gov/lyme/stats/index.html

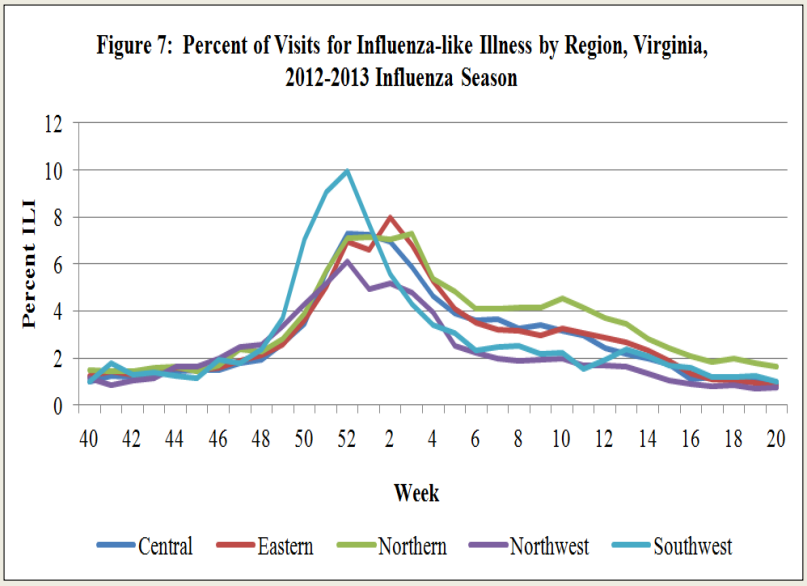
Influenza

According to the Centers for Disease Control (CDC), the 2012-2013 influenza was an intense season that began early and remained elevated for 15 consecutive weeks, making the season slightly longer than usual.[8] The cumulative hospital rate for seniors (65 years old and older) peaked the week of March March 17-23, at 182 per 100,000, and this group accounted for 50% of all reported hospitalizations .[8]

Pneumonia and influenza diagnoses (P & I) peaked the week ending January 19, 2013 at 9.9 percent and was above the epidemic threshold for 11 weeks this season. This P & I is comparable to recorded percentages for past severe seasons, including 2003-2004 when it reached 10 percent.

Pediatric deaths are the only nationally notifiable outcome for seasonal influenza. 149 laboratory-confirmed, influenza-associated pediatric deaths were reported this season. These deaths were reported from 38 states, with the greatest numbers of deaths from Texas (18), New York (14), and Florida (eight).[9]

The Virginia Department of Health monitors influenza-like illness (ILI) activity each week from October through May. Those are the months when influenza ("flu") is most likely to occur in VA.



Flu surveillance is not designed to count every person who has the disease, but assesses ILI activity at the community level. VDH monitors changes in ILI activity by five health planning regions. ILI is defined as a fever along with a cough and/or a sore throat.

Figure 7 is a graph of percent of visits for ILI, by region. Although LFHD does not have district level data for ILI, they are included in the Northwest region, which had lower levels of ILI compared to the rest of the state.

There were no reported influenza-associated pediatrics deaths in the LFHD during the 2012-13 influenza season.

For Healthcare Providers

- ACIP recommends routine influenza vaccination for all persons aged 6 months and older.
- ACIP recommends routine influenza vaccination for all healthcare workers
- Vaccination efforts should continue throughout the season, because the duration of the season varies and may not peak until February or March

