2017 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
2017 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 2017.

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.

I especially want to recognize our District Epidemiologist, Meredith Davis, without whose diligent efforts this report would not exist. Ms. Davis is available to assist you with any communicable disease issue and can be reached by phone 540-771-3725 or by email at Meredith.davis@vdh.virginia.gov.

Sincerely,

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

Table of Contents

2017 LFHD Population Estimates*

Clarke County	14,312
Frederick County	85,820
Page County	23,665
Shenandoah County	42,525
Warren County	39,239
Winchester City	28,005
TOTAL	233,566

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

District News and Updates

- ★ **WEB-BASED REPORTING:** It is now possible for healthcare providers to submit disease reports online. To use the secure web-based reporting system, go to http://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastate-board-of-health/, and click the red button Confidential Morbidity Report Portal (Epi-1).

- ★ **DATA DASHBOARD:** Reportable disease data are available online in an interactive dashboard (http://www.vdh.virginia.gov/surveillance-and-investigation/virginia-reportable-disease-surveillance-data/virginia-monthly-morbidity-surveillance-report-2018/). Case counts are updated on a monthly basis (on the 15th of each month for the previous month).

- ★ **TIMELINESS:** Remember that you should not wait for laboratory confirmation before notifying your local health department if you strongly suspect a reportable condition.

- ★ **FLU SURVEILLANCE:** LFHD is seeking additional sentinel surveillance providers for the 2018-19 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 16) if you are interested in becoming a sentinel site.

COMMUNICABLE DISEASE SUMMARY

In 2017, 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 rates of the most common reportable conditions in LFHD in 2017, based on an estimated total population of 233,566.

Figure 1. Rates of most frequently reported communicable disease, Lord Fairfax Health District, 2017.

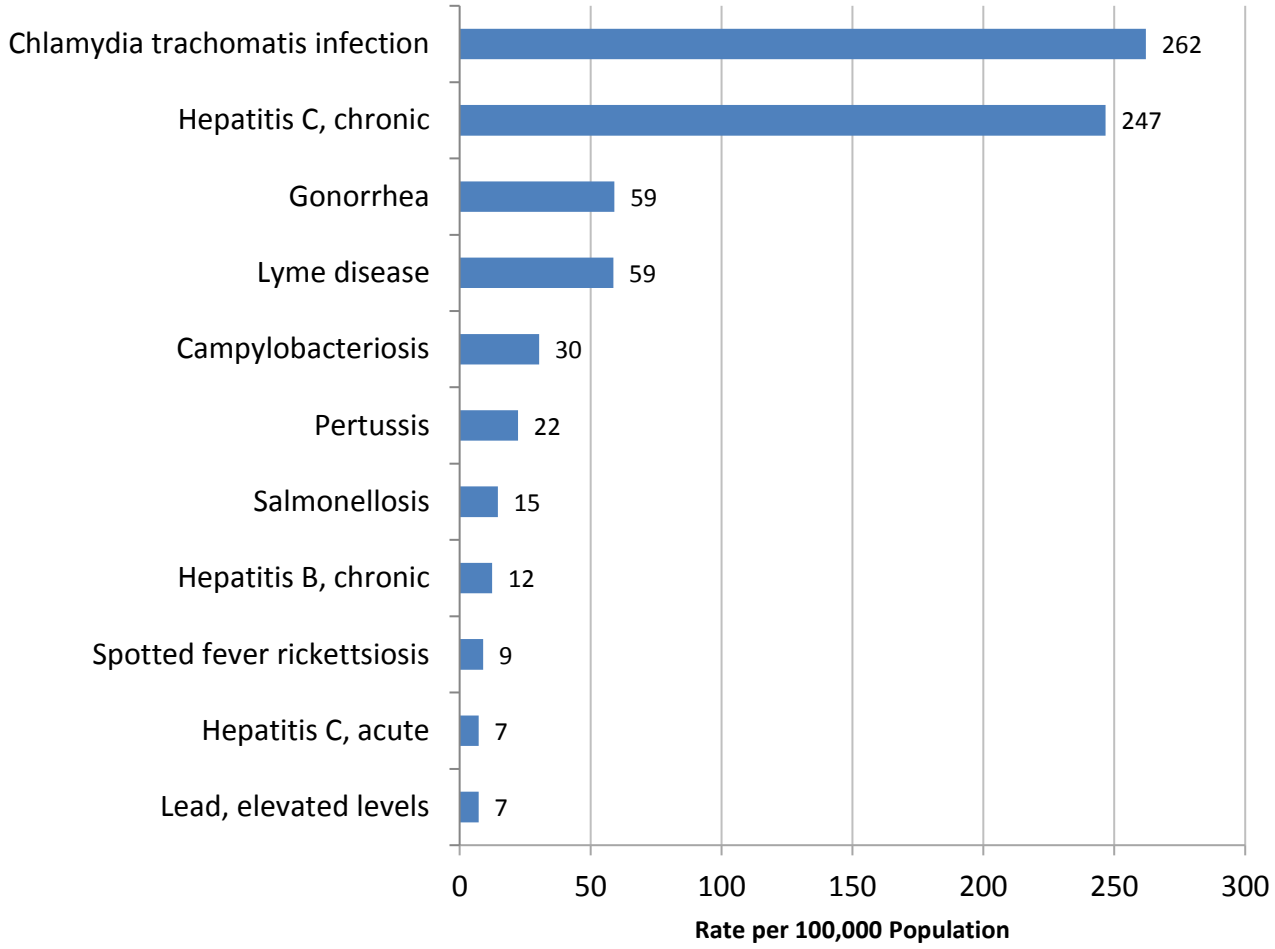


Table 1 shows counts of cases meeting surveillance case definitions for selected conditions in 2017 and the previous four years.

Table 1: Reported cases of selected diseases, Lord Fairfax Health District, 2013-2017[α].

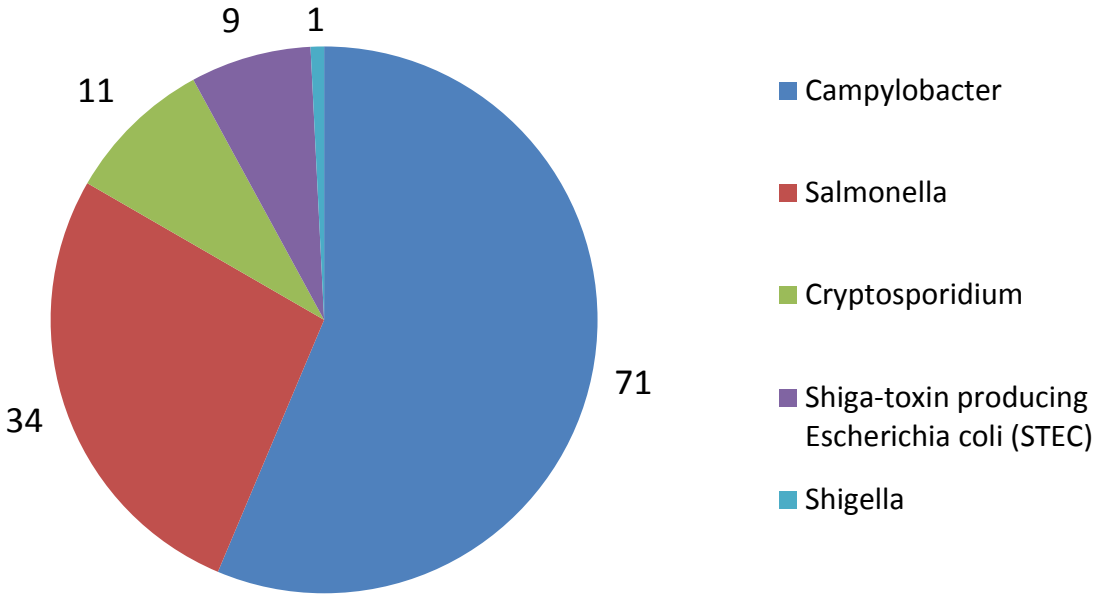
Disease	2013	2014	2015	2016	2017[α]	5 year average
Amebiasis	0	0	0	1	0	0.2
Arboviral disease*	0	0	0	3	2	0.75
Arsenic, elevated levels	0	0	2	3	3	1.6
Botulism, infant	1	0	1	0	1	0.6
Brucellosis	0	1	0	0	0	0.2
Campylobacteriosis	60	59	80	82	71	70.3
***Chlamydia trachomatis* infection**	680	631	630	573	612	625.2
Cryptosporidiosis	0	1	4	8	11	4.8
Cyclosporiasis	1	0	1	0	0	0.4
E. coli infection, shiga toxin-producing	8	12	6	12	9	9.4
Ehrlichiosis/Anaplasmosis	1	6	4	1	11	4.6
Giardiasis	6	9	6	5	4	6
Gonorrhea	99	69	79	79	138	92.8
***Haemophilus influenzae*, invasive**	8	5	6	6	8	6.6
Hepatitis A, acute	2	2	2	7	3	3.2
Hepatitis B, acute	4	2	1	2	3	2.4
Hepatitis B, chronic^	17	19	15	18	27	18
Hepatitis C, acute	4	4	2	7	17	6.8
Hepatitis C, chronic^	188	172	226	496	574	331.2
HIV	9	8	14	9	7	9.4
Lead, elevated levels**	10	3	3	14	17	9.4
Legionellosis	3	2	6	0	7	3.6
Listeriosis	0	0	0	1	0	0.2
Lyme disease	111	108	122	109	137	117.4
Meningococcal disease (*Neisseria meningitidis*)	0	0	0	0	1	0.2
Mumps	0	0	0	0	1	0.2
Pertussis	8	43	9	2	52	22.8
Q Fever	1	1	0	0	0	0.4
Salmonellosis	37	49	31	37	34	37.6
Shigellosis	1	1	5	2	1	2
Spotted Fever Rickettsiosis (including RMSF†)	14	15	7	6	21	12.6
***Streptococcus pneumoniae*, invasive (age < 5)**	3	0	0	1	2	1.2
Streptococcus, Group A, invasive	7	18	9	8	14	11.2
Syphilis - early stage	0	4	5	6	8	4.6
Toxic-shock syndrome, streptococcal	0	0	1	1	4	1.2
Tuberculosis	2	2	1	1	1	1.4
Varicella (Chickenpox)	19	14	20	2	12	13.4
Vibriosis, non-cholera	0	0	1	0	0	0.2
Yersiniosis	0	2	0	1	0	0.6

[α]2017 data are provisional; * Arboviral infection = West Nile Virus and Zika virus; ^ chronic hepatitis cases counted the year they are initially reported to public health; ** Lead = blood lead levels ≥5 ug/dL; †RMSF = Rocky Mountain Spotted Fever

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 caused by FoodNet agents in LFHD in 2017.

Figure 2. Number of foodborne illness cases, by causal agent, Lord Fairfax Health District, 2017.



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

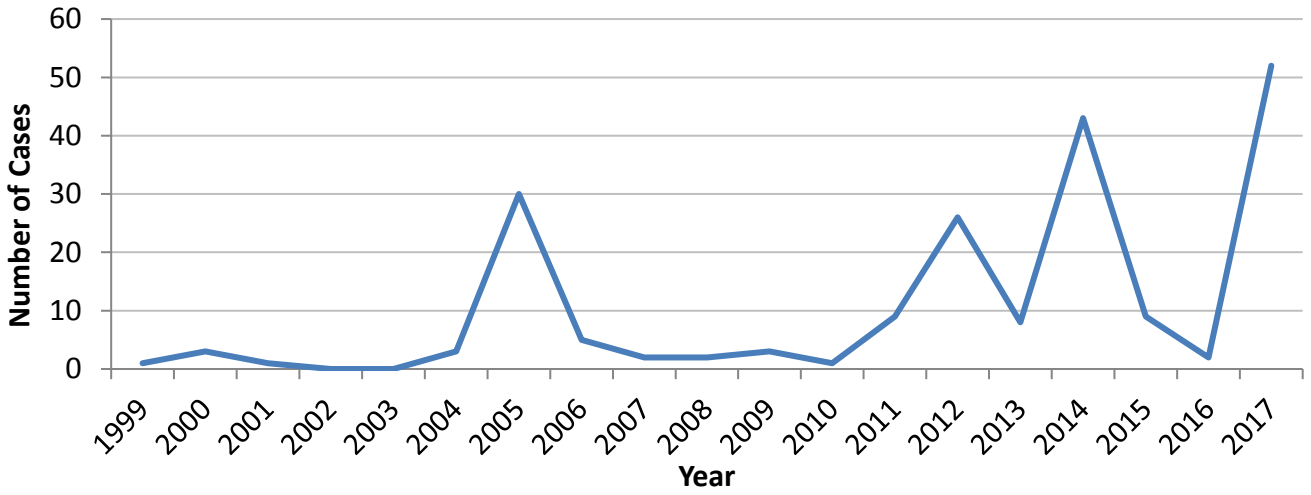
- Investigate each reported case of a foodborne illness. During the investigation, LFHD will provide prevention information, identify potential sources of infection, and recommend control measure to prevent further disease transmission.
- Inspect facilities, including restaurants, when indicated during 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. 2014. MMWR Weekly. 63(15);328-332. http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6315a3.htm

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. In 2016, there were approximately 18,000 reported cases of pertussis nationwide.[2] LFHD experienced two pertussis outbreaks in 2017, one in Warren County, and one in Frederick County/Winchester City, leading to the highest annual case count in many years (n=52; Figure 3).

Figure 3. Number of pertussis cases, Lord Fairfax Health District, 1999-2017.



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 patients are fully vaccinated according to ACIP Guidelines.
- Ensure that ALL staff are immunized with Tdap.
- Report suspected cases to LFHD as soon as the case is suspected. Laboratory confirmed is not required if clinical presentation strongly indicates pertussis.

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.

[2] CDC, 2017. Reported cases of notifiable diseases and rates per 100,000, excluding U.S. territories – United States, 2016. https://wonder.cdc.gov/nndss/static/2016/annual/2016-table1-H.pdf

HEPATITIS B AND C

Hepatitis, or liver inflammation, can be caused by a variety of factors, including infection with hepatitis viruses. The most common types of viral hepatitis are A, B, and C; hepatitis B and C can range from a mild, acute illness to serious chronic conditions.[3] Sharing items that may be contaminated with blood is a risk factor for both hepatitis B and C, and the ongoing opioid epidemic in the U.S. is likely related to an increase in acute hepatitis C infections.

Surveillance for chronic hepatitis B and C is challenging, since many people are asymptomatic any may not seek health care. The CDC estimates that 850,000-2.2 million people in the U.S. are living with chronic hepatitis B, and 3.5 million with chronic hepatitis C, with many being unaware they are infected. Chronic hepatitis case counts for a given year represent cases newly reported to public health that year; they do not reflect year of diagnosis or year of infection.

The number of acute and chronic hepatitis B cases in Lord Fairfax Health District are shown in Figure 4, and acute and chronic hepatitis C cases in LFHD in Figure 5.

Figure 4. Acute and chronic hepatitis B cases, Lord Fairfax Health District, 2013-2017.

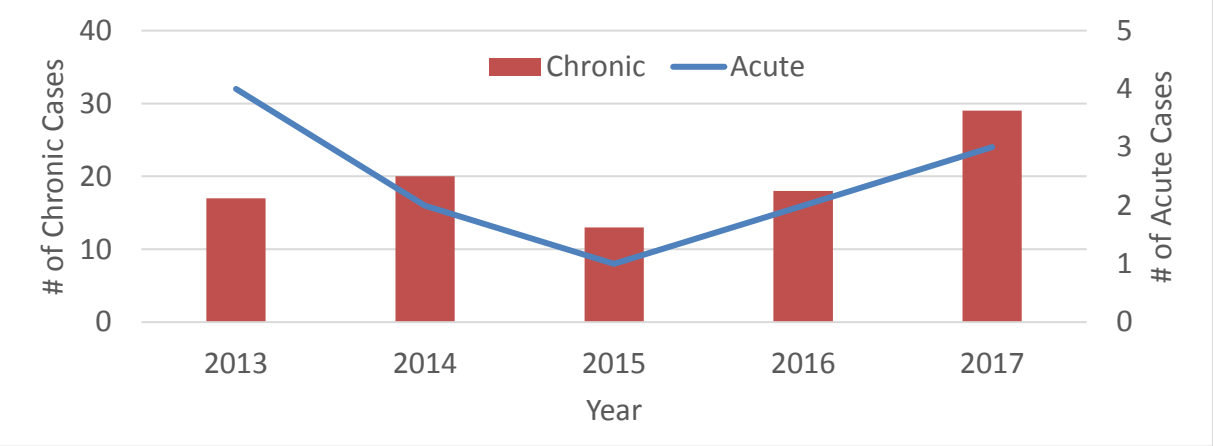
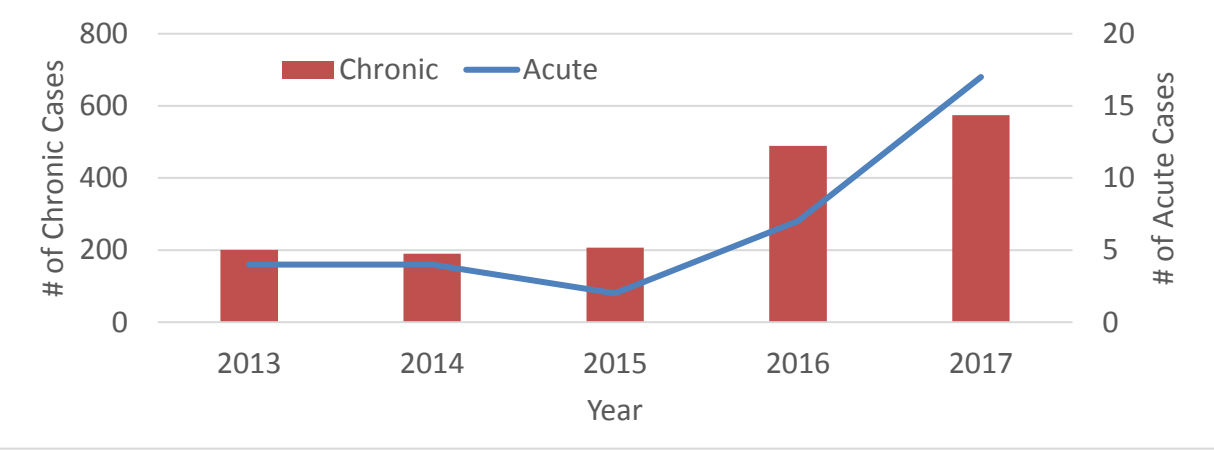


Figure 5. Acute and chronic hepatitis C cases, Lord Fairfax Health District, 2013-2017.



[3] CDC, 2018. Viral hepatitis. https://www.cdc.gov/hepatitis/abc/index.htm, Accessed July 6, 2018.

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. There was one human rabies case in Virginia in 2017, not in LFHD. Controlling rabies depends on vaccination of domestic pets, especially dogs, and use of rabies vaccine for post-exposure prophylaxis (PEP) after a possible rabies exposure to humans.

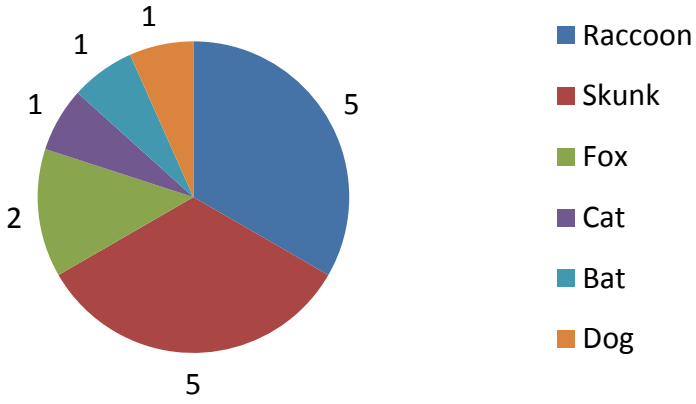
Table 2. Number of potential human rabies exposures, LFHD, 2017.

Jurisdiction	Number of Encounters
Clarke	36
Frederick	313
Page	97
Shenandoah	172
Warren	245
Winchester	103
Total	**966**

LFHD received reports of 967 human exposures to potentially rabid animals in 2017; all but one occurred within LFHD's jurisdiction (Table 2). Of those, 42 people (about 4%) 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.

In 2017, LFHD tested 130 animals for rabies; 15 were positive. Among these were 5 raccoons, 5 skunks, and 1 dog (Figure 6).

Figure 6. Animals testing positive for rabies, LFHD, 2017.



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

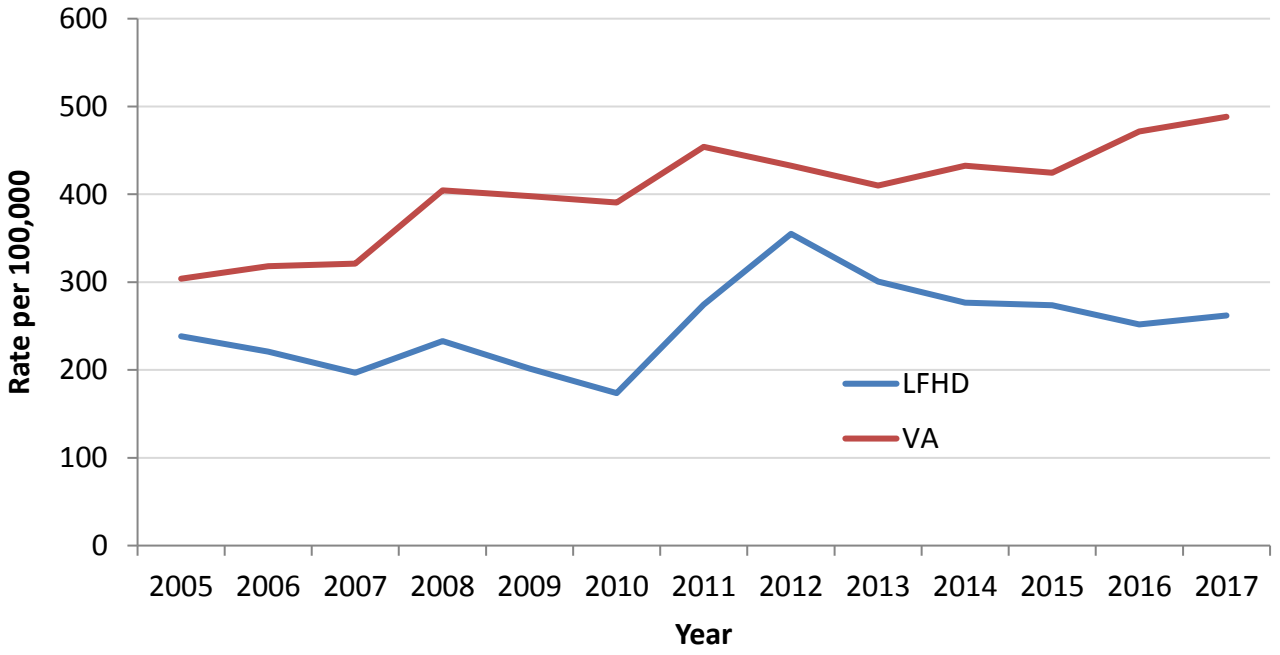
- Report all exposures immediately to your local health department.
- Not all individuals exposed to a potentially rabid animal will need post-exposure prophylaxis (PEP). If the animal is located, PEP should be delayed pending results of animal testing or confinement.
- When feasible, the full dose of 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 2016, there were 1.6 million cases of chlamydia in the U.S., a rate of 497 cases per 100,000 people.[4] Chlamydia is associated 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 7).

Figure 7. Chlamydia rates by year, Lord Fairfax Health District and Virginia, 2008-2017.



**2017 data are preliminary*

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 16) for hours and appointments.

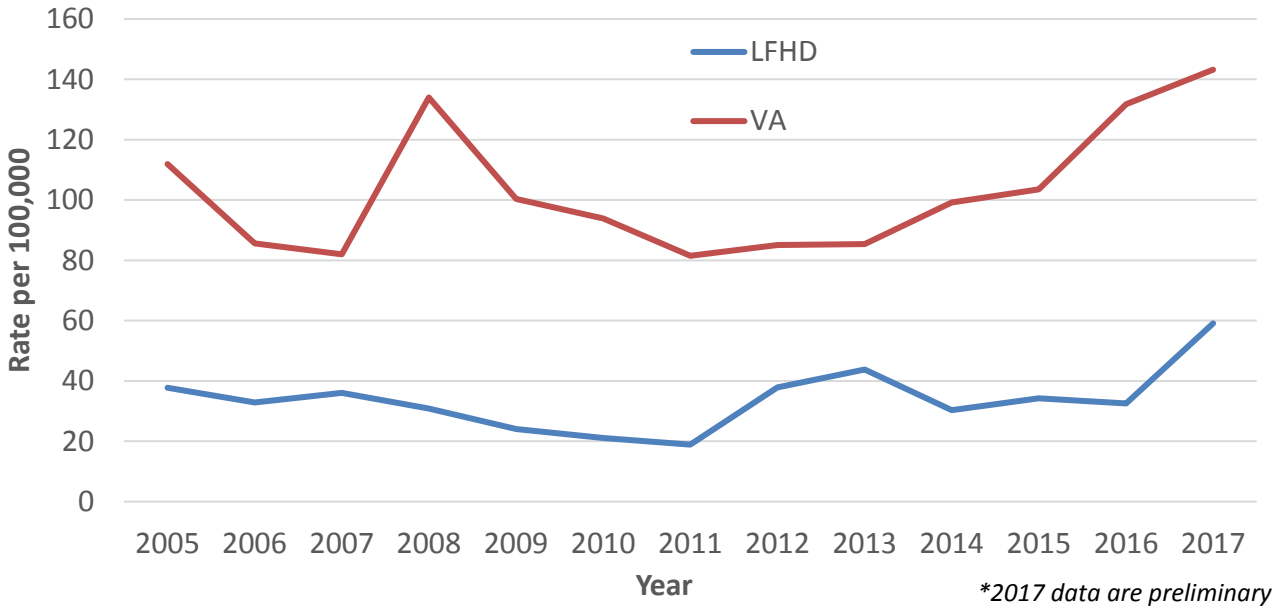
[4] CDC. Reported STDs in the United States. https://www.cdc.gov/std/stats16/default.htm. Accessed May 22, 2018.

GONORRHEA

Gonorrhea is a bacterial infection caused by *Neisseria gonorrhoeae.* It is the second most commonly reported notifiable disease in the U.S. Gonorrhea is transmitted through sexual contact and perinatally from mother to child during birth. Untreated gonorrhea can cause pelvic inflammatory disease in women, infertility in men, and disseminated gonococcal infection in anyone. In 2016, there were 468,514 cases of gonorrhea in the U.S., or 145.8 cases per 100,000 people.

In LFHD, the gonorrhea rate in 2017 was 59.1 per 100,000, a significant increase from previous years. However, the LFHD rate remained well below the statewide rate of 143.2 per 100,000.

Figure 8. Gonorrhea rates by year, Lord Fairfax Health District and Virginia, 2008-2017.



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 gonorrhea.
- Sexually active men who have sex with men should be tested annually for gonorrhea.
- Sexual partners of those diagnosed with gonorrhea 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

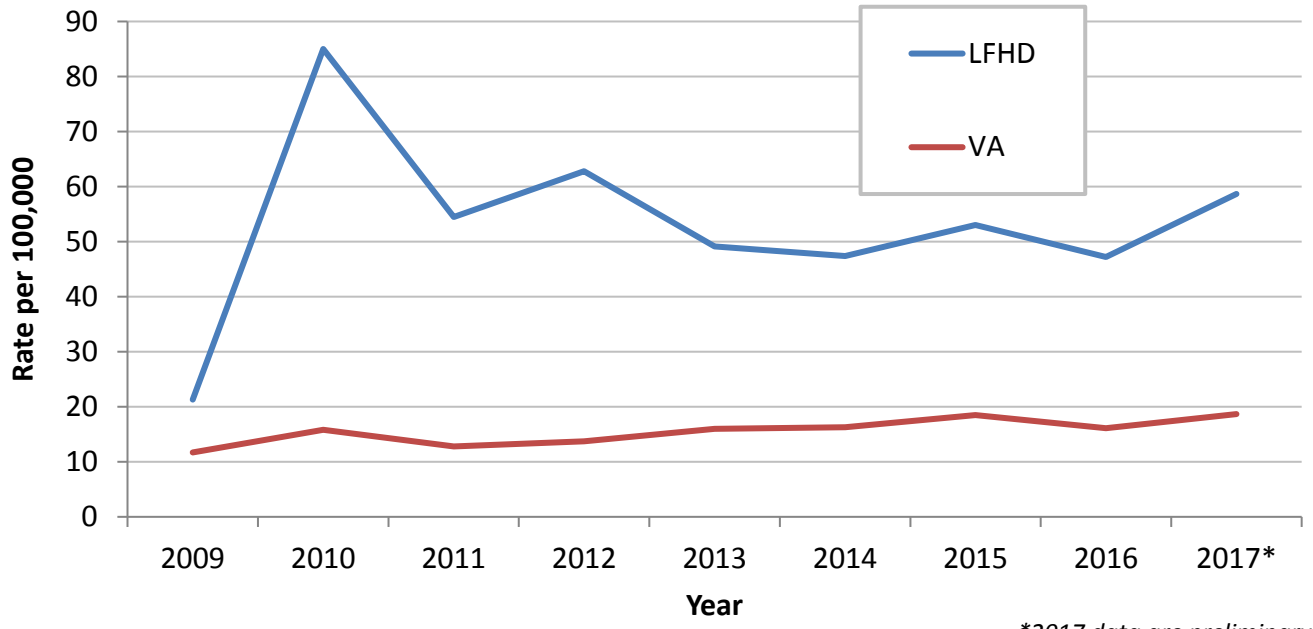
- Testing for gonorrhea is available at local health departments in LFHD.
- Please call the local health department (see page 16) for hours and appointments.

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.

As shown in Figure 9, 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 2017, there were 137 cases of Lyme disease, 21 cases of RMSF, 9 cases of ehrlichiosis, and 2 cases of anaplasmosis.

Figure 9. Rates of Lyme Disease, Lord Fairfax Health District and Virginia, 2009-2017.

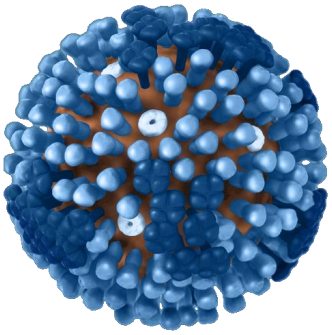


**2017 data are preliminary*

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 (see page 16).
- 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.
- CDC recommends empiric treatment with doxycycline for patients with suspected RMSF.

INFLUENZA (FLU)



According to the Centers for Disease Control and Prevention (CDC), the 2017-2018 U.S. influenza season was characterized by high severity and widespread geographic activity for an extended period. Peak activity occurred during January and February. The highest percentage of outpatient visits for influenza-like illness (ILI) was 7.5%, significantly higher than the previous several years.[5] 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 171 laboratory-confirmed, influenza-associated pediatric deaths in the U.S during the 2017-18 season. There were no reported influenza-associated pediatrics deaths in LFHD.

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.

For Healthcare Providers

- The Advisory Committee on Immunization Practices (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 once again available and recommended as an option by ACIP.[6]
- 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 16) for more information.

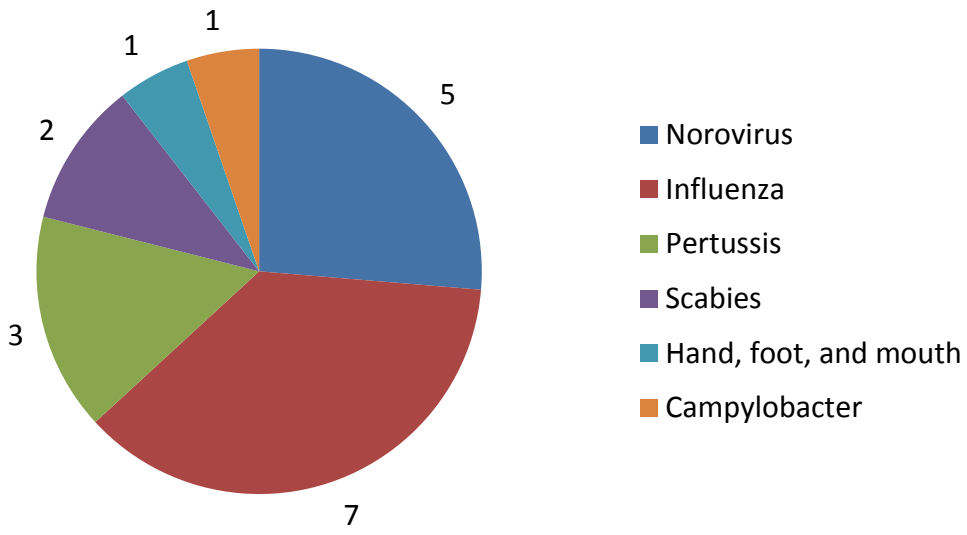
[5] CDC, 2018. Update: Influenza activity in the United States during the 2017-18 season and composition of the 2018-19 influenza vaccine. https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a4.htm?s_cid=mm6722a4_x.
[6] CDC, 2018. Update: ACIP recommendations for the use of quadrivalent live attenuated influenza vaccine (LAIV4) – United States, 2018-19 influenza season. https://www.cdc.gov/mmwr/volumes/67/wr/mm6722a5.htm?s_cid=mm6722a5_x.

OUTBREAK SUMMARY, 2017

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 2017, LFHD investigated 19 outbreaks of illness, 7 (37%) caused by influenza, 5 (26%) by norovirus, and 3 (16%) by pertussis (Figure 10). The majority of outbreaks (13; 68%) occurred in nursing homes or assisted living facilities.

Figure 10. Outbreaks in Lord Fairfax Health District, by etiology, 2017.



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, 2017[α]

Disease	Clarke	Frederick	Page	Shenandoah	Warren	Winchester	Total
Arboviral infection	0	0	0	0	1	1	**2**
Botulism, infant	0	1	0	0	0	0	**1**
Campylobacteriosis	8	13	10	29	6	5	**71**
***Chlamydia trachomatis* infection**	28	195	49	110	96	134	**612**
Cryptosporidiosis	1	4	1	2	1	2	**11**
E. coli infection, shiga toxin-producing	0	5	1	0	2	1	**9**
Ehrlichiosis/Anaplasmosis	1	5	0	0	3	2	**11**
Giardiasis	0	0	0	1	3	0	**4**
Gonorrhea	5	38	14	15	30	36	**138**
***Haemophilus influenzae*, invasive**	0	3	3	1	1	0	**8**
Hepatitis A, acute	0	2	0	1	0	0	**3**
Hepatitis B, acute	0	1	1	0	1	0	**3**
Hepatitis B, chronic	0	10	1	3	2	11	**27**
Hepatitis C, acute	0	5	1	2	6	4	**17**
Hepatitis C, chronic	20	144	38	63	122	187	**574**
HIV	0	3	0	1	2	1	**7**
Lead, elevated levels*	0	2	0	3	2	2	**17**
Legionellosis	1	1	0	4	0	1	**7**
Lyme disease	9	57	15	22	23	11	**137**
Meningococcal disease (*Neisseria meningitidis*)	0	0	0	1	0	0	**1**
Mumps	0	0	1	0	0	0	**1**
Pertussis	1	21	0	4	23	3	**52**
Salmonellosis	4	10	6	9	2	3	**34**
Shigellosis	0	1	0	0	0	0	**1**
Spotted Fever Rickettsiosis (including RMSF)	3	9	1	5	2	1	**21**
***Streptococcus pneumoniae*, invasive (age < 5)**	0	1	0	1	0	0	**2**
Streptococcus, Group A, invasive, or TSS	1	7	0	1	5	4	**18**
Syphilis - early stage	0	1	0	2	1	4	**8**
Tuberculosis	0	1	0	0	0	0	**1**
Varicella (Chickenpox)	1	4	1	2	2	2	**12**

[α]2017 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	Phone	Fax
Clarke County	100 North Buckmarsh Street, Berryville VA 22611	540-955-1033	540-955-4094
Frederick/Winchester	10 Baker Street, Winchester VA 22601	540-722-3470	540-722-3475
Page County	75 Court Lane, Luray VA 22835	540-743-6528	540-743-3811
Shenandoah County	494 North Main Street, #100, Woodstock VA 22664	540-459-3733	540-459-8267
Warren County	465 West 15th Street, Suite 200, Front Royal VA 22630	540-635-3159	540-635-9698
After Hours Phone		540-665-8611	
District Epidemiologist		540-771-3725	

Data Source

Unless otherwise noted, data are LFHD primary surveillance data available in the Virginia Electronic Disease Surveillance System (VEDSS) as of June 8, 2018. All 2017 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) via web, 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: