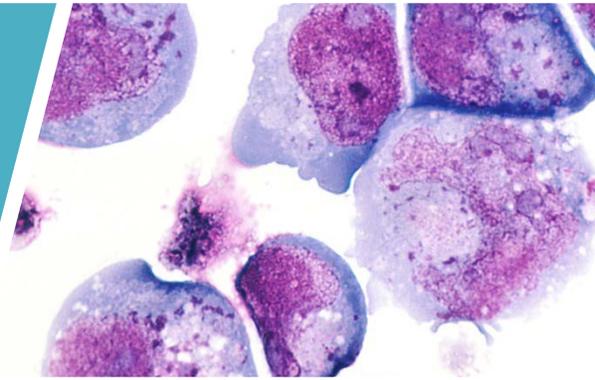




Communicable Disease Provider Packet

May 2019



LONG BEACH
HEALTH & HUMAN SERVICES

TABLE OF CONTENTS

1 DISEASE REPORTING	3
Reportable Disease and Conditions Letter from City Health Officer	5
Reportable Disease and Conditions	6
HIPAA and Public Health Disclosures	7
Confidential Morbidity Report	9
Influenza Death Case History Form.....	10
Carbapenem-Resistant Enterobacteriaceae Report	11
CalREDIE Provider Portal.....	12
2 STD GUIDELINES AND RECOMMENDATIONS	13
Syphilis Stages, Symptoms and Treatment.....	15
Syphilis Testing Algorithm.....	16
Recommendations for Syphilis Testing	17
California STD Treatment Guidelines Table for Adults and Adolescents.....	18
3 HIV REPORTING	20
HIV Adult Case Report Form	21
HIV Adult Case Report Form Instructions	25
Request for Patient Information.....	27
HIV Diagnostic Testing Algorithm.....	28

1 DISEASE REPORTING

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ANISSA DAVIS, MD, MPH
City Health Officer

November 14, 2018

SUBJECT: REPORTABLE DISEASES AND CONDITIONS

For the purposes of disease surveillance, prevention, and control efforts, public health professionals, medical providers, and other mandated reporters within the State of California have a legal responsibility to provide information necessary for the public health investigation of a reportable communicable disease to their local health department within the required timeframe (California Code of Regulations, Title 17, Section 2500). Under State laws, the reporting of communicable diseases to the local public health department is exempt from HIPAA (Section 164.512 [b]). Patient consent is not required. Patient information is always treated with strict confidence, and information requested is the minimum necessary for public health purposes.

The [list of reportable diseases](#) in the City of Long Beach is attached to this packet. To report a disease or condition, providers and mandated reporters must submit a Confidential Morbidity Report (CMR) to the local health department of the patient's jurisdiction of residence. All Southern California counties, in addition to the cities of Pasadena and Long Beach, operate their own local health department.

Diseases that are investigated in the City of Long Beach are reported to the California Department of Public Health (CDPH) via the California Reportable Disease Information Exchange (CalREDIE), a web-based disease reporting and surveillance system for reportable diseases and conditions in California. Healthcare providers may also choose to report communicable diseases electronically through CalREDIE using the [provider portal](#) (refer to flyer).

Thank you for your assistance with improving the health and safety of Long Beach residents. If you have questions, please contact the Epidemiology Program at (562) 570-4302.

REPORTABLE DISEASES AND CONDITIONS

Title 17, California Code of Regulations (CCR) §2500

It shall be the duty of every health care provider, knowing of or in attendance on a case or suspected case of any of the diseases or condition listed below, to report to the local health officer for the jurisdiction where the patient resides. Where no health care provider is in attendance, any individual having knowledge of a person who is suspected to be suffering from one of the diseases or conditions listed below may make such a report to the local health officer for the jurisdiction where the patient resides.

URGENCY REPORTING REQUIREMENTS

☎=Report immediately by telephone

☒=Report within 1 working day

Report within 7 calendar days from time of identification

REPORTABLE DISEASES

- ☒ Amebiasis
- Anaplasmosis
- ☎ Anthrax
- ☒ Babesiosis
- ☎ Botulism (Infant, Foodborne, Wound)
- Brucellosis, animal (except infections due to *Brucella canis*)
- ☎ Brucellosis, human
- ☒ Campylobacteriosis
- Chancroid
- ☒ Chickenpox (Varicella), (outbreaks, hospitalizations and deaths)
- ☒ Chikungunya Virus Infection
- Chlamydia trachomatis* infections, including Lymphogranuloma Venereum (LGV)
- ☎ Cholera
- ☎ Ciguatera Fish Poisoning
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- ☒ Cryptosporidiosis
- Cyclosporiasis
- Cysticercosis or Taeniasis
- ☎ Dengue Virus Infection
- ☎ Diphtheria
- ☎ Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- Ehrlichiosis
- ☒ Encephalitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ☎ *Escherichia coli*: shiga toxin producing (STEC) including *E. coli* O157
- ☎ Flavivirus Infection of Undetermined Species
- ☒ Foodborne Disease
- Giardiasis
- Gonococcal Infections
- ☒ *Haemophilus influenzae*, invasive disease, all serotypes (report an incident of less than 5 years of age)
- ☒ Hantavirus Infections
- ☎ Hemolytic Uremic Syndrome
- ☒ Hepatitis A
- Hepatitis B (specify acute case or chronic)
- Hepatitis C (specify acute case or chronic)
- Hepatitis D (Delta) (specify acute case or chronic)
- Hepatitis E, acute infection
- Human Immunodeficiency Virus (HIV) Infection, stage 3 (AIDS)
- Human Immunodeficiency Virus (HIV), Acute
- ☎ Influenza, novel strains (human)
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- ☒ Listeriosis
- Lyme Disease
- ☒ Malaria
- ☎ Measles (Rubeola)
- ☒ Meningitis, Specify Etiology: Viral, Bacterial, Fungal, Parasitic
- ☎ Meningococcal Infections
- Mumps
- ☎ Novel Virus Infection with Pandemic Potential
- ☎ Paralytic Shellfish Poisoning
- ☒ Pertussis (Whooping Cough)
- ☎ Plague, Human or Animal
- ☒ Poliovirus Infection
- ☒ Psittacosis
- ☒ Q Fever
- ☎ Rabies, Human or Animal
- ☒ Relapsing Fever
- Rickettsial Diseases (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-like illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- Respiratory Syncytial Virus (only report a death in a patient less than five years of age)
- ☒ Salmonellosis (Other than Typhoid Fever)
- ☎ Scombroid Fish Poisoning
- ☎ Shiga toxin (detected in feces)
- ☒ Shigellosis
- ☎ Smallpox (Variola)
- ☒ Streptococcal Infections (Outbreaks of any type and Individual Cases in Food Handlers and Dairy Workers Only)
- ☒ Syphilis
- Tetanus
- ☒ Trichinosis
- ☒ Tuberculosis†
- Tularemia, animal
- ☎ Tularemia, human
- ☒ Typhoid Fever, Cases and Carriers
- ☒ *Vibrio* Infections
- ☎ Viral Hemorrhagic Fevers (e.g., Crimean-Congo, Ebola, Lassa, and Marburg viruses)
- ☒ West Nile Virus (WNV) Infection
- ☎ Yellow Fever
- ☒ Yersiniosis
- ☎ Zika Virus Infection
- ☎ OCCURRENCE of ANY UNUSUAL DISEASE
- ☎ OUTBREAKS of ANY DISEASE (Including diseases not listed in §2500). Specify if institutional and/or open community.

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.5-2643.20

Human Immunodeficiency Virus (HIV) infection is reportable by traceable mail or person-to-person transfer within seven calendar days by completion of the HIV/AIDS Case Report form (CDPH 8641A) available from the local health department. For completing HIV-specific reporting requirements, see Title 17, CCR, §2641.5-2643.20 and <http://www.cdph.ca.gov/programs/aids/Pages/OAHIVReporting.aspx>

REPORTABLE NONCOMMUNICABLE DISEASES AND CONDITIONS §2800–2812 and §2593(b)

Disorders Characterized by Lapses of Consciousness (§2800-2812)

Pesticide-related illness or injury (known or suspected cases)**

Cancer, including benign and borderline brain tumors (except (1) basal and squamous skin cancer unless occurring on genitalia, and (2) carcinoma in-situ and CIN III of the cervix) (§2593)**

LOCALLY REPORTABLE DISEASES (If Applicable):

- ☒ Positive Skin Tests in Children Less Than 3 years of Age Without History of BCG Vaccination;
- Carbapenem-Resistant Enterobacteriaceae (CRE) (Acute care hospitals and skilled nursing facilities only) Report monthly via NHSN. If not enrolled in NHSN, must report by CMR.
- ☒ *Norovirus* in Food Employees
- Influenza, deaths in lab-confirmed cases

To report a case or outbreak of any disease contact the Epidemiology Program:

Phone: (562) 570-4302 • Fax: (562) 570-4374 • After Hours: (562) 500-5537 • HIV/STD Hotline: (562) 570-4321

* Failure to report is a misdemeanor (Health and Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).** Failure to report is a citable offense and subject to civil penalty (§250) (Health and Safety Code §105200).

*** The Confidential Physician Cancer Reporting Form may also be used. See Physician Reporting Requirements for Cancer Reporting in CA at: www.ccrca.org.
CDPH 110a (revised 2/2017)



RON CHAPMAN, MD, MPH
Director

State of California—Health and Human Services Agency
California Department of Public Health



EDMUND G. BROWN JR.
Governor

June 15, 2012

To All California Health Care Providers:

Re: HIPAA and Public Health Disclosures

Dear Health Care Provider,

There has been some confusion surrounding the effect of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule on public health reporting requirements. Therefore, the California Department of Public Health is providing this document to clarify your ongoing legally mandated reporting requirements.

Your reporting obligations for communicable diseases have not changed under HIPAA. Furthermore, you continue to have a legal obligation to provide information for public health, surveillance/reporting, investigations and interventions.

The HIPAA Privacy Rule (at 45 Code of Federal Regulations, § 160.203(c) indicates that State law, including State procedures established under such law, is not preempted or overridden by contrary HIPAA privacy provisions in the area of public health disease or injury reporting and the conduct of public health surveillance, investigation, or intervention. The following provisions of State law are applicable and are not preempted by HIPAA:

Under California law, health care providers are required to report specified diseases or conditions to the local health officer for the jurisdiction where the patient resides. (Cal. Code Regulations, title 17, § 2500.) The State and local health departments are authorized by law to conduct infectious disease investigations and interventions. Upon receiving a report of a disease, the local health officer must take whatever steps are deemed necessary for the investigation and control of the disease, condition or outbreak reported. (Cal. Code Regulations, title 17, § 2501.) Further, local health officers must prepare individual case and outbreak reports and provide these to the State Department of Public Health. It is mandatory to supply personal health information related to the individual's disease to the local health officer who collects the information in order to prepare such case reports. (Cal. Code Regulations, title 17, § 2502(g)). The authority of local health officers with respect to reportable and communicable diseases is spelled out in the Health and Safety Code, § 120175:

"Each health officer knowing or having reason to believe that any case of the diseases made reportable by regulation of the department, or any other contagious, infectious or communicable disease exists, or has recently existed, within the territory under his or her jurisdiction, shall take measures as may be necessary to prevent the spread of the disease or occurrence of additional cases."

With respect to sexually transmitted diseases, Health and Safety Code, § 120575 provides:

"It is the duty of the local health officers to use every available means to ascertain the existence of cases of infectious venereal diseases within their respective jurisdictions, to investigate all cases that are not, or probably are not, subject to proper control measures approved by the board, to ascertain so far as possible all sources of infection, and to take all measures reasonably necessary to prevent the transmission of infection."

State law also makes it a misdemeanor if you do not provide the requested information to aid in the conduct of the investigation of sexually transmitted diseases. (Health & Safety Code, §120600.)

The California Department of Public Health appreciates your cooperation in continuing to protect the health, safety, and privacy of all Californians and stands ready to help you in these challenging times with data, security and privacy requirements.

If you have any further questions, we advise you to contact your local attorney. You may also contact Dr. Bauer directly at the number or email below.

Sincerely,



Heidi Bauer, M.D., M.P.H.
Chief, STD Control Branch
(510) 620-3178
Heidi.bauer@cdph.ca.gov



Stephen A. Stuart
Senior Counsel and Privacy Officer
Privacy Office, Office of Legal Services
(916) 440-7432 or (877) 421-9634
Stephen.Stuart@CDPH.ca.gov
or Privacy@CDPH.ca.gov

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Use this form for reporting all conditions except Tuberculosis, HIV, and conditions reportable to DMV.

DISEASE BEING REPORTED

Patient Name - Last Name		First Name		MI	Ethnicity (check one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino <input type="checkbox"/> Unknown	
Home Address: Number, Street				Apt./Unit No.		
City		State	ZIP Code			
Home Telephone Number		Cell Telephone Number		Work Telephone Number		
Email Address				Primary Language <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____		
Birth Date (mm/dd/yyyy)		Age	<input type="checkbox"/> Years <input type="checkbox"/> Months <input type="checkbox"/> Days		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Not Listed <input type="checkbox"/> M to F Transgender <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Gender Non-Binary <input type="checkbox"/> Gender Queer	
Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Est. Delivery Date (mm/dd/yyyy)		Country of Birth		
Occupation or Job Title				Occupational or Exposure Setting (check all that apply): <input type="checkbox"/> Food Service <input type="checkbox"/> Day Care <input type="checkbox"/> Health Care <input type="checkbox"/> Correctional Facility <input type="checkbox"/> School <input type="checkbox"/> Other (specify): _____		

Date of Onset (mm/dd/yyyy)	Date of First Specimen Collection (mm/dd/yyyy)	Date of Diagnosis (mm/dd/yyyy)	Date of Death (mm/dd/yyyy)
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Reporting Health Care Provider		Reporting Health Care Facility		REPORT TO: City of Long Beach Department of Health & Human Services Epidemiology Program 2525 Grand Ave, Room 229 Long Beach, CA 90815 Phone: (562) 570-4302 STD/HIV Phone: (562) 570-4321 Fax: (562) 570-4374 (Obtain additional forms from your local health department.)	
Address: Number, Street		Suite/Unit No.			
City		State	ZIP Code		
Telephone Number		Fax Number			
Submitted by		Date Submitted (mm/dd/yyyy)			

Laboratory Name	City	State	ZIP Code
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SEXUALLY TRANSMITTED DISEASES (STDs)

Gender of Sex Partners (check all that apply) <input type="checkbox"/> Male <input type="checkbox"/> M to F Transgender <input type="checkbox"/> Female <input type="checkbox"/> F to M Transgender <input type="checkbox"/> Unknown <input type="checkbox"/> Gender Non-Binary <input type="checkbox"/> Not Listed <input type="checkbox"/> Gender Queer	STD TREATMENT <input type="checkbox"/> Treated in office <input type="checkbox"/> Given prescription Drug(s), Dosage, Route _____ _____	Treatment Began (mm/dd/yyyy) _____ _____	<input type="checkbox"/> Untreated <input type="checkbox"/> Will treat <input type="checkbox"/> Unable to contact patient <input type="checkbox"/> Patient refused treatment <input type="checkbox"/> Referred to: _____
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If reporting Syphilis, Stage: <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Secondary <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Latent (unknown duration) <input type="checkbox"/> Late latent > 1 year <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Congenital Neurosyphilis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Syphilis Test Results <input type="checkbox"/> RPR <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> VDRL <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> FTA-ABS <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> TP-PA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> EIA/CLIA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other: _____ On PrEP for HIV Prevention? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Titer _____ _____	If reporting Chlamydia and/or Gonorrhea: Specimen Source(s) (check all that apply) <input type="checkbox"/> Cervical <input type="checkbox"/> Pharyngeal <input type="checkbox"/> Rectal <input type="checkbox"/> Urethral <input type="checkbox"/> Urine <input type="checkbox"/> Vaginal <input type="checkbox"/> Other: _____	If reporting Pelvic Inflammatory Disease: (check all that apply) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Cervical <input type="checkbox"/> Gonococcal PID <input type="checkbox"/> No <input type="checkbox"/> Chlamydial PID <input type="checkbox"/> Unknown <input type="checkbox"/> Other/Unknown Etiology PID Partner(s) Treated? <input type="checkbox"/> Yes, treated in this clinic <input type="checkbox"/> No, instructed patient to refer partner(s) for treatment <input type="checkbox"/> Yes, Meds/Prescription given to patient for their partner(s) <input type="checkbox"/> No, referred partner(s) to: _____ <input type="checkbox"/> Yes, other: _____ <input type="checkbox"/> Unknown
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VIRAL HEPATITIS

Diagnosis (check all that apply) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B (acute) <input type="checkbox"/> Hepatitis B (chronic) <input type="checkbox"/> Hepatitis B (perinatal) <input type="checkbox"/> Hepatitis C (acute) <input type="checkbox"/> Hepatitis C (chronic) <input type="checkbox"/> Hepatitis D <input type="checkbox"/> Hepatitis E	Is patient symptomatic? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Suspected Exposure Type(s) <input type="checkbox"/> Blood transfusion, dental or medical procedure <input type="checkbox"/> IV drug use <input type="checkbox"/> Other needle exposure <input type="checkbox"/> Sexual contact <input type="checkbox"/> Household contact <input type="checkbox"/> Perinatal <input type="checkbox"/> Child care <input type="checkbox"/> Other: _____	ALT (SGPT) Result: _____ Upper Limit: _____ AST (SGOT) Result: _____ Upper Limit: _____ Bilirubin result: _____	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th>Pos</th> <th>Neg</th> <th></th> <th>Pos</th> <th>Neg</th> </tr> </thead> <tbody> <tr> <td>Hep A anti-HAV IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep C anti-HCV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Hep B HBsAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>RIBA</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBc total</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>HCV RNA (e.g., PCR)</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBc IgM</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep D anti-HDV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>anti-HBs</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Hep E anti-HEV</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>HBeAg</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>anti-HBe</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> </tr> <tr> <td>HBV DNA: _____</td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>		Pos	Neg		Pos	Neg	Hep A anti-HAV IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep C anti-HCV	<input type="checkbox"/>	<input type="checkbox"/>	Hep B HBsAg	<input type="checkbox"/>	<input type="checkbox"/>	RIBA	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc total	<input type="checkbox"/>	<input type="checkbox"/>	HCV RNA (e.g., PCR)	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBc IgM	<input type="checkbox"/>	<input type="checkbox"/>	Hep D anti-HDV	<input type="checkbox"/>	<input type="checkbox"/>	anti-HBs	<input type="checkbox"/>	<input type="checkbox"/>	Hep E anti-HEV	<input type="checkbox"/>	<input type="checkbox"/>	HBeAg	<input type="checkbox"/>	<input type="checkbox"/>				anti-HBe	<input type="checkbox"/>	<input type="checkbox"/>				HBV DNA: _____					
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HBV DNA: _____																																																									

Remarks:

INFLUENZA DEATH CASE HISTORY FORM

Fax this form to (562) 570-4374

PATIENT INFORMATION				
Last name		First name		Date of birth
Street address		City	Zip code	Local health jurisdiction of residence
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	Race <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> Native American <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other <input type="checkbox"/> Unknown		
ONSET, VACCINATION HISTORY, HOSPITALIZATION AND DEATH INFORMATION				
Date of onset of symptoms	Received this season's influenza vaccine? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Date received: Dose 1		Dose 2
If hospitalized, hospital name and location		Date of hospital admission		Date of hospital discharge
If died, date of death	If died, location of death (e.g. home, ED-name of hospital ED, etc.)			If died, autopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
INFLUENZA LABORATORY TESTING INFORMATION (Please attach a copy of the test result, if available)				
Date of specimen collection	Specimen type (e.g. nasopharyngeal swabs, endotracheal aspirate, bronchoalveolar lavage)			
Influenza type and/or subtype Influenza A: <input type="checkbox"/> (H3) <input type="checkbox"/> (2009H1N1) <input type="checkbox"/> (A Unknown – PCR) <input type="checkbox"/> (A Unknown – rapid test, culture or DFA) <input type="checkbox"/> (A – PCR unsubtypeable (i.e. novel)) Influenza B: <input type="checkbox"/> (Yamagata) <input type="checkbox"/> (Victoria) <input type="checkbox"/> (B Unknown) <input type="checkbox"/> (B Unknown -- rapid test, culture or DFA)				Where was testing performed?
REPORTING AGENCY INFORMATION				
Reporting local health jurisdiction	Name of reporter		Telephone number of reporter	
CLINICAL COURSE				
Received antiviral treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Type of antiviral <input type="checkbox"/> Oseltamivir <input type="checkbox"/> Zanamivir <input type="checkbox"/> Other Specify other: _____			
Date antiviral treatment started	Date antiviral treatment ended	Intubated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Complications <input type="checkbox"/> Pneumonia <input type="checkbox"/> ARDS <input type="checkbox"/> Sepsis <input type="checkbox"/> Acute renal failure <input type="checkbox"/> Encephalitis/encephalopathy <input type="checkbox"/> Required vasopressor <input type="checkbox"/> Required hemodialysis <input type="checkbox"/> Pulmonary embolus <input type="checkbox"/> Secondary bacterial infection If yes, specify organism: _____ <input type="checkbox"/> Other Specify other: _____				
SIGNIFICANT PAST MEDICAL HISTORY				
Did the patient have underlying medical conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Cardiac disease <input type="checkbox"/> Chronic pulmonary disorder <input type="checkbox"/> Immunosuppression (e.g. cancer) <input type="checkbox"/> Immunosuppressive medications (e.g. chemotherapy, steroids) <input type="checkbox"/> Metabolic disorder (e.g. diabetes mellitus, renal) <input type="checkbox"/> Neurological disorder (e.g. cerebral palsy) <input type="checkbox"/> Hemoglobinopathy (e.g. sickle cell disease) <input type="checkbox"/> Genetic disorder (e.g. Downs) <input type="checkbox"/> Obesity If obese, BMI (if known): ____ Height: ____ Weight: ____ <input type="checkbox"/> Pregnant If pregnant, estimated delivery date: _____ <input type="checkbox"/> Postpartum If postpartum, delivery date: _____ <input type="checkbox"/> Other conditions (e.g. hypertension, hyperlipidemia) If yes for any of the above, please specify:				
NOTES SECTION (Please attach relevant medical records if available)				

CalREDIE Provider Portal

From paper and fax machines to electronic reporting!

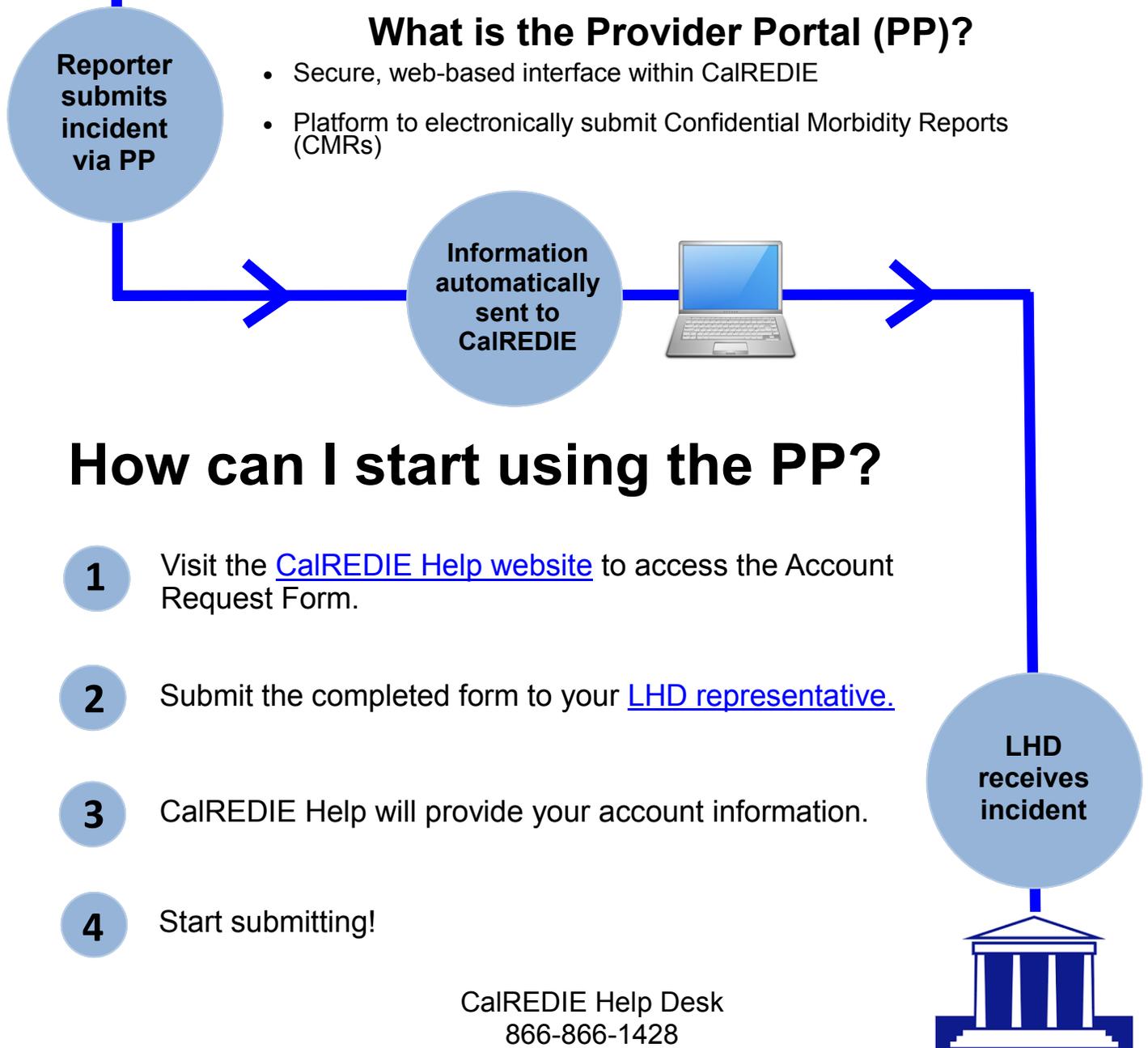
What is CalREDIE?



- California Reportable Disease Information Exchange (CalREDIE) is the California Department of Public Health's (CDPH) communicable disease reporting and surveillance system of record.
- It is used by state and local public health officials and healthcare providers for communicable disease reporting and surveillance.

What is the Provider Portal (PP)?

- Secure, web-based interface within CalREDIE
- Platform to electronically submit Confidential Morbidity Reports (CMRs)



How can I start using the PP?

- 1 Visit the [CalREDIE Help website](#) to access the Account Request Form.
- 2 Submit the completed form to your [LHD representative](#).
- 3 CalREDIE Help will provide your account information.
- 4 Start submitting!

CalREDIE Help Desk
866-866-1428
CalREDIEHelp@cdph.ca.gov

2 STD REPORTING

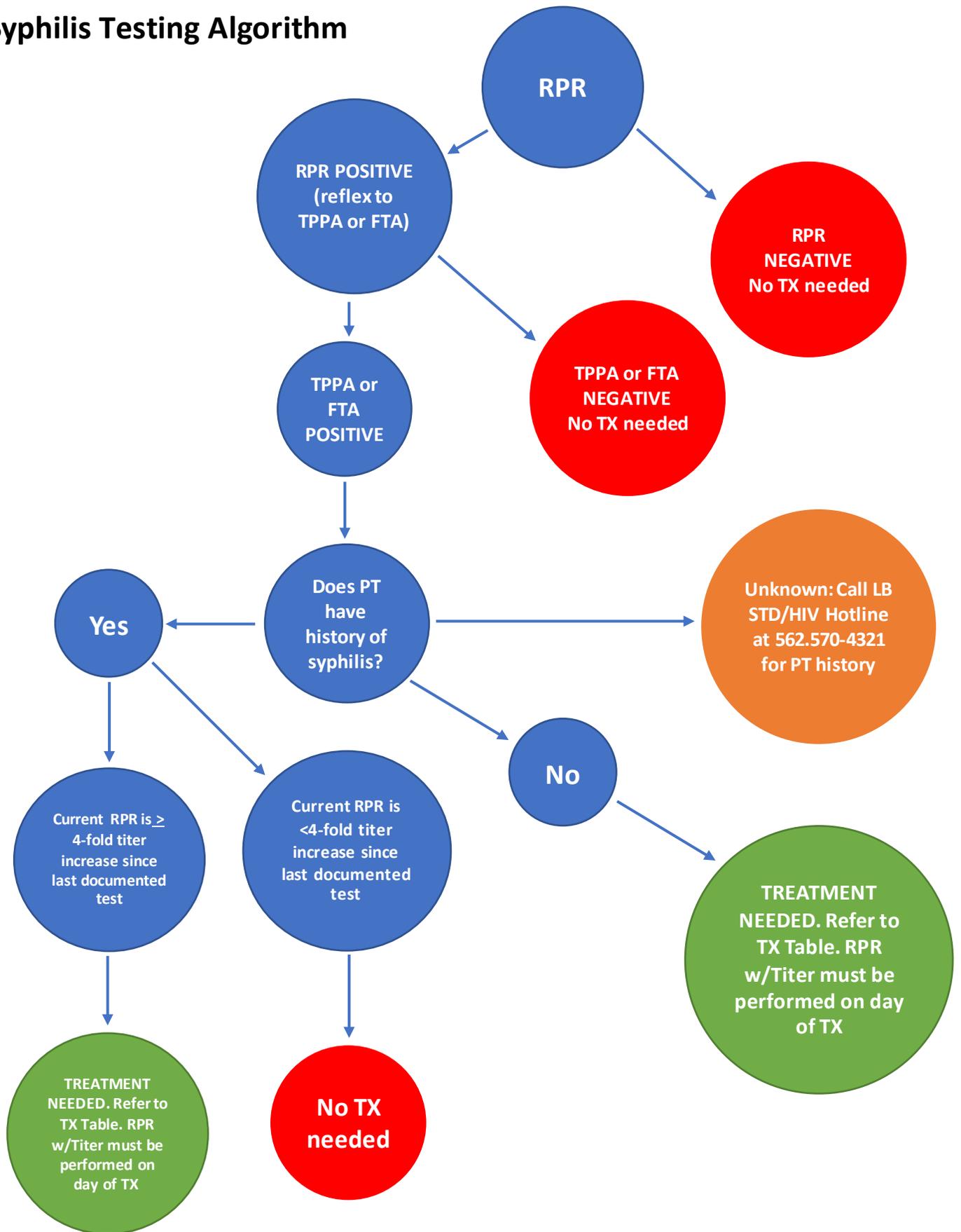
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Syphilis Stages, Symptoms and Treatment