LFHD Services

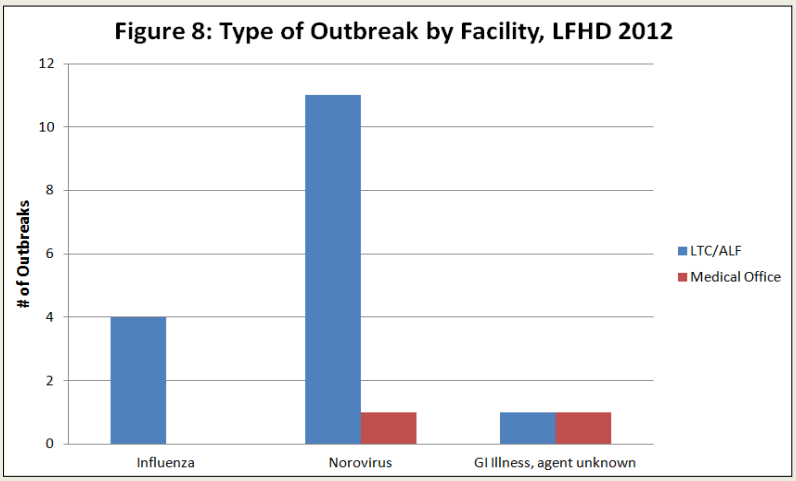
- LFHD provides influenza vaccine. Please call your local health department for more information (numbers can be found at the end of this report)

[8]CDC. 2011-2012 Flu Season Draws to a Close. Found at: http://www.cdc.gov/flu/spotlights/2012-2013-flu-season-wrapup.htm

[9]CDC. Morbidity and Mortality Weekly Report. Influenza Activity-United States, 2012-13 Season and Composition of the 2013-14 Influenza Vaccine. Found at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6223a5.htm

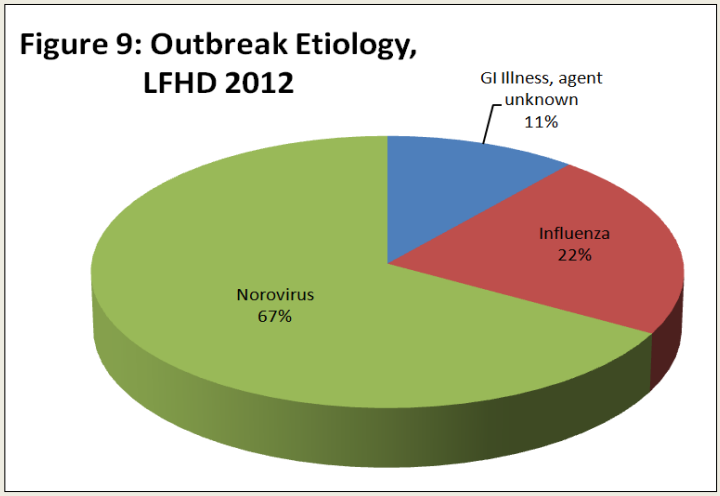
Outbreak Summary, 2012

According to the World Health Organization (WHO) and for public health purposes, an outbreak is defined as the occurrence of cases of disease in excess of what would normally be expected in a defined community, geographical area or season.[10] A single case of a communicable disease long absent from a population, or caused by an agent not previously recognized or the emergence of a previously unknown disease, may also constitute an outbreak and should be reported and investigated.



- In 2012, LFHD investigated 18 outbreaks of illness
- As in previous years, non-foodborne gastroenteritis outbreaks in long term care or assisted living facilities were the most commonly reported outbreak in LFHD (Figure 8)

- Of the 18 outbreaks in 2012, 67% were due to norovirus, followed by GI illness, agent unknown at 11% (Figure 9).
- There were no foodborne outbreaks in the LFHD in 2012.



