2016 Communicable Disease Report

LORD FAIRFAX HEALTH DISTRICT

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

Lord Fairfax Health District
2016 Communicable Disease Report

Dear Colleague:

Welcome to the 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 our district in 2016.

In addition to communicable disease data, the report also describes LFHD communicable disease services and offers practical guidance for clinicians to 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 LFHD. 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.

As you may know, the Virginia Reportable Disease regulations were updated this year (see page 14). If you need an additional copy of this list, please contact your local health department. Our District Epidemiologist, Meredith Davis, is available to assist you with any communicable disease issue and can be reached by phone 540-722-3470, x143 or by email at Meredith.davis@vdh.virginia.gov.

Sincerely,

Colin M. Greene, MD, MPH
Director, Lord Fairfax Health District

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2016 LFHD Population Estimates*

Clarke County	14,240
Frederick County	83,998
Page County	23,586
Shenandoah County	41,938
Warren County	39,181
Winchester City	27,531
TOTAL	**230,474**

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

COMMUNICABLE DISEASE SUMMARY

In 2016, the LFHD conducted hundreds of communicable disease investigations in response to reports from healthcare providers and laboratories. To be included in annual case counts, the case must meet condition-specific surveillance case definitions, which include clinical and/or laboratory criteria. All communicable disease data are primary surveillance data from the Lord Fairfax Health District and the Virginia Department of Health.

Understanding the most commonly occurring reportable conditions is helpful to determine public health priorities and develop effective health promotion interventions. Figure 1 shows the seven most common reportable conditions in LFHD in 2016, based on an estimated total population of 230,474.

Figure 1. Rates of most frequently reported communicable disease, Lord Fairfax Health District, 2016.

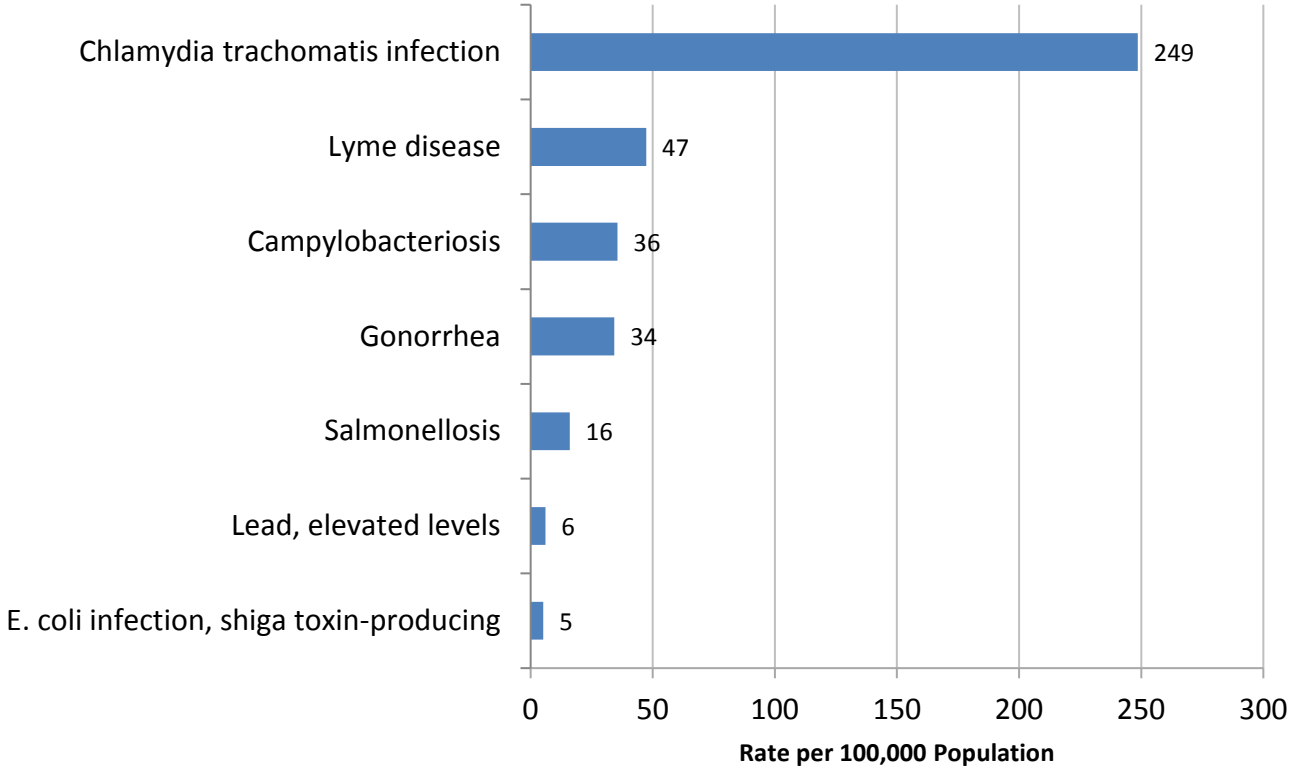


Table 1 shows counts of cases meeting surveillance case definitions for selected conditions in 2016 and the previous four years.

Table 1: Reported cases of selected diseases, Lord Fairfax Health District, 2012-2016.