Disease stage	Primary treatment	Alternative treatment
Primary syphilis: painless lesion in genitalia or other part of body (can be found on hands, feet, tongue or whatever the exposure to the syphilis bacteria occurred)	Benzathine penicillin G -2.4 million units IM x 1	Doxycycline 100 mg PO BID x 14 days
Secondary syphilis: rash (palmer/planter and/or generalized body rash) and/or alopecia (patches of hair loss)	Benzathine penicillin G 2.4 million units IM x 1	Doxycycline 100 mg PO BID x 14 days
Early latent syphilis: no symptoms and a documented negative lab result or seroconversion or documented increase in titer within the last twelve months	Benzathine penicillin G 2.4 million units IM x 1	Doxycycline 100 mg PO BID x 14 days
Late latent syphilis: no symptoms and no documented lab result within a year from when they were tested	Benzathine penicillin G 2.4 million units IM x 3, at 1-week intervals (totaling 7.2 million units) If 2 nd or 3 rd dose is given more than 10 days after previous dose, must restart series from the beginning Pregnant women must get all 3 doses EXACTLY 7 days apart	Doxycycline 100 mg PO BID x 28 days
Neurosyphilis/Ocular syphilis: results when the infection has entered the cerebral spinal fluid and/or brain. This can happen at ANY stage. Primary, Secondary and Early Latent with Neurosyphilis/Ocular syphilis Late Latent with Neurosyphilis/Ocular syphilis	Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV q4hrs or continuous infusion x 10d Aqueous crystalline penicillin G 18-24 million units per day, administered as 3-4 million units IV q4hrs or continuous infusion x 14d AND on day 14 of IV treatment MUST give 2.4 million units IM x 1	No alternative treatment

- No differences in treatment regimens for pregnant women or HIV infected individuals
- There is no alternative treatment for pregnant women

Syphilis Testing Algorithm





CITY OF LONG BEACH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

2525 Grand Ave. ☐ Long Beach, CA 90815 ☐ (562) 570-4321 FAX (562) 570-4374

Anissa Davis, MD, MPH
City Health Officer

HIV/STD SURVEILLANCE PROGRAM

April 19, 2019

SUBJECT: Recommendations for Syphilis Testing

Dear Health Care Provider,

For testing and diagnosis of syphilis, two serological tests are required:

- 1) A nontreponemal antibody test (RPR)
- 2) A treponemal antibody test (either TP-PA or FTA-ABS)

For ease of testing, we recommend ordering the RPR with reflex to titer and confirmatory testing or ordering both tests (RPR and treponemal) simultaneously. At this time, both Lab Corp and Quest Diagnostics offer the reflex option:

Lab Corp: Rapid Plasma Reagin (RPR) Test with Reflex to Quantitative RPR and Confirmatory *Treponema pallidum* Antibodies #012005

Quest Diagnostics: RPR (Diagnosis) with Reflex to Titer and Confirmatory Testing #36126

Both tests are required as the RPR detects antibodies that are not specifically directed against the *Treponema pallidum* bacterium. Reactive RPRs may be a biological false positive and require the treponemal test for confirmation.

For syphilis treatment, see attached California Department of Public Health (CDPH) guidelines.

Additional Resources from CDPH Sexually Transmitted Diseases Guidelines Webpage:

- California STD Treatment Guidelines for Adults and Adolescents, 2015 (2-page Summary) (PDF)
- CDC Treatment Guidelines 2015
- Treponemal Immunoassays For Syphilis Diagnosis and Screening

Main Link to CDPH Guidelines:

<http://www.cdph.ca.gov/pubsforms/Guidelines/Pages/SexuallyTransmittedDiseasesScreeningandTreatmentGuidelines.aspx>

If you have any questions regarding testing or treatment, please contact the **Long Beach HIV/STD Hotline at (562) 570-4321**.

As a reminder, it is your legal responsibility to report within the required timeframe and provide information necessary for the public health investigation of communicable disease (Title 17, California Code of Regulations, Section 2500). Reliance on **laboratory** reporting is NOT a substitute. Under State laws, the reporting of communicable diseases to the local public health department is exempt from HIPAA (Section 164.512 (b)). **Patient consent is not required**. Patient information is always treated with strict confidence, and information requested is the minimum necessary for public health purposes.

CALIFORNIA STD TREATMENT GUIDELINES TABLE FOR ADULTS & ADOLESCENTS 2015

These guidelines reflect recent updates in the 2015 CDC STD Treatment Guidelines for both HIV-uninfected and HIV-infected adults and adolescents; treatments that differ for HIV-infected populations are designated by a red ribbon. Call the local health department for assistance with confidential notification of sexual partners of patients with syphilis, gonorrhea, chlamydia or HIV infection. For STD clinical management consultation, call (510-620-3400) or submit your question online to the STD Clinical Consultation Network at www.stdccn.org

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen.
CHLAMYDIA (CT)			
Genital/Rectal/Pharyngeal Infections ¹	<ul style="list-style-type: none"> Azithromycin or Doxycycline² 	1 g po 100 mg po bid x 7 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Levofloxacin² 500 mg po qd x 7 d or Ofloxacin² 300 mg po bid x 7 d or Doxycycline² (delayed release) 200 mg po qd x 7 d
Pregnant Women ³	<ul style="list-style-type: none"> Azithromycin 	1g po	<ul style="list-style-type: none"> Amoxicillin⁴ 500 mg po tid x 7 d or Erythromycin base 500 mg po qid x 7 d or Erythromycin base 250 mg po qid x 14 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Erythromycin ethylsuccinate 400 mg po qid x 14 d
GONORRHEA (GC): Dual therapy with ceftriaxone 250 mg IM PLUS azithromycin 1 g po is recommended for all patients with gonorrhea regardless of chlamydia test results.⁵ Dual therapy should be simultaneous and by directly observed therapy. Azithromycin is preferred second antimicrobial; if allergy to azithromycin, can use doxycycline 100 mg po bid x 7 days.			
Genital/Rectal Infections ^{1,5}	Dual therapy with <ul style="list-style-type: none"> Ceftriaxone PLUS Azithromycin 	250 mg IM 1 g po	Dual therapy with <ul style="list-style-type: none"> Cefixime⁶ 400 mg po PLUS Azithromycin 1 g po or Doxycycline 100 mg po bid x 7 d Cephalosporin allergy or IgE mediated penicillin allergy <ul style="list-style-type: none"> Gemifloxacin² 320 mg po PLUS Azithromycin 2 g po or Gentamicin² 240 mg IM PLUS Azithromycin 2 g po
Pharyngeal Infections ⁵	Dual therapy with <ul style="list-style-type: none"> Ceftriaxone PLUS Azithromycin 	250 mg IM 1 g po	If cephalosporin allergy or IgE mediated penicillin allergy (e.g., anaphylaxis, Stevens-Johnson syndrome, or toxic epidermal necrolysis), limited data exist on alternatives. See footnotes. ⁷
Pregnant Women ^{3,5}	Dual therapy with <ul style="list-style-type: none"> Ceftriaxone PLUS Azithromycin 	250 mg IM 1 g po	<ul style="list-style-type: none"> Cefixime⁶ 400 mg po PLUS Azithromycin 1g po If cephalosporin allergy or IgE mediated penicillin allergy, consult with specialist, see footnotes. ³
PELVIC INFLAMMATORY DISEASE^{8,9} (Etiologies: CT, GC, anaerobes, possibly <i>M. genitalium</i> , others)	Parenteral <ul style="list-style-type: none"> Either Cefotetan or Cefoxitin plus Doxycycline² or Clindamycin plus Gentamicin IM/Oral <ul style="list-style-type: none"> Either Ceftriaxone or Cefoxitin with Probenecid plus Doxycycline² plus Metronidazole if BV is present or cannot be ruled out 	2 g IV q 12 hrs 2 g IV q 6 hrs 100 mg po or IV q 12 hrs 900 mg IV q 8 hrs 2 mg/kg IV or IM followed by 1.5 mg/kg IV or IM q 8 hrs 250 mg IM 2 g IM, 1 g po 100 mg po bid x 14 d 500 mg po bid x 14 d	Parenteral <ul style="list-style-type: none"> Ampicillin/Sulbactam 3 g IV q 6 hrs plus Doxycycline² 100 mg po or IV q 12 hrs Oral¹⁰ <ul style="list-style-type: none"> Levofloxacin² 500 mg po qd x 14 d or Ofloxacin² 400 mg po bid x 14 d or Moxifloxacin² 400 mg po qd x 14 d or Ceftriaxone 250 mg IM in a single dose plus Azithromycin 1 g po once a week for 2 weeks plus Metronidazole 500 mg po bid x 14 d if BV is present or cannot be ruled out
CERVICITIS^{8,11,12} (Etiologies: CT, GC, <i>T. vaginalis</i> , HSV, possibly <i>M. genitalium</i>)	<ul style="list-style-type: none"> Azithromycin or Doxycycline² 	1 g po 100 mg po bid x 7 d	
NONGONOCOCCAL URETHRITIS (NGU)^{8,12}	<ul style="list-style-type: none"> Azithromycin or Doxycycline 	1 g po 100 mg po bid x 7 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 7 d or Erythromycin ethylsuccinate 800 mg po qid x 7 d or Levofloxacin 500 mg po qd x 7 d or Ofloxacin 300 mg po bid x 7 d
RECURRENT/PERSISTENT NGU (Etiologies: <i>M. genitalium</i>, <i>T. vaginalis</i>, other bacteria)¹²	<ul style="list-style-type: none"> Moxifloxacin plus Metronidazole¹² or Tinidazole¹² 	400 mg po qd x 7d 2 g po 2 g po	
EPIDIDYMITIS⁸	Likely due to GC or CT <ul style="list-style-type: none"> Ceftriaxone plus Doxycycline Likely due to GC, CT or enteric organisms (history of anal insertive sex) <ul style="list-style-type: none"> Ceftriaxone plus Levofloxacin or Ofloxacin Likely due to enteric organisms <ul style="list-style-type: none"> Levofloxacin¹³ or Ofloxacin¹³ 	250 mg IM 100 mg po bid x 10 d 250 mg IM 500 mg po qd x 10 d 300 mg po bid x 10 d 500 mg po qd x 10 d 300 mg po bid x 10 d	
LYMPHOGRANULOMA VENEREUM	<ul style="list-style-type: none"> Doxycycline² 	100 mg po bid x 21 d	<ul style="list-style-type: none"> Erythromycin base 500 mg po qid x 21 d
TRICHOMONIASIS^{14,15}			
Adults/Adolescents	<ul style="list-style-type: none"> Metronidazole or Tinidazole¹⁶ 	2 g po 2 g po	<ul style="list-style-type: none"> Metronidazole 500 mg po bid x 7 d
Pregnant Women	<ul style="list-style-type: none"> Metronidazole 	2 g po	
HIV-infected Women 	<ul style="list-style-type: none"> Metronidazole 	500 mg po bid x 7 d	