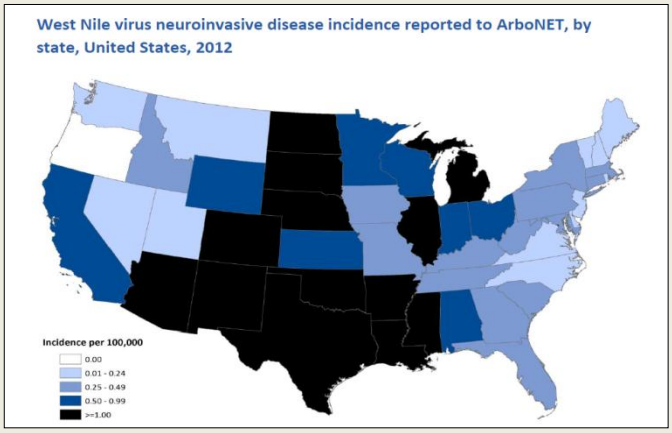
For Healthcare Providers

- Report all suspected outbreaks for any disease to your local health department as soon as possible
- For each reported outbreak, LFHD will conduct an investigation to determine the causative agent and assist the facility with implementing prevention and control measures
- Frequent and proper hand washing with soap and water is the key measure for preventing most norovirus and other GI outbreaks.

[10]World Health Organization. Disease Outbreaks. Found at: http://www.who.int/topics/disease_outbreaks/en/

West Nile Virus

West Nile virus (WNV), an arbovirus most commonly spread by the bite of an infected mosquito is the leading cause of domestically acquired arboviral disease in the United States.[11,12] It was first detected in North America in 1999 and has since spread across the United States and Canada. The annual incidence of Neuroinvasive disease peaked in 2002 and 2003 (1.02 and 0.98 per 100,000 respectively), then remained relatively low from 2004-2011 (median: 0.31; range: 0.13–0.50), and peaked again in 2012 (0.92 per 100,000).[12] In 2012, CDC received 5,674 reports of WNV.[12]



- In 2012, Virginia reported 20 cases of Neuroinvasive WNV and 10 cases of non-Neuroinvasive WNV. As noted in the United States map of WNV in 2012 (left), Virginia's incidence rate for Neuroinvasive disease in 2012 was ≤ 0.24 per 100,000. The LFHD reported 3 cases of Neuroinvasive and 1 case of non-Neuroinvasive disease in 2012.

For Healthcare Providers

Clinical Diagnosis

West Nile virus (WNV) disease should be considered in any person with a febrile or acute neurologic illness who has had recent exposure to mosquitoes, blood transfusion, or organ transplantation, especially during the summer months in areas where virus activity has been reported.

Signs & Symptoms

An estimated 70-80% of human WNV infections are asymptomatic. Most symptomatic persons experience:

- Fever, headache, weakness
- Myalgia or arthralgia
- Gastro-intestinal symptoms
- Transient maculopapular rash
- Less than 1% develop neuroinvasive disease (meningitis, encephalitis, acute flaccid paralysis)

Treatment

There is no specific treatment; clinical management is supportive.

Prevention

Prevention of WNV disease depends on:

- Community-level mosquito control programs to reduce vector densities
- Personal protective measures to decrease exposure to infected mosquitoes
    - mosquito repellents
    - wearing long-sleeved shirts and long pants
    - limiting outdoor exposure from dusk to dawn
- Screening of blood and organ donors.

WNV disease is a nationally notifiable condition and all cases should be reported to your local health department in a timely manner.

[11]CDC. FAQ: General Questions About West Nile Virus. Found at: http://www.cdc.gov/westnile/faq/genQuestions.html
[12]CDC. Morbidity and Mortality Weekly Report. West Nile Virus and Other Arboviral Diseases-United States. Found at:
http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6225a1.htm

Data Source
Unless otherwise noted, data are LFHD primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of May 31, 2013. All 2012 data are considered provisional.

Acknowledgements

This report was prepared by Patricia Bair, MPH, Regional Epidemiologist with the Virginia Department of Health, and approved by LFHD Health Director Charles A. Devine, MD; any errors are solely their responsibility. Feedback is welcome: patricia.bair@vdh.virginia.gov or charles.devine@vdh.virginia.gov.

Contact Information for Reportable Diseases

Conditions listed in **black** can be submitted within three days of suspected or confirmed diagnosis on an Epi-1 form, by mail or fax.

Conditions listed in **RED** must be reported immediately by the most rapid means available (preferably phone call).