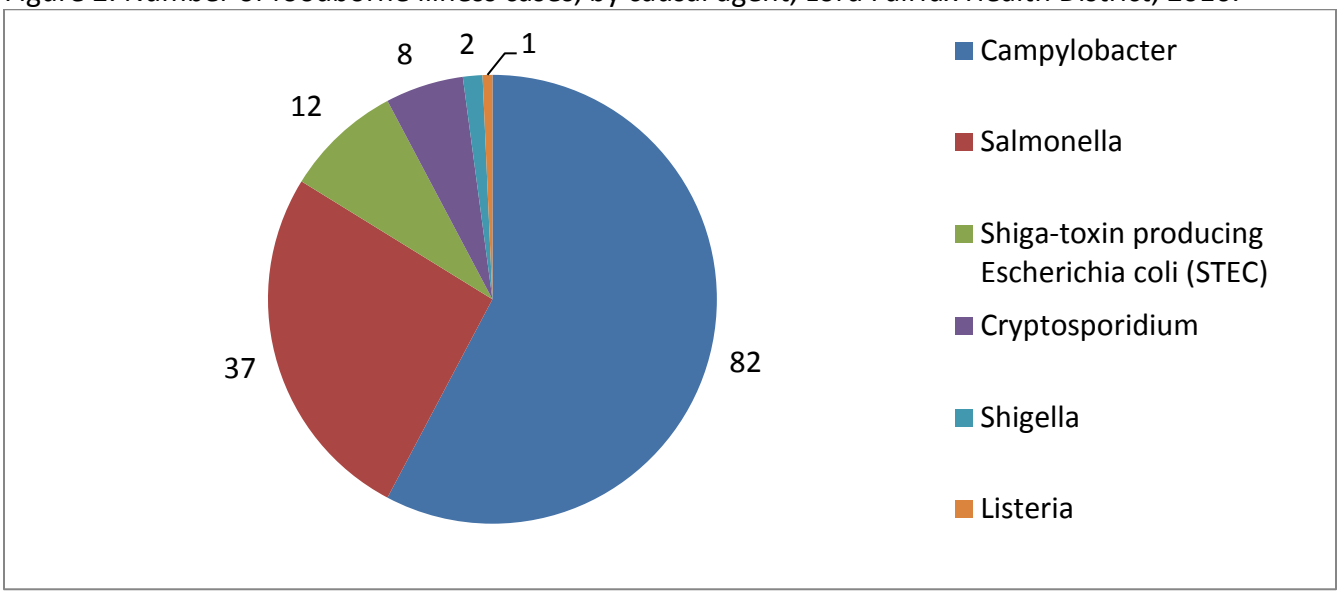
Disease	2012	2013	2014	2015	2016□	5-Year Average
Amebiasis	0	0	0	0	1	0.2
Arboviral infection*	4	0	0	0	3	1.4
Botulism, infant	0	1	0	1	0	0.4
Brucellosis	0	0	1	0	0	0.2
Campylobacteriosis	45	60	59	80	82	65.2
***Chlamydia trachomatis* infection**	797	680	631	630	573	661.8
Cryptosporidiosis	2	0	1	4	8	3
Cyclosporiasis	0	1	0	1	0	0.4
E. coli infection, shiga toxin-producing	8	8	12	6	12	9.2
Ehrlichiosis/Anaplasmosis	11	1	6	4	1	4.6
Giardiasis	7	6	9	6	5	6.6
Gonorrhea	85	99	69	79	79	82.2
***Haemophilus influenzae*, invasive**	4	8	5	6	6	5.8
Hepatitis A, acute	4	2	2	2	7	3.4
Hepatitis B, acute	3	4	2	1	2	2.4
Hepatitis C, acute	9	4	4	2	7	5.2
HIV	5	9	8	14	9	9
Lead, elevated levels**	8	10	3	2	14	7.6
Legionellosis	6	3	2	6	0	3.4
Listeriosis	0	0	0	0	1	0.2
Lyme disease	141	111	108	122	109	118.2
Malaria	1	0	0	0	0	0.2
Meningococcal disease (*N. meningitidis*)	0	0	0	0	0	0
Pertussis	26	8	43	9	2	17.6
Q Fever	0	1	1	0	0	0.4
Salmonellosis	37	37	49	31	37	38.2
Shigellosis	1	1	1	5	2	2
Spotted fever rickettsiosis (including RMSF^)	9	14	15	7	6	10.2
Streptococcus, Group A, invasive or TSS^	9	7	18	10	8	1
***Streptococcus pneumoniae*, invasive (age < 5)**	1	3	0	0	1	10.6
Syphilis, early stage	0	0	4	5	4	2.6
Tuberculosis	2	2	2	1	1	1.6
Varicella (Chickenpox)	26	19	14	20	2	16.2
Vibriosis, non-cholera	1	0	0	1	0	0.4
Yersiniosis	0	0	2	0	1	0.6
Total	**1252**	**1099**	**1071**	**1054**	**984**	

[α]2016 data are provisional; * Arboviral infection = West Nile Virus and Zika virus; ** Lead = blood lead levels ≥5 ug/dL; ^RMSF = Rocky Mountain Spotted Fever, TSS = Streptococcal toxic shock syndrome

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) conducts surveillance for bacterial infections caused by *Campylobacter, Cryptosporidium, Cyclospora, Listeria, Salmonella,* Shiga toxin-producing *Escherichia coli* (STEC), *Shigella, Vibrio*, and *Yersinia*. Figure 2 shows the number of confirmed cases of illness causes by FoodNet agents in LFHD in 2016. As noted, *Campylobacter* was the most commonly identified agent, followed by *Salmonella.*

Figure 2. Number of foodborne illness cases, by causal agent, Lord Fairfax Health District, 2016.