¹ Annual screening is recommended for women aged < 25 years. Nucleic acid amplification tests (NAATs) are recommended. All patients should be re-tested 3 months after treatment for CT or GC.

² Contraindicated for pregnant and nursing women.

³ Every effort should be made to use a recommended regimen. Test-of-cure follow-up (preferably by NAAT) 3-4 weeks after completion of therapy is recommended in pregnancy. In case of allergy to both alternative and recommended regimens, consult with the CA STD Control Branch at 510-620-3400 or the STD Clinical Consultation Network at www.stdccn.org

⁴ Amoxicillin is now an alternative regimen due to chlamydial persistence in animal and in vitro studies.

⁵ If the patient has been treated with a recommended regimen for GC, reinfection has been ruled out, and symptoms have not resolved, perform a test-of-cure using culture and antibiotic susceptibility testing and report to the local health department. For clinical consult and for help in obtaining GC culture call the CA STD Control Branch at 510-620-3400. For specific treatment guidance, go to www.std.ca.gov ("STD Guidelines, California Gonorrhea Treatment Guidelines --- Suspected Gonorrhea Treatment Failure").

⁶ Oral cephalosporins give lower and less-sustained bactericidal levels than ceftriaxone 250 mg; limited efficacy for treating pharyngeal GC. Cefixime should only be used when ceftriaxone is not available.

⁷ Dual therapy with gemifloxacin 320 mg po plus azithromycin 2 g po or gentamicin 240 mg IM plus azithromycin 2 g po are potential alternatives. ID specialist consult may be prudent. Azithromycin monotherapy is no longer recommended due to resistance concerns and treatment failure reports. Pharyngeal GC patients treated with an alternative regimen should have a test of cure (with culture or NAAT) 14 days after treatment.

⁸ Testing for gonorrhea and chlamydia is recommended because a specific diagnosis may improve compliance and partner management and because these infections are reportable by state law.

⁹ Evaluate for bacterial vaginosis. If present or cannot be ruled out, also use metronidazole. If parenteral therapy is selected, discontinue 24-48 hours after patient improves clinically and continue with oral therapy for a total of 14 days.

¹⁰ In the setting of allergy to cephalosporins, fluoroquinolones can be considered for PID if the risk of GC is low, a NAAT test for GC is performed, and follow-up of the patient can be assured. If GC is documented, the patient should be re-treated based on antimicrobial susceptibility test results (if available). If antimicrobial susceptibility testing reveals fluoroquinolone resistance or if testing is unavailable then consultation with ID specialist is recommended for treatment options.

¹¹ If patient lives in community with high GC prevalence, or has risk factors (e.g. age <25 years, new partner, partner with concurrent sex partners, or sex partner with a STD), consider empiric treatment for GC.

¹² *Mycoplasma genitalium* causes urethritis and possibly cervicitis that can persist despite treatment with azithromycin. Moxifloxacin 400 mg orally for 7 days is recommended for persistent NGU in men and can be considered for persistent cervicitis in women. In areas of high *T. vaginalis* prevalence, men who have sex with women (MSW) with persistent urethritis should also be treated for *T. vaginalis*.

¹³ Gonorrhea should be ruled out prior to starting a fluoroquinolone-based regimen.

¹⁴ For suspected drug-resistant trichomoniasis, rule out re-infection; see 2015 CDC Guidelines, Persistent or Recurrent Trichomonas section, for other treatment options, and evaluate for metronidazole-resistant *T. vaginalis*. For consultation call (510-620-3400) or contact the STD Clinical Consultation Network at www.stdccn.org

¹⁵ All women should be retested for trichomoniasis 3 months after treatment.

¹⁶ Safety in pregnancy has not been established; avoid during pregnancy. When using tinidazole, breastfeeding should be deferred for 72 hours after 2 g dose.

DISEASE	RECOMMENDED REGIMENS	DOSE/ROUTE	ALTERNATIVE REGIMENS: To be used if medical contraindication to recommended regimen
BACTERIAL VAGINOSIS			
Adults/Adolescents	<ul style="list-style-type: none"> Metronidazole or Metronidazole gel or Clindamycin cream¹⁷ 	500 mg po bid x 7 d 0.75%, one full applicator (5 g) Intravaginally qd x 5 d 2%, one full applicator (5 g) Intravaginally qhs x 7 d	<ul style="list-style-type: none"> Tinidazole¹⁶ 2 g po qd x 2 d or Tinidazole¹⁶ 1 g po qd x 5 d or Clindamycin 300 mg po bid x 7 d or Clindamycin ovules¹⁷ 100 mg intravaginally qhs x 3 d
Pregnant Women	<ul style="list-style-type: none"> Metronidazole or Metronidazole gel or Clindamycin cream¹⁷ 	500 mg po bid x 7 d 0.75%, one full applicator (5 g) Intravaginally qd x 5 d 2%, one full applicator (5 g) Intravaginally qhs x 7 d	<ul style="list-style-type: none"> Clindamycin 300 mg po bid x 7 d or Clindamycin ovules¹⁷ 100 mg intravaginally qhs x 3 d
ANOGENITAL WARTS			
External Genital/Perianal Warts	Patient-Applied <ul style="list-style-type: none"> Imiquimod^{17,18} 5% cream or Imiquimod^{17,18} 3.75% cream or Podofilox¹⁶ 0.5% solution or gel or Sinecatechins^{16,17} 15% ointment Provider-Administered <ul style="list-style-type: none"> Cryotherapy or Trichloroacetic acid (TCA) 80%-90% or Bichloroacetic acid (BCA) 80%-90% or Surgical removal 	Topically qhs 3 times/ wk up to 16 wks Topically qhs up to 16 wks Topically bid x 3 d followed by 4 d no tx for up to 4 cycles Topically tid, for up to 16 wks Apply once q 1-2 wks Apply once q 1-2 wks Apply once q 1-2 wks	Alternative Regimen – Provider Administered <ul style="list-style-type: none"> Podophyllin resin^{16,19} 10%-25% in tincture of benzoin apply q 1-2 wks or Intralesional interferon or Photodynamic therapy or Topical cidofovir
Mucosal Genital Warts ²⁰	<ul style="list-style-type: none"> Cryotherapy or Surgical removal or TCA or BCA 80%-90% 	Vaginal, urethral meatus, cervical, anal Vaginal, urethral meatus, cervical, anal Vaginal, cervical, anal	
ANOGENITAL HERPES²¹			
First Clinical Episode of Anogenital Herpes	<ul style="list-style-type: none"> Acyclovir or Acyclovir or Valacyclovir or Famciclovir 	400 mg po tid x 7-10 d 200 mg po 5x/day x 7-10 d 1 g po bid x 7-10 d 250 mg po tid x 7-10 d	
Established Infection Suppressive Therapy ²²	<ul style="list-style-type: none"> Acyclovir or Valacyclovir or Valacyclovir or Famciclovir²² 	400 mg po bid 500 mg po qd 1 g po qd 250 mg po bid	
Suppressive Therapy for Pregnant Women (start at 36 weeks gestation)	<ul style="list-style-type: none"> Acyclovir or Valacyclovir 	400 mg po tid 500 mg po bid	
Episodic Therapy for Recurrent Episodes	<ul style="list-style-type: none"> Acyclovir or Acyclovir or Acyclovir or Valacyclovir or Valacyclovir or Famciclovir or Famciclovir or Famciclovir 	400 mg po tid x 5 d 800 mg po bid x 5 d 800 mg po tid x 2 d 500 mg po bid x 3 d 1 g po qd x 5 d 125 mg po bid x 5 d 1g po bid x 1 d 500 mg po once, then 250 mg bid x 2 d	
HIV Co-Infected²³ ♂			
Suppressive Therapy ²²	<ul style="list-style-type: none"> Acyclovir or Valacyclovir or Famciclovir²² 	400-800 mg po bid or tid 500 mg po bid 500 mg po bid	
Episodic Therapy for Recurrent Episodes	<ul style="list-style-type: none"> Acyclovir or Valacyclovir or Famciclovir 	400 mg po tid x 5-10 d 1g po bid x 5-10 d 500 mg po bid x 5-10 d	
SYPHILIS^{24,25}			
Primary, Secondary, and Early Latent	<ul style="list-style-type: none"> Benzathine penicillin G 	2.4 million units IM	<ul style="list-style-type: none"> Doxycycline²⁶ 100 mg po bid x 14 d or Tetracycline²⁶ 500 mg po qid x 14 d or Ceftriaxone²⁶ 1 g IM or IV qd x 10-14 d
Late Latent	<ul style="list-style-type: none"> Benzathine penicillin G 	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	<ul style="list-style-type: none"> Doxycycline²⁶ 100 mg po bid x 28 d or Tetracycline²⁶ 500 mg po qid x 28 d
Neurosyphilis and Ocular Syphilis ²⁷	<ul style="list-style-type: none"> Aqueous crystalline penicillin G 	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	<ul style="list-style-type: none"> Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probenecid 500 mg po qid x 10-14 d or Ceftriaxone²⁶ 2 g IM or IV qd x 10-14 d
Pregnant Women²⁸ NOTE: Pregnant women who miss any dose of therapy must repeat full course of treatment.			
Primary, Secondary, and Early Latent	<ul style="list-style-type: none"> Benzathine penicillin G 	2.4 million units IM	<ul style="list-style-type: none"> None
Late Latent	<ul style="list-style-type: none"> Benzathine penicillin G 	7.2 million units, administered as 3 doses of 2.4 million units IM each, at 1-week intervals	<ul style="list-style-type: none"> None
Neurosyphilis and Ocular Syphilis ²⁷	<ul style="list-style-type: none"> Aqueous crystalline penicillin G 	18-24 million units daily, administered as 3-4 million units IV q 4 hrs x 10-14 d	<ul style="list-style-type: none"> Procaine penicillin G, 2.4 million units IM qd x 10-14 d plus Probenecid 500 mg po qid x 10-14 d

¹⁶ Safety in pregnancy has not been established; avoid during pregnancy. When using tinidazole, breastfeeding should be deferred for 72 hours after 2 g dose.

¹⁷ May weaken latex condoms and contraceptive diaphragms. Patients should follow directions on package insert carefully regarding whether to wash area after treatment (e.g. imiquimod) versus leaving product on the affected area (e.g. sinecatechins).

¹⁸ Limited human data on imiquimod use in pregnancy; animal data suggest low risk.

¹⁹ Podophyllin resin is now an alternative rather than recommended regimen; severe toxicity has been reported.

²⁰ Cervical and intra-anal warts should be managed in consultation with specialist.

²¹ Counseling about natural history, asymptomatic shedding, and sexual transmission is an essential component of herpes management.

²² The goal of suppressive therapy is to reduce recurrent symptomatic episodes and/or to reduce sexual transmission. Famciclovir is somewhat less effective for suppression of viral shedding.

²³ If HSV lesions persist or recur during antiviral treatment, drug resistance should be suspected. Obtaining a viral isolate for sensitivity testing and consulting with an infectious disease expert is recommended.

²⁴ Benzathine penicillin G (generic name) is the recommended treatment for syphilis not involving the central nervous system and is available in only one long-acting formulation, Bicillin® L-A (the trade name), which contains only benzathine penicillin G. Other combination products, such as Bicillin® C-R, contain both long- and short-acting penicillins and are not effective for treating syphilis.

²⁵ Persons with HIV infection should be treated according to the same stage-specific recommendations for primary, secondary, and latent syphilis as used for HIV-negative persons. Available data demonstrate that additional doses of benzathine penicillin G, amoxicillin, or other antibiotics in early syphilis do not result in enhanced efficacy, regardless of HIV status.

²⁶ Alternates should be used only for penicillin-allergic patients because efficacy of these therapies has not been established. Compliance with some of these regimens is difficult, and close follow-up is essential. If compliance or follow-up cannot be ensured, the patient should be desensitized and treated with benzathine penicillin.

²⁷ Some specialists recommend 2.4 million units of benzathine penicillin G once weekly for up to 3 weeks after completion of neurosyphilis treatment.

²⁸ Pregnant women allergic to penicillin should be desensitized and treated with penicillin. There are no alternatives. Pregnant women who miss any dose of therapy (greater than 7 days between doses) must repeat the full course of treatment.

3 HIV REPORTING

ADULT HIV/AIDS CASE REPORT FORM

(Patients ≥ 13 Years of Age at Time of Diagnosis)

Date Form Received:

I. Health Department/Reporting Facility Information

(Record All Dates as mm/dd/yyyy)

Shaded Fields are Required.

Name of Person Completing Form:	Person's Phone Number: ()	STATENO:	CITYNO:
Date Form Completed: ____/____/____	Reporting Health Department - City/County:		Document Source:
Report Status: <input type="checkbox"/> 1- New <input type="checkbox"/> 2- Update	Physician's Name:	Physician's Phone Number: ()	Hospital/Facility Name:
Did this report initiate a new case investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Surveillance Method: <input type="checkbox"/> Active <input type="checkbox"/> Passive <input type="checkbox"/> Follow Up <input type="checkbox"/> Reabstraction <input type="checkbox"/> Unknown		Report Medium: <input type="checkbox"/> 1- Field Visit <input type="checkbox"/> 2- Mailed <input type="checkbox"/> 3- Phone <input type="checkbox"/> 4- Electronic Transfer <input type="checkbox"/> 5- CD/Disk

II. Patient Identificatio

Patient Last Name:	Middle Name:	First Name:
Alternate Name Type (e.g. Alias, Married, etc.):	Last Name:	Middle Name: First Name:
Address Type: <input type="checkbox"/> Residential <input type="checkbox"/> Bad Address <input type="checkbox"/> Correctional Facility <input type="checkbox"/> Foster Home <input type="checkbox"/> Homeless <input type="checkbox"/> Postal <input type="checkbox"/> Shelter <input type="checkbox"/> Temporary		
Current Street Address: City: County:		
State/Country:	ZIP Code:	Phone Number: ()
Social Security Number:		Other ID Type #1:
Other ID Type #1 Number:	Other ID Type #2:	Other ID Type #2 Number:

III. Patient Demographics *(See Appendix 2.0 for Further Details) (Record All Dates as mm/dd/yyyy)*

Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown	Country of Birth: <input type="checkbox"/> U.S. <input type="checkbox"/> Other/U.S. Dependency (please specify): _____	Date of Birth: ____/____/____
Alias Date of Birth: ____/____/____	Vital Status: <input type="checkbox"/> 1- Alive <input type="checkbox"/> 2- Dead	Date of Death: ____/____/____
State of Death:		Status: <input type="checkbox"/> HIV <input type="checkbox"/> AIDS
Current Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender: Male-to-Female (MTF) <input type="checkbox"/> Transgender: Female-to-Male (FTM) <input type="checkbox"/> Unknown <input type="checkbox"/> Other Gender Identity (specify): _____		Race: <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Pacific Islande <input type="checkbox"/> Chinese <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Japanese <input type="checkbox"/> Asian Indian <input type="checkbox"/> Guamanian <input type="checkbox"/> Filipino <input type="checkbox"/> Laotian <input type="checkbox"/> Samoan <input type="checkbox"/> Korean <input type="checkbox"/> Cambodian <input type="checkbox"/> Other (specify): _____
Ethnicity: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino <input type="checkbox"/> Unknown	Expanded Ethnicity:	
Expanded Race:		

IV. Residence at Diagnosis *(See Appendix 3.0 for Further Details - Add Additional Addresses in Comments and Local/Optional Fields Section) (Required as Appropriate Based on Status)*

Address Type (check all that apply): <input type="checkbox"/> Residence at HIV Diagnosis <input type="checkbox"/> Residence at AIDS Diagnosis <input type="checkbox"/> Check if SAME as Current Address				
Address of Residence at HIV Diagnosis	Street Address:	City:	County:	State/Country: ZIP Code:
Address of Residence at AIDS Diagnosis	Street Address:	City:	County:	State/Country: ZIP Code:

V. Facility at Diagnosis (See Appendix 4.0 for Further Details - Add Additional Facilities in Comments and Local/Optional Fields Section) **STATENO:** _____

Diagnosis Type (check all that apply to facility): <input type="checkbox"/> HIV Diagnosis <input type="checkbox"/> AIDS Diagnosis <input type="checkbox"/> Check if SAME as Facility Providing Information			
Facility Name:	Phone Number: ()	Street Address:	City:
County:	State/Country:	ZIP Code:	Provider Name:
Facility Type:	<i>Inpatient:</i> <input type="checkbox"/> Hospital <input type="checkbox"/> Other (specify): _____		
	<i>Outpatient:</i> <input type="checkbox"/> Private Physician <input type="checkbox"/> Adult HIV Clinic <input type="checkbox"/> Other (specify): _____		
	<i>Screening, Diagnostic, Referral Agency:</i> <input type="checkbox"/> CTS <input type="checkbox"/> STD Clinic <input type="checkbox"/> Other (specify): _____		
	<i>Other Facility:</i> <input type="checkbox"/> Emergency Room <input type="checkbox"/> Laboratory <input type="checkbox"/> Corrections <input type="checkbox"/> Unknown <input type="checkbox"/> Other (specify): _____		

VI. Patient History (See Appendix 5.0 for Further Details - Respond to All Questions) **Pediatric Risk** (Please Enter in Comments and Local/Optional Fields Section)

After 1977 and before the earliest known diagnosis of HIV infection, this patient had:		
Sex with a male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Sex with a female: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Injected non-prescription drugs: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
HETEROSEXUAL relations with any of the following:	Has the patient:	
Contact with intravenous/injection drug user (IDU): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Received clotting factor for hemophilia/coagulation disorder: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Contact with a bisexual male: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Received transfusion of blood/blood components (non-clotting): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Contact with a person with AIDS or documented HIV infection, risk not specified <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other documented risk: (if yes, specify): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Contact with transplant recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	
Contact with transfusion recipient with documented HIV: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	_____	

VII. Laboratory Data (Record All Dates as mm/dd/yyyy) (See Instructions for Details)

HIV Antibody Tests (Non-Type Differentiating) [HIV-1 vs. HIV-2]		
TEST 1: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): <input type="checkbox"/>	Collection Date: ____/____/____
TEST 2: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): <input type="checkbox"/>	Collection Date: ____/____/____
TEST 3: <input type="checkbox"/> HIV-1 EIA <input type="checkbox"/> HIV-1/2 EIA <input type="checkbox"/> HIV-1/2 Ag/Ab <input type="checkbox"/> HIV-1 WB <input type="checkbox"/> HIV-1 IFA <input type="checkbox"/> HIV-2 EIA <input type="checkbox"/> HIV-2 WB <input type="checkbox"/> Other (specify test): _____		
RESULT: <input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Manufacturer: _____	RAPID TEST (check if rapid): <input type="checkbox"/>	Collection Date: ____/____/____
HIV Antibody Tests (Type Differentiating) [HIV-1 vs. HIV-2]		
TEST: <input type="checkbox"/> HIV-1/2 Differentiating (e.g. Multispot)		
RESULT: <input type="checkbox"/> HIV-1 <input type="checkbox"/> HIV-2 <input type="checkbox"/> Both (undifferentiated) <input type="checkbox"/> Neither (negative) Collection Date: ____/____/____		

VII. Laboratory Data (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____

HIV Detection Tests (Qualitative)		
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture	
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: ____/____/____	
TEST 2:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-1 P24 Antigen <input type="checkbox"/> HIV-1 Culture <input type="checkbox"/> HIV-2 RNA/DNA NAAT (Qual) <input type="checkbox"/> HIV-2 Culture	
RESULT:	<input type="checkbox"/> Positive/Reactive <input type="checkbox"/> Negative/Nonreactive <input type="checkbox"/> Indeterminate Collection Date: ____/____/____	
HIV Detection Tests (Quantitative Viral Load) <i>Note: Include earliest test after diagnosis</i>		
TEST 1:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____	
RESULT:	<input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: ____/____/____	
TEST 2:	<input type="checkbox"/> HIV-1 RNA/DNA NAAT (Quantitative Viral Load) <input type="checkbox"/> RT-PCR <input type="checkbox"/> bDNA <input type="checkbox"/> Other (specify test): _____	
RESULT:	<input type="checkbox"/> Detectable <input type="checkbox"/> Undetectable Copies/mL: _____ Log: _____ Collection Date: ____/____/____	
Immunologic Tests (CD4 Count and Percentage)		
CD4 at or closest to current diagnosis status:	CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: ____/____/____	
First CD4 result <200 cells/μL or <14%:	CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: ____/____/____	
Other CD4 result <200 cells/μL or <14%:	CD4 count: _____ cells/ μ L CD4 percentage: _____ % Collection Date: ____/____/____	
Documentation of Tests (Complete only if none of the following was positive: HIV-1 Western blot, IFA, culture, p24 Ag test, viral load, or qualitative NAAT [RNA or DNA])		
Did documented laboratory test results meet approved HIV diagnostic algorithm? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, provide date (specimen collection date if known) of earliest positive test for this algorithm: ____/____/____		
If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, provide date of documentation by physician: ____/____/____		

VIII. Clinical (Check Boxes Where Applicable) (Record All Dates as mm/dd/yyyy)

	✓	Date		✓	Date
Candidiasis, esophageal			Kaposi's sarcoma		
Cryptococcosis, extrapulmonary			Pneumocystis carinii pneumonia		
Cytomegalovirus disease (other than in liver, spleen or nodes)			Wasting syndrome due to HIV		
Herpes simplex: chronic ulcer(s) (>1 mo. duration), bronchitis, pneumonitis or esophagitis			Other (specify):		

IX. Treatment/Services Referrals (Record All Dates as mm/dd/yyyy)

Has This Patient Been Informed of His/Her HIV Infection? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Patient's Medical Treatment is Primarily Reimbursed by: <input type="checkbox"/> 1- Medicaid <input type="checkbox"/> 2- Private Insurance/HMO <input type="checkbox"/> 3- No Coverage <input type="checkbox"/> 4- Other Public Funding <input type="checkbox"/> 9- Unknown	
For Female Patient:	
Is This Patient Currently Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Has This Patient Delivered Live-Born Infants? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

IX. Treatment/Services Referrals (continued) (Record All Dates as mm/dd/yyyy)

STATENO: _____

For Children of Patient: (Record Most Recent Birth Below; Record Additional or Multiple Births in Comments and Local/Optional Fields Section)			
Child's Name:	Child's Soundex:	Child's Date of Birth: ____/____/____	
Child's Coded ID:	Child's STATENO:		
Hospital of Birth: (If Child Was Born at Home, Enter "Home Birth" for Hospital Name)			
Hospital Name:		Phone Number: ()	
Street Address:		City:	
County:	State/Country:	ZIP Code:	

X. HIV Testing and Antiretroviral Use History (TTH) (Record All Dates as mm/dd/yyyy) (Required Sections for New Case Report Only)

Main Source of Testing and Treatment History Information (select one): <input type="checkbox"/> Patient Interview <input type="checkbox"/> Medical Record Review			Date Patient Reported Information: ____/____/____
<input type="checkbox"/> Provider Report <input type="checkbox"/> NHM&E/PEMS <input type="checkbox"/> Other (specify): _____			
Ever Had a Positive HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	Date of First Positive HIV Test: ____/____/____	Ever Had a Negative HIV Test? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	Date of Last Negative HIV Test: (If date is from a lab test with test type, enter in Laboratory Data Section.) ____/____/____
Number of Negative HIV Tests Within 24 Months Before First Positive Test (#): _____ <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown			
Ever Taken Any Antiretrovirals (ARVs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused <input type="checkbox"/> Don't Know/Unknown	If Yes, What ARV Medications? _____		
Date ARVs First Taken: ____/____/____	Date ARVs Last Taken (mm/dd/yyyy): ____/____/____		

XI. Duplicate Review (Office use)

Status (check one): <input type="checkbox"/> Same As <input type="checkbox"/> Different Than <input type="checkbox"/> Pending	State Name: _____	STATENO: _____
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XII. Comments and Local/Optional Fields

Assignee: _____ Reviewed by: _____ Entered by: _____ Entry Date: _____

PROVIDERS: SUBMIT COMPLETED FORM MARKED "CONFIDENTIAL" TO

**LONG BEACH DEPARTMENT OF HEALTH & HUMAN SERVICES
2525 GRAND AVENUE, SUITE 229
LONG BEACH, CA 90815**

TO DOWNLOAD THIS FORM, GO TO http://www.longbeach.gov/health/info_stats/hiv_reports.asp

TO REPORT THROUGH PHONE, PLEASE CALL (562) 570-4213. DO NOT SEND THE REPORT OVER THE FAX.

INSTRUCTIONS

HIV Adult Case Report Form

The following information should be filled out on the form:



Name
Phone number
Date form is completed
Physician's name
Physician's phone number
Facility name

1 HEALTH DEPARTMENT/ REPORTING FACILITY



Patient's name (last, middle, first)
Patient's address
Patient's phone number
Patient's social security number

Medical record number and lab accession numbers can be placed in the other box.

2 PATIENT IDENTIFICATION



Sex assigned at birth
Country of birth
Date of birth
Vital status
Status (HIV or AIDS)
Race and ethnicity (REQUIRED TO REPORT)

3 PATIENT DEMOGRAPHICS



Sex with men
Sex with women
Injected non-prescription drugs
Heterosexual indications
"Has the patient" section

4 PATIENT HISTORY



Any labs performed on the patient should be indicated here.

Check the type of test, result, and specimen collection date.

5 LABORATORY DATA

HIV/STD Hotline: (562) 570-4321



Indicate whether any AIDS defining diseases or opportunistic infections exist and the date the disease was documented.

6 CLINICAL



Has the patient been informed
Type of insurance
If the patient is female, indicate if she is currently pregnant and if she has delivered live-born infants.

7 TREATMENT/
SERVICES REFERRALS



Source of testing/treatment history
Date reported
Previously diagnosed
Date of previous diagnosis
Prior HIV negative test and date
Previously taken ARVs (which ones, date started, date last taken)

8 HIV TESTING AND
ANTIRETROVIRAL USE



Please note if this patient is transferring care from another city or state or returning to care.
If there is information you would like to include or are not sure where it belongs, please put it in the comments section.

9 COMMENTS



Mail completed form in a double envelope to:

Long Beach Department of Health and Human Services
Epidemiology Program, Suite 229
2525 Grand Avenue
Long Beach, CA 90815

10 MAIL REPORT



CITY OF LONG BEACH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

2525 Grand Ave. ☐ Long Beach, CA 90815 ☐ (562) 570-4321 FAX (562) 570-4374

Anissa Davis, MD, MPH
City Health Officer

HIV/STD SURVEILLANCE PROGRAM

April 19, 2019

SUBJECT: REQUEST FOR PATIENT INFORMATION (RELEASE OF INFORMATION)

For the purposes of disease surveillance, prevention, and control efforts within the City of Long Beach, we are requesting additional patient information for a positive lab report for a **reportable communicable disease**.

By State law, HIV infection is a reportable condition in California. This requires laboratories, health care providers, and testing providers to report all cases of HIV infection to their local health department. This reporting requirement is necessary to timely monitor current trends in the epidemic, and to ensure continued funding by federal and State funding agencies for local AIDS treatment and HIV prevention services.

California Health and Safety (H&S) Code Section 121022(a) requires health care providers and laboratories to report cases of HIV infection by name to local health departments. H&S Code Section 121023(a) requires that all CD4 + T-Cell test results also be reported to the local health department. By law, and per State regulations, laboratories must report all CD4 + T-Cell test results and any HIV-indicative test, including all viral load results and confirmed antibody tests to their local health department **within 7 days**.

Laboratories located in Long Beach are responsible for reporting **all** CD4 T-Cell test results (not just those < 200/ul or < 14%), as well as any HIV-indicative test - including all viral loads (even if undetectable) and confirmed antibody tests - to Long Beach's Health Officer. The Health Officer's designee - HIV Epidemiology Program - will follow up with health care providers for laboratory reports sent in order to complete the HIV/AIDS registry.

Health care providers are responsible for providing the client's **full name**, date of birth and gender when submitting laboratory requisitions for any test used to identify HIV, a component of HIV, or antibodies or antigens to HIV.

Thank you for your assistance with this important public health matter. If you have questions, please contact Belinda Prado, HIV/STD Surveillance Coordinator, at (562) 570-4213. Please mail requested information in a double envelope to:

Long Beach Department of Health and Human Services
Epidemiology Program, Suite 229
2525 Grand Avenue
Long Beach, CA 90815

As a reminder, it is your legal responsibility to report within the required timeframe and provide information necessary for the public health investigation of communicable disease (Title 17, California Code of Regulations, Section 2500). Reliance on laboratory reporting is NOT a substitute. Under State laws, the reporting of communicable diseases to the local public health department is exempt from HIPAA (Section 164.512 (b)). **Patient consent is not required**. Patient information is always treated with strict confidence, and information requested is the minimum necessary for public health purposes.

JONATHAN E. FIELDING, MD, MPH
Director and Health Officer

CYNTHIA A. HARDING, MPH
Chief Deputy Director

Division of HIV and STD Programs
Mario J. Pérez, Director
600 South Commonwealth Avenue, 10th Floor
Los Angeles, California 90005
TEL (213) 351-8000 • FAX (213) 387-0912

www.publichealth.lacounty.gov

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April 18, 2014

RE: New HIV Testing Algorithm Reporting Requirements

Dear Laboratory Director,

California law requires that clinical laboratories report HIV-related tests from cases of HIV infection including positive HIV antibody tests, HIV genotype results and all viral load and CD4 test results. The Los Angeles County Department of Public Health (LAC-DPH) HIV Surveillance Unit has worked with local laboratories to establish efficient mechanisms to receive these HIV-related test results. We would like to bring to your attention the newly developed **HIV Laboratory Diagnostic Testing Algorithm** and its impact on HIV laboratory reporting.

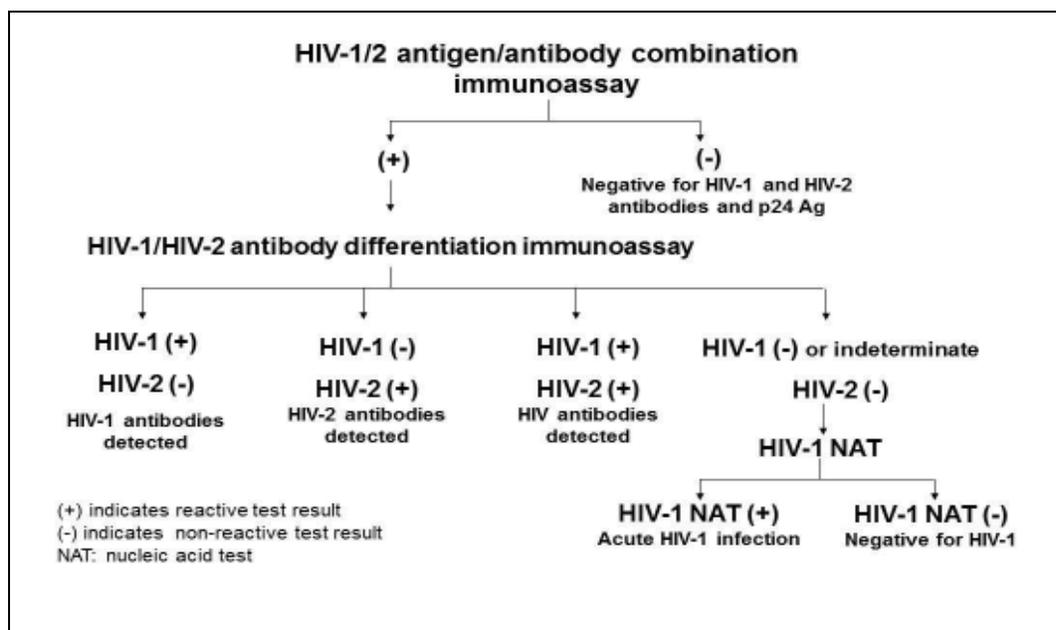
The new testing algorithm that has been recommended by the Centers for Disease Control and Prevention (CDC), the Association of Public Health Laboratories (APHL) and the Clinical and Laboratory Standards Institute (CLSI)¹⁻³ offers several advantages over the conventional algorithm, including the earlier detection of HIV infections and the ability to accurately classify HIV-1 and HIV-2 infections⁴. The use of this new HIV testing algorithm for California laboratories was approved by a California State Emergency Public Health Regulation in June 2013⁵.

This letter provides information regarding the new testing algorithm and how to report test results to HIV Surveillance in accordance with the guidance put forth by APHL's HIV/Hepatitis Subcommittee report entitled "Suggested Reporting Language for the HIV Laboratory Diagnostic Testing Algorithm⁶."

A. Recommended HIV laboratory diagnostic testing algorithm for serum or plasma specimens

A flowchart of the new testing algorithm is shown below (Figure 1). This testing algorithm does not include the conventional Western blot or indirect immunofluorescence assay (IFA) confirmatory test. The algorithm starts with an initial 4th generation HIV-1/2 antigen/antibody combination immunoassay (HIV-1/2 Ag/Ab combo IA) – or a less sensitive 3rd generation HIV-1/2 immunoassay – which, if reactive, is followed by supplemental testing with an HIV-1/2 antibody differentiation assay. Specimens negative or indeterminate by the HIV-1/2 antibody differentiation assay will proceed with a qualitative HIV-1 nucleic acid test (NAT).

Figure 1: HIV Diagnostic Testing Algorithm



B. Interpretation of test results from the HIV testing algorithm and reporting to LAC-DPH

The following table describes the test result interpretation and guidance for reporting to the Los Angeles County Department of Public Health.

1st test: HIV-1/2 Ag/Ab IA	2nd test: HIV-1/2 Ab Differentiation IA	3rd test: HIV-1 NAT	Overall Interpretation	Reporting to LAC-DPH
Nonreactive	N/A	N/A	No laboratory evidence of HIV infection	Public Health reporting not required
Reactive	HIV-1 (+), HIV-2 (+) HIV-1 (+), HIV-2 (-) HIV-1 (-), HIV-2 (+) HIV-1/2 (+) undifferentiated	N/A	Laboratory evidence of HIV-1 and/or HIV-2 infection	Report 1 st and 2 nd HIV test results to Public Health
Reactive	HIV-1/2 (-) or indeterminate	Detected	<i>Acute</i> or early HIV-1 infection	Report 1 st , 2 nd , and 3 rd HIV test results to Public Health
Reactive	HIV-1/2 (-) or indeterminate	Not detected	HIV infection not confirmed; No laboratory evidence of HIV infection	Public Health reporting not required

In summary:

- Test results with a negative or inconclusive overall interpretation (indicating no laboratory evidence of HIV infection) should not be reported.
- All test results with a positive overall interpretation (indicating the presence of HIV infection) should be reported to the Department of Public Health. Please include all negative/nonreactive or indeterminate results that were performed as part of the testing algorithm (e.g., initial 4th or 3rd generation test result, HIV-1/2 differentiation test, and NAT).

The LAC-DPH HIV Surveillance Unit is working with the CDC to collect and document laboratory data from the new testing algorithm for HIV surveillance. We will continue to work with your laboratory to ensure complete, timely and accurate reporting of all HIV-related test results.

If you have any questions or would like assistance with reporting requirements for the new HIV testing algorithm, please contact:

- Zhijuan Sheng, HIV Surveillance Epidemiologist, at (213) 351-8767 or email: zsheng@ph.lacounty.gov
- Virginia Hu, Chief, Data Analysis Unit, at (213) 351-8140 or email: vhu@ph.lacounty.gov
- LaTonya Taylor, Chief Data Acquisition Unit, Lataylor@ph.lacounty.gov

Also, please find attached a list of LOINC codes for these new tests from the Centers for Disease Control and Prevention.

Sincerely,



Douglas Frye, MD, MPH
Chief, HIV Epidemiology
Division of HIV and STD Programs
Phone: (213) 351-8190

Attachment

References:

1. Laboratory Testing Guidance. Centers for Disease Control and Prevention. <http://www.cdc.gov/hiv/testing/lab/guidelines/index.html>. Accessed February 11, 2014.
2. DRAFT Recommendations: Diagnostic Laboratory Testing for HIV Infection in the United States. Presented at the 2012 HIV Diagnostics Conference Feedback Session held on December 14, 2012. http://www.cdc.gov/hiv/pdf/policies_Draft_HIV_Testing_Algo_Rec_508.2.pdf. Accessed February 11, 2014.
3. CLSI. Criteria for Laboratory Testing and Diagnosis of Human Immunodeficiency Virus Infection; Approved Guideline. CLSI Document M-53A, 2011 (CLSI Document M-53A is available only through purchase from <http://www.CLSI.org>).
4. Branson, BM. The Future of HIV Testing. *J Acquir Immune Defic Syndr* 2010;55:S102-S105.
5. State of California Office of Administrative Law. Department of Public Health Emergency Regulatory Action. Approved June 26, 2013. http://www.oal.ca.gov/res/docs/pdf/emergencies/recent%20action,%20moved%20emergencies/2013-0617-01E_App.pdf. Accessed February 11, 2014.
6. Suggested Reporting Language for the HIV Laboratory Diagnostic Testing Algorithm. Association of Public Health Laboratories. Published November 2013. http://www.aphl.org/AboutAPHL/publications/Documents/ID_2013Nov_HIV-Reporting-Language.pdf. Accessed February 11, 2014.



LONG BEACH
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