Health Department	Address	City	Zip	Phone	Fax
Clarke County	100 N. Buckmarsh St.	Berryville	22611	540-955-1033	540-955-4094
Frederick/Winchester	10 Baker St.	Winchester	22601	540-722-3470	540-722-3475
Page County	75 Court Ln.	Luray	22835	540-743-6528	540-743-3811
Shenandoah County	494 N. Main St. #100	Woodstock	22664	540-459-3733	540-459-8267
Warren County	134 Peyton St.	Front Royal	22630	540-635-3159	540-635-9698
After Hours Phone:	540-665-8611				
District Epidemiologist	540-722-3470, x143				

Virginia Reportable Disease List

Reporting of the following diseases is required by state law (§32.1-36 and §32.1-37 of the *Code of Virginia* and 12VAC5-90-80 and 12VAC5-90-90 of the Board of Health *Regulations for Disease Reporting and Control,* http://www.vdh.virginia.gov/epidemiology/regulations.htm). Report all conditions when suspected or confirmed to your local health department within three days on an Epi-1 form, except those listed in **RED** must be reported immediately by the most rapid means available.

- Acquired immunodeficiency syndrome (AIDS)
- Amebiasis
- I **ANTHRAX**
- Arboviral infections (e.g., dengue, EEE, LAC, SLE, WNV)
- **BOTULISM**
- I **BRUCELLOSIS**
- Campylobacteriosis
- Chancroid
- Chickenpox (Varicella)
- *Chlamydia trachomatis* infection
- I **CHOLERA**
- Creutzfeldt-Jakob disease if <55 years of age
- Cryptosporidiosis
- Cyclosporiasis
- I **DIPHTHERIA**
- **DISEASE CAUSED BY AN AGENT THAT MAY HAVE BEEN USED AS A WEAPON**
- Ehrlichiosis/Anaplasmosis
- ^ I *Escherichia coli* infection, Shiga toxin-producing
- Giardiasis
- Gonorrhea
- Granuloma inguinale
- I ***HAEMOPHILUS INFLUENZAE* INFECTION, INVASIVE**
- Hantavirus pulmonary syndrome
- Hemolytic uremic syndrome (HUS)
- **HEPATITIS A**
- Hepatitis B (acute and chronic)
- Hepatitis C (acute and chronic)
- Hepatitis, other acute viral
- Human immunodeficiency virus (HIV) infection
- # Influenza
- I (report **INFLUENZA A, NOVEL VIRUS** immediately)
- **INFLUENZA-ASSOCIATED DEATHS IN CHILDREN <18 YEARS OF AGE**
- Lead, elevated blood levels
- Legionellosis
- Leprosy (Hansen disease)
- I Listeriosis Lyme disease
- Lymphogranuloma venereum
- Malaria
- **MEASLES (RUBEOLA)**
- **MENINGOCOCCAL DISEASE**
- I
- **MONKEYPOX**
- Mumps
- **MYCOBACTERIAL DISEASES (INCLUDING AFB),**
- I **(IDENTIFICATION OF ORGANISM) AND DRUG SUSCEPTIBILITY**
- Ophthalmia neonatorum
- **OUTBREAKS, ALL** (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne)
- I **PERTUSSIS**
- I **PLAGUE**
- I **POLIOVIRUS INFECTION, INCLUDING POLIOMYELITIS**
- **PSITTACOSIS**
- I **Q FEVER**
- **RABIES, HUMAN AND ANIMAL**
- Rabies treatment, post-exposure
- **RUBELLA, INCLUDING CONGENITAL RUBELLA SYNDROME**
- I Salmonellosis
- **SEVERE ACUTE RESPIRATORY SYNDROME (SARS)**
- I Shigellosis
- **SMALLPOX (VARIOLA)**
- Spotted fever rickettsiosis
- *Staphylococcus aureus* infection,
- (invasive methicillin-resistant) and
- I (vancomycin-intermediate or vancomycin-resistant)
- I Streptococcal disease, Group A, invasive or toxic shock
- *Streptococcus pneumoniae* infection, invasive, in children <5 years of age
- Syphilis (report **PRIMARY** and **SECONDARY** immediately)
- Tetanus
- Toxic substance-related illness
- Trichinosis (Trichinellosis)
- I **TUBERCULOSIS, ACTIVE DISEASE**
- Tuberculosis infection in children <4 years of age
- **TULAREMIA**
- I **TYPHOID/PARATYPHOID FEVER**
- **UNUSUAL OCCURRENCE OF DISEASE OF PUBLIC HEALTH CONCERN**
- **VACCINIA, DISEASE OR ADVERSE EVENT**
- ***VIBRIO* INFECTION**
- **VIRAL HEMORRHAGIC FEVER**
- **YELLOW FEVER**
- I Yersinia