For Healthcare Providers

If a foodborne illness is suspected, conduct confirmatory testing whenever possible. All positive isolates from stool specimens (except those positive for *Campylobacter* or *Cryptosporidium*) are forwarded by local laboratories to the state laboratory (Division of Consolidated Laboratory Services, DCLS) for confirmatory testing. LFHD uses this information to identify outbreaks of foodborne illness.

Public Health Actions

- Investigate 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.
- Inspect facilities, including restaurants, when indicated during an investigation.

[1] CDC. Incidence and trends of infections with pathogens transmitted commonly through food – foodborne diseases active surveillance network, 10 U.S. sites, 2006-2013. MMWR Weekly. 63(15);328-332. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6315a3.htm

ZIKA VIRUS

The emergence of Zika virus in Central and South America in 2015-2016 presented a challenge for the public health community around the world. Zika virus spreads to people primarily through the bites of infected mosquitoes. Although most people infected with Zika have no symptoms or mild illness, Zika can pass from a pregnant woman to her baby during pregnancy and cause birth defects including microcephaly.

In 2016, the Virginia Department of Health collaborated with the Division of Consolidated Laboratory Services (DCLS) to offer Zika virus testing to potentially exposed persons. Public health testing continues on a limited basis, primarily for pregnant women and infants.

There were 112 cases of non-congenital Zika virus disease in Virginia in 2016; all were travel-associated.

For Healthcare Providers

- Advise pregnant patients to avoid travel to areas with CDC travel notices (https://wwwnc.cdc.gov/travel/page/world-map-areas-with-zika).
- Counsel patients returning from Zika-affected areas to prevent mosquito bites for 3 weeks after returning. Recommend that patients avoid sex or use barrier protection with sexual partners who may have been exposed to Zika virus (8 weeks for female travelers, 6 months for male travelers).
- If Zika virus disease is suspected, ensure testing through the health department or a private lab.
- Work with LFHD to ensure that pregnant women with laboratory evidence of Zika virus and their infants are enrolled in the Zika Pregnancy Registry (http://www.vdh.virginia.gov/us-zika-pregnancy-registry/), and that surveillance data is collected.
- Visit www.ZikaVA.org for current guidance and resources related to Zika virus.

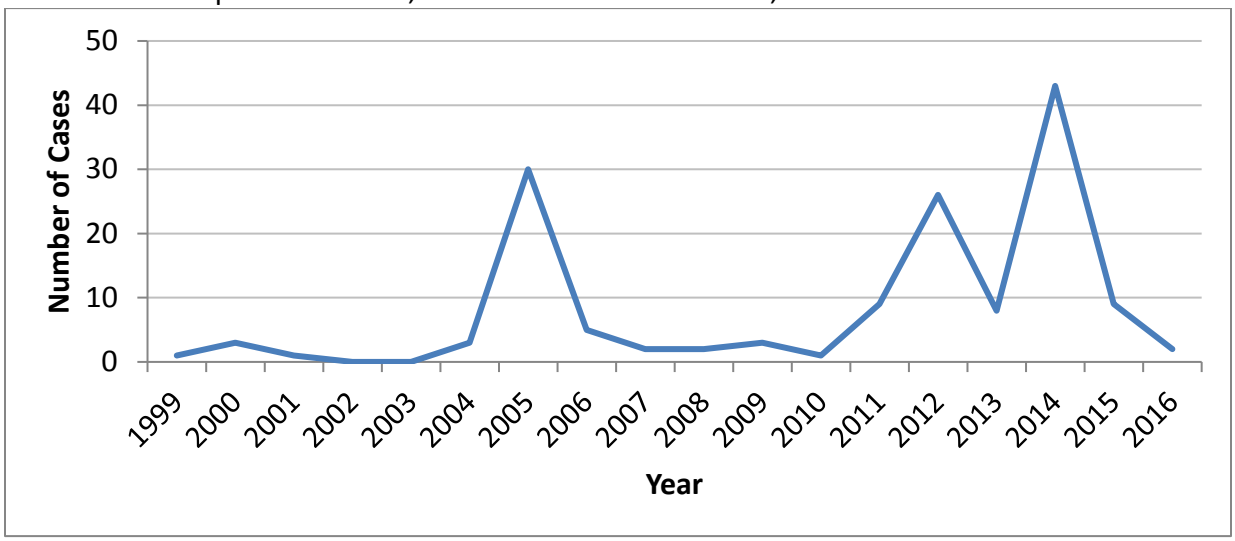
Lord Fairfax Health District Services

- Facilitating Zika virus testing on a limited basis for persons meeting criteria (http://www.vdh.virginia.gov/content/uploads/sites/3/2016/11/Zika-algorithm.pdf). Private laboratories offer Zika testing for people who do not meet criteria for public health testing.
- Providers in LFHD can request public health Zika virus testing by submitting an online test request form at https://redcap.vdh.virginia.gov/redcap/surveys/?s=8C8AEAXTM8. This form should be used only by clinicians, not by individuals seeking testing.
- Facilitating enrollment of pregnant women with laboratory evidence of Zika virus and their infants into the U.S. Zika Pregnancy Registry.

PERTUSSIS

Pertussis, or whooping cough, is a respiratory disease caused by the bacterium *Bordetella pertussis*. Pertussis is highly contagious, and has been shown to cause outbreaks, even among vaccinated populations, as immunity wanes over time. As shown in Figure 3, LFHD experienced pertussis outbreaks in 2005, 2012, and 2014. There were 2 cases in 2016.

Figure 3. Number of pertussis cases, Lord Fairfax Health District, 1999-2016.



Prevention

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. Preteens (11-12 years) should receive a dose of Tdap, as should teens and adults who did not receive a dose as a preteen. Pregnant women should receive a dose of Tdap during each pregnancy, preferably during the third trimester, to confer protection on their baby.

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 ALL staff are immunized with Tdap.
- Report suspected cases of pertussis to LFHD 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 follows up with contacts of individuals with pertussis and provides recommendations for post-exposure prophylaxis as indicated (www.cdc.gov/pertussis/outbreaks/pep.html).
- LFHD offers Tdap vaccine.

RABIES

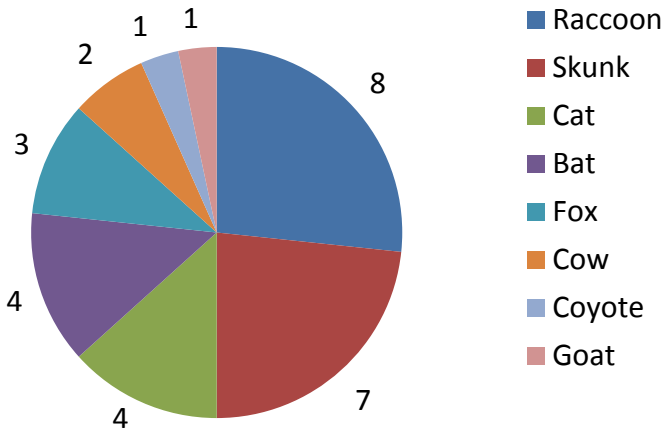
Rabies is a preventable viral disease affecting the central nervous system, causing brain disease and death. Most reported cases in the U.S. occur in wild animals like raccoons, skunks, and bats. The virus is transmitted to humans through the saliva of an infected animal. The number of reported human rabies cases averages two to three per year in the U.S. Vaccination of domestic pets, especially dogs, is largely responsible for rabies control in the U.S. In addition, an effective vaccine is available and can be used for post-exposure prophylaxis (PEP) after a possible rabies exposure.

LFHD received reports of 955 human exposures to potentially rabid animals in 2016, of which 947 occurred within LFHD's jurisdiction (Table 2). Of those, 50 people (about 5%) received PEP. Most cases did not receive PEP because: 1) the biting animal was domestic and could be observed for 10 days to rule out the possibility transmission, or 2) the animal was wild or feral and was captured, euthanized, and tested negative for rabies.

Table 1. Number of Potential Rabies Exposures, LFHD, 2016

County	Bites Reported
Clarke	56
Frederick/Winchester	437
Page	90
Shenandoah	142
Warren	222
Total	947

Figure 4. Animals testing positive for rabies, LFHD, 2016.



In 2016, LFHD tested 174 animals for rabies; 30 were positive. Among these were 8 raccoons, 7 skunks, and other species including bats, cats, and foxes (Figure 4).

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.

For Healthcare Providers

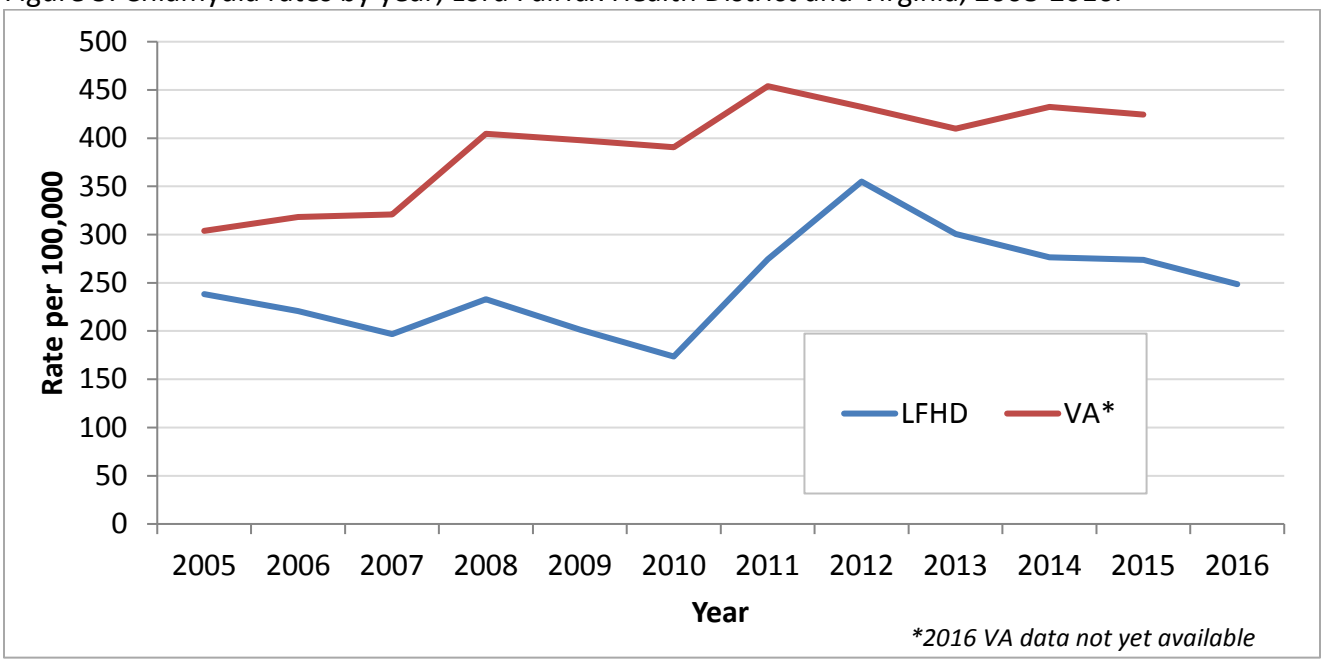
- All exposures should be reported immediately to your local health department.
- Not all individuals exposed to a potentially rabid animal will need PEP. If the animal is located, PEP should be delayed pending the outcome of animal testing or confinement.
- When feasible, the full dose of RIG should be infiltrated into and around the wound.
- PEP administration should be reported to LFHD using the VDH Morbidity Report.

