APPENDIX A

Communicable Disease Service
New Jersey Department of Health and Senior Services

Electronic Laboratory Reporting
Technical Manual

May 2007

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1. Introduction

In an effort towards improving disease surveillance and timely notification of reportable diseases for public health intervention, the New Jersey Departmnet of health and Senior Services (NJDHSS) Communicable Disease Service (CDS) is mandating electronic reporting of laboratory test results from all licensed state, commercial and hospital laboratories. Electronic laboratory reports (ELR) are critical for an effective public health response both for routinely reportable diseases as well as potential bioterrorism (BT) agents.

Currently the Communicable Disease Reporting and Surveillance System (CDRSS), is the data repository of all communicable diseases (with the exception of HIV, TB and STDs) and is designed to accept ELR in the CDC-recommended, PHIN-compliant format of Health Level 7 (HL 7). In addition, as per CDC-recommended industry standards, all HL 7 messages will include Logical Observation Identifiers Names and Codes (LOINC) and Systematized Nomenclature of Medicine (SNOMED) codes, where applicable, to describe the tests and organisms found. In order to standardize results, no text fields will be used to describe tests and results.

2. Acceptable File Formats

2.1 HL 7 File format

2.1.1 HL 7 2.5

The preferred format for electronic transmission of ELR data is HL 7 version 2.5.1, as supplemented and implemented, and as specified by the CDC standards at http://www.cdc.gov/phin/architecture/implementation_guides.

2.1.2 HL 7 2.3

HL 7 Version 2.3.z will also be accommodated on a case-by-case basis. File specification of HL 7 version 2.3.z is available at –
http://www.cdc.gov/nedss/ELR/HL7Spec.pdf.

File specifications can also be requested from NJDHSS, by writing to the Communicable Disease Service, PO Box 369, Trenton, NJ -08625-0369

2.2 XML Schema

2.2.1 File format

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2.2.2 Sample Schema

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3. LOINC/ SNOMED

3.1 LOINC

All electronic test results should include LOINC values to identify the