These conditions are reportable by directors of laboratories. In addition, these and all other conditions except methicillin-resistant *Staphylococcus aureus* (MRSA), invasive and mycobacterial diseases are reportable by physicians and directors of medical care facilities. Laboratory reports may be by computer-generated printout, Epi-1 form, CDC surveillance form, or upon agreement with VDH, by means of secure electronic transmission.

I A laboratory identifying evidence of these conditions shall notify the local health department of the positive culture and submit the initial isolate to the Virginia Division of Consolidated Laboratory Services (DCLS) or, for tuberculosis, to another lab designated by the Board.

^ Laboratories that use a Shiga toxin EIA methodology without a simultaneous culture should forward all positive stool specimens or positive broth cultures to DCLS for confirmation and further characterization.

\# Physicians and directors of medical care facilities should report influenza by number of cases only (report total number per week and by type of influenza, if known); however, individual cases of influenza A novel virus should be reported immediately by rapid means.

Note: 1. Central line-associated bloodstream infections in adult intensive care units are reportable. Contact the VDH Healthcare-Associated Infections Program at (804) 864-8141 or see 12VAC5-90-370 for more information.

2. Cancers are also reportable. Contact the VDH Virginia Cancer Registry at (804) 864-7866 or see 12VAC5-90-150-180 for more information.

Effective March 28, 2011

VDH VIRGINIA DEPARTMENT OF HEALTH
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VIRGINIA DEPARTMENT OF HEALTH

Confidential Morbidity Report

Patient's Name (Last, First middle Initial)	SSN: Home#: ( ) Work #: ( )
Patient's Address (Street, City or Town) Zip	City or County of Residence

Date of Birth: (mm/dd/yyyy)	Age:	Race: [ ] American Indian/Alaskian Native [ ] Asian [ ] Black/African American [ ] Other [ ] White [ ] Unknown [ ] Hawaiian/Pacific Islander	Hispanic Sex [ ] Yes [ ] F [ ] No [ ] M

Disease or Condition:	Pregnant [ ] Yes [ ] No [ ] Unknown	Death: [ ] Yes [ ] No Death Date:

Date of Onset:	Date of Diagnosis:	Influenza: (Report # and type only) No Patient Identification). Number of Cases: Type, if known:

Physician's Name: Phone:

Address:

Hospital Admission? [ ] Yes [ ] No Hospital Name:

Date of Admission: Medical Record Number

Laboratory Information and Results

Source of Specimen:	Date Collected:

Laboratory Test and Findings :

Name/Address of Lab: CLIA Number:	

Other Information

Comments: (E.g., Risk Situation [Food handling, Patient Care, Day Care], Treatment [including dates], Immunization Status [including dates], Signs/Symptoms, Exposure, Outbreak Associated etc.)

Name, Address, and Phone Number of Person Completing this Form:	Date Reported: For more forms, go to: http://www.vdh.virginia.gov/epidemiology/documents/pdf/Epi1.pdf

For Health Department Use

	Date Received: VEDSS Patient ID :

Please complete as much of this form as possible

Form Epi-1, 03/2011