CHLAMYDIA

Chlamydia, the disease caused by *C. trachomatis* infection, is the most commonly reported notifiable disease in the U.S. In 2015, there were 1.5 million cases of chlamydia in the U.S., a rate of 479 cases per 100,000 people.[2] Chlamydia's public health importance results primarily from its association with pelvic inflammatory disease, or PID, which causes infertility, ectopic pregnancy, and pelvic pain. Since reporting began in 1994, chlamydia rates have increased steadily in the U.S.

The chlamydia incidence rate in LFHD remains well below the rate for the rest of Virginia (Figure 5).

Figure 5. Chlamydia rates by year, Lord Fairfax Health District and Virginia, 2008-2016.



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 for chlamydia is available at local health departments in LFHD.
- Please call the local health department (see page 12) for hours and appointments.

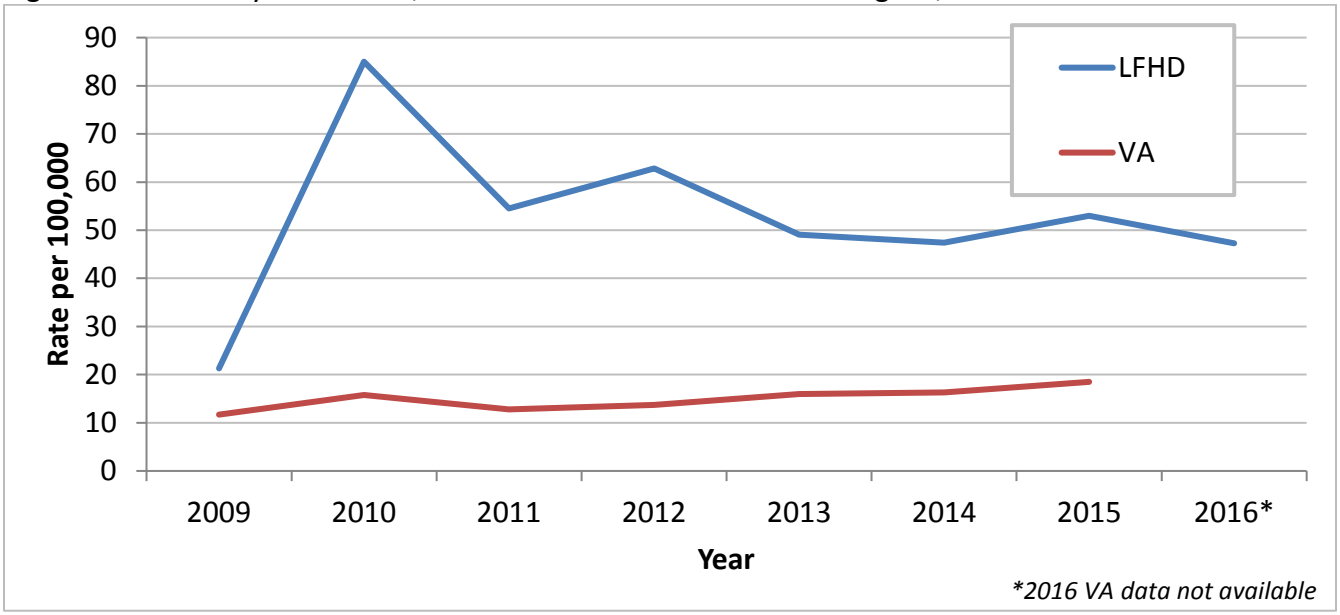
[2] CDC. Reported STDs in the United States. https://www.cdc.gov/std/stats15/tables/1.htm. Accessed June 21, 2017.

Lyme and Other Tickborne Diseases

Tickborne diseases in Virginia include Lyme disease, Rocky Mountain Spotted Fever (RMSF), ehrlichiosis and anaplasmosis. Lyme disease is the most commonly reported tickborne illness in the United States; in 2015, it was the 6th most common nationally notifiable disease. However this disease is concentrated heavily in the Northeast and upper Midwest. In 2015, 95% of Lyme disease cases were reported from 14 states, including Virginia.[3]

As shown in Figure 6, rates of Lyme disease are notably higher in Lord Fairfax Health District than in Virginia overall. Lyme disease is endemic in all counties of the district. In 2016, there were 109 cases of Lyme disease, 6 cases of RMSF and 1 case of ehrlichiosis.

Figure 6. Rates of Lyme Disease, Lord Fairfax Health District and Virginia, 2009-2016.

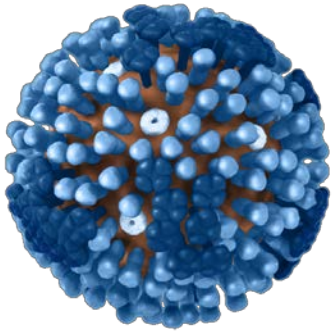


For Healthcare Providers

- Consider tickborne infections in patients with febrile illness during warm weather months. Most patients treated early with antibiotics quickly recover.
- Report all suspected cases of Lyme, Rocky Mountain Spotted Fever, ehrlichiosis and anaplasmosis to your local health department. Contact information is found at the end of this report.
- Testing for Lyme disease is a two-step process:
  1) **EIA** (enzyme immunoassay) or IFA (indirect immunofluorescence assay), **AND**;
  2) If EIA is positive or equivocal, **Western Blot IgM and IgG** serology should be performed.

[3] CDC. Lyme disease website. http://www.cdc.gov/lyme/stats/index.html. Accessed June 20, 2017.

INFLUENZA (FLU)



According to the Centers for Disease Control and Prevention (CDC), influenza activity in the U.S. during the 2016-2017 season was moderate. Peak activity in the U.S. occurred during the week ending February 11, 2017 (MMWR Week 6). The highest percentage of outpatient visits for influenza-like illness (ILI) was 5.1%.[4] The most predominant circulating strain was influenza A (H3N2), although influenza B viruses were common in late spring.

Pediatric deaths are the only nationally notifiable outcome for seasonal influenza. There were 98 laboratory-confirmed, influenza-associated pediatric deaths in the U.S during the 2016-17 season. There were no reported influenza-associated pediatrics deaths in LFHD during the season.

The Virginia Department of Health monitors ILI activity each week from October through May, the months when influenza is most likely to occur in VA. **ILI is defined as fever with cough and/or sore throat.** 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.

LFHD is seeking additional sentinel surveillance providers for the 2017-2018 influenza season. Sentinel providers, including physician offices, urgent care facilities, and hospitals, forward nasopharyngeal specimens to the state laboratory, DCLS, for confirmatory testing. This helps to identify which influenza strains are circulating. Please contact your local health department (see page 13) if you are interested in becoming a sentinel site.

For Healthcare Providers

- ACIP recommends routine influenza vaccination for **all persons** aged 6 months and older.
- Healthcare workers may be required to receive vaccination or sign a waiver.
- The live attenuated influenza vaccine is no longer recommended.
- Vaccination efforts should continue throughout the season, because the duration of the season varies and may not peak until February or March.

Lord Fairfax Health District Services

- LFHD provides influenza vaccine. Please call your local health department (see page 13) for more information.

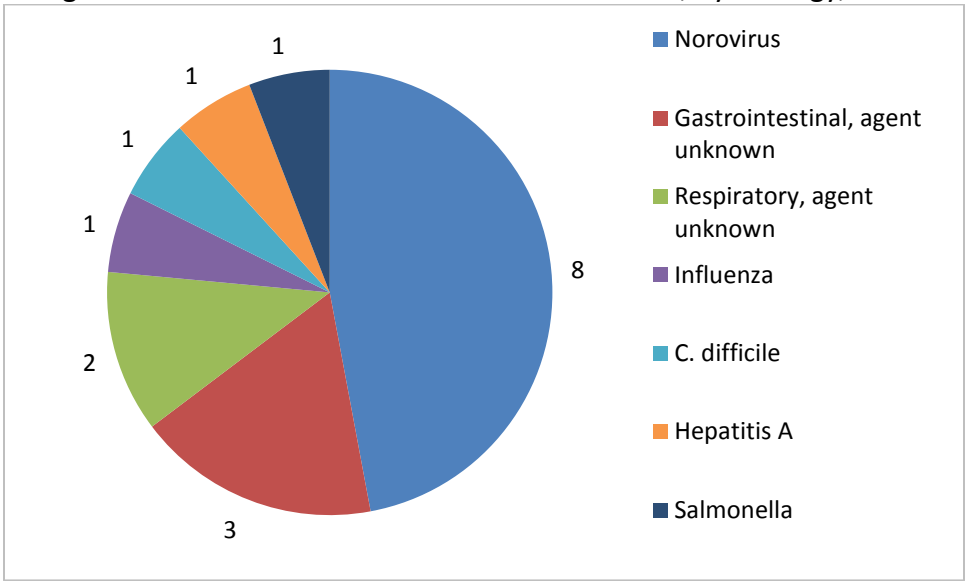
[4] CDC, 2017. Update: Influenza activity in the United States During the 2016-17 season and composition of the 2017-18 influenza vaccine. https://www.cdc.gov/mmwr/volumes/66/wr/mm6625a3.htm?s_cid=mm6625a3_e.

OUTBREAK SUMMARY, 2016

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 2016, LFHD investigated 16 outbreaks of illness, most of which were gastrointestinal illness (Figure 7). The majority of outbreaks (13; 81%) occurred in nursing homes or assisted living facilities.

Figure 7. Outbreaks in Lord Fairfax Health District, by etiology, 2016.



For Healthcare Providers, Long-Term Care Facilities, and Schools

- Report all suspected outbreaks for any disease to your local health department as soon as possible.
- Frequent and proper hand washing with soap and water is the key measure for preventing most norovirus and other gastrointestinal outbreaks.

LFHD Services

- For each reported outbreak, LFHD will conduct an investigation to determine the causative agent and assist individuals and facilities with implementing prevention and control measures.

COUNTY-SPECIFIC CASE COUNTS, 2016

Disease	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Total
Amebiasis	0	0	0	0	0	1	1
Arboviral disease*	0	1	0	1	0	1	3
Campylobacteriosis	2	21	13	31	6	9	82
***Chlamydia trachomatis* infection**	27	192	26	81	112	135	573
Cryptosporidiosis	1	5	0	1	1	0	8
E. coli infection, shiga toxin-producing	1	5	0	2	2	2	12
Ehrlichiosis/ Anaplasmosis	0	0	0	0	1	0	1
Giardiasis	0	2	0	1	1	1	5
Gonorrhea	1	19	2	22	19	16	79
***Haemophilus influenzae*, invasive**	0	1	0	2	2	1	6
Hepatitis A, acute	0	0	6	0	1	0	7
Hepatitis B, acute	0	1	0	0	1	0	2
Hepatitis C, acute	2	1	0	0	3	1	7
HIV	2	1	1	1	2	2	9
Lead, elevated levels**	1	2	1	8	1	1	14
Listeriosis	0	1	0	0	0	0	1
Lyme disease	14	41	8	15	22	9	109
Pertussis	0	1	1	0	0	0	2
Salmonellosis	4	11	0	8	10	4	37
Shigellosis	0	0	0	0	0	2	2
Spotted Fever Rickettsiosis^	0	1	1	2	2	0	6
***Streptococcus pneumoniae*, invasive (age < 5)**	0	0	0	0	0	1	1
Streptococcus, Group A, invasive, or TSS†	0	3	1	2	2	1	9
Syphilis - early stage	0	0	0	0	1	3	4
Tuberculosis	0	0	0	0	0	1	1
Varicella (Chickenpox)	0	2	0	0	0	0	2
Yersiniosis	1	0	0	0	0	0	1
Total	**56**	**311**	**60**	**177**	**189**	**191**	**984**

[α]2016 data are provisional; * Arboviral infection = West Nile Virus and Zika virus; ** Lead = blood lead levels ≥5 ug/dL; ^includes Rocky Mountain Spotted Fever; †TSS = Streptococcal toxic shock syndrome

LORD FAIRFAX COMMUNICABLE DISEASE EPIDEMIOLOGY PROGRAM CONTACT INFORMATION

Health Department	Address	City	Zip	Phone	Fax
Clarke County	100 North 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 North Main St., #100	Woodstock	22664	540-459-3733	540-459-8267
Warren County	465 West 15th St., Suite 200	Front Royal	22630	540-635-3159	540-635-9698
After Hours Phone	540-665-8611				
District Epidemiologist	540-722-3470, x143				

Data Source

Unless otherwise noted, data are LFHD primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of June 20, 2017. All 2016 data are considered provisional.

Acknowledgements and Feedback

This report was prepared by Meredith Davis, MPH, District Epidemiologist with the Virginia Department of Health, and approved by LFHD Health Director, Colin M. Greene, MD, MPH; any errors are solely their responsibility. We welcome your feedback and suggestions at meredith.davis@vdh.virginia.gov or colin.greene@vdh.virginia.gov.

REPORTABLE DISEASES

Suspected or confirmed diagnosis should be submitted on an Epi-1 form (see next page) by mail or fax.

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

REPORT IMMEDIATELY

Anthrax [a]
Botulism [a]
Brucellosis [a]
Cholera [a]
Coronavirus infection, severe (e.g., SARS-CoV, MERS-CoV) [a]
Diphtheria [a]
Disease caused by an agent that may have been used as a weapon
***Haemophilus influenzae* infection, invasive** [a]
Hepatitis A [a]
Influenza-associated deaths <18 years of age
Influenza A, novel virus [a]
Measles (Rubeola) [a]
Meningococcal disease [a]
Outbreaks, all (including but not limited to foodborne, healthcare-associated, occupational, toxic substance-related, and waterborne)
Pertussis [a]
Plague [a]
Poliovirus infection, including poliomyelitis [a]
Psittacosis [a]
Q fever [a]
Rabies, human and animal [a]
Rubella [a], including congenital rubella syndrome [a]
Smallpox (Variola) [a]
Syphilis, primary and secondary [a]
Tuberculosis (TB), active disease [a,b]
Tularemia [a]
Typhoid/Paratyphoid fever [a]
Unusual occurrence of disease of public health concern
Vaccinia, disease or adverse event [a]
***Vibrio* infection** [a]
Viral hemorrhagic fever [a]
Yellow fever [a]

LEGEND

[a] Reportable by directors of laboratories. These and all other conditions listed must be reported by physicians and directors of medical care facilities.
[b] Laboratories report AFB, mycobacterial identification, and drug susceptibility for *M. tuberculosis*
[c] Laboratories that use EIA without a positive culture should forward positive stool specimens or enrichment broth to DCLS
[d] Physicians and directors of medical care facilities 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 or influenza-related deaths in persons <18 must be reported immediately

REPORT WITHIN 3 DAYS

Acquired immunodeficiency syndrome (AIDS)
Amebiasis [a]
Arboviral infections (e.g., CHIK, dengue, EEE, LAC, SLE, WNV, Zika) [a]
Babesiosis [a]
Campylobacteriosis [a]
Chancroid [a]
Chickenpox (Varicella) [a]
Chlamydia trachomatis infection [a]
Creutzfeldt-Jakob disease <55 years of age [a]
Cryptosporidiosis [a]
Cyclosporiasis [a]
Ehrlichiosis/Anaplasmosis [a]
***Escherichia coli* infection, Shiga toxin-producing** [a,c]
Giardiasis [a]
Gonorrhea [a]
Granuloma inguinale
Hantavirus pulmonary syndrome [a]
Hemolytic uremic syndrome (HUS)
Hepatitis B (acute and chronic) [a]
Hepatitis C (acute and chronic) [a]
Hepatitis, other acute viral [a]
Human immunodeficiency virus (HIV) infection [a]
Influenza [a,d]
Lead, reportable levels [a]
Legionellosis [a]
Leprosy (Hansen's disease)
Leptospirosis [a]
Listeriosis [a]
Lyme disease [a]
Lymphogranuloma venereum
Malaria [a]
Mumps [a]
Ophthalmia neonatorum
Rabies treatment, post-exposure
Salmonellosis [a]
Shigellosis [a]
Spotted fever rickettsiosis [a]
***Staphylococcus aureus* infection, vancomycin-intermediate or vancomycin-resistant** [a]
Streptococcal disease, Group A, invasive or toxic shock [a]
Streptococcus pneumoniae infection, invasive, <5 years of age [a]
Syphilis, other than primary and secondary
Tetanus
Toxic substance-related illness [a]
Trichinosis (Trichinellosis) [a]
Tuberculosis (TB) infection <4 years of age
Yersiniosis [a]

Effective October 20, 2016

MAIL THE TOP TWO COPIES TO YOUR LOCAL HEALTH DEPARTMENT

VIRGINIA DEPARTMENT OF HEALTH
Confidential Morbidity Report

Patient's Name (Last, First, Middle Initial):

SSN: ___-___-___

Home #: ( ) ___-___

Work #: ( ) ___-___

Patient's Address (Street, City or Town, State, Zip Code):

City or County of Residence

Date of Birth: (mm/dd/yyyy) | Age: | Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Unknown | Hispanic: ☐ Yes ☐ No | Sex: ☐ F ☐ 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(s) and Finding(s):

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:

Check here if you need more of these forms, or call your local health department. (Be sure your address is complete.) ☐

For Health Department Use

Date Received:

VEDSS Patient ID:

Please complete as much of this form as possible

Form Epi-1, 10/2011

LORD FAIRFAX HEALTH DISTRICT

Suspected Outbreak Form

VDH VIRGINIA DEPARTMENT OF HEALTH

All known or suspected outbreaks are reportable to your local health department. Use this form to gather as much information as possible. Call 540-722-3470 ext 143 or fax to 540-722-3475.

Contact Information Date: _____

Name_____ Phone number _____ Email _____

Facility: _____

Address: _____ City: _____ Zip: _____

Outbreak Information

Disease Suspected:			Residents/ Students/Other	Staff
First Symptom Onset Date :		Number Ill		
		Number Hospitalized		
Affected Area:	☐ One classroom, wing, or floor ☐ Multiple wings or floors ☐ Whole facility	Total Number in Facility		
		For vaccine-preventable diseases only (e.g. pertussis, mumps):		
		Number ill who are vaccinated		
		Total number vaccinated		

Signs & Symptoms

Respiratory	☐ Fever ☐ Cough ☐ Sore Throat ☐ Congestion ☐ Other _____	**Rash**	☐ Suspect Scabies ☐ Suspect MRSA ☐ Suspect Hand, Foot, and Mouth Disease ☐ Other _____ Please describe progression of the rash:
GI	☐ Vomiting ☐ Diarrhea ☐ Abdominal Cramps ☐ Fever ☐ Other _____	**Other**	Please describe symptoms:

Lab: Please describe any relevant lab results _____

Infection Control Measures Currently Implemented

☐ Emphasized hand hygiene	☐ Served meals in rooms
☐ Isolated or cohorted sick residents	☐ Used paper plates, cups, etc
☐ Excluded sick staff from work	☐ Removed food and drinks from common areas
☐ Cohorted staff to work only with sick OR with well	☐ Posted signs to limit visitors
☐ Conducted thorough environmental cleaning	☐ Closed facility to new admissions
☐ Discontinued group activities	☐ Used personal protective equipment

Other Comments/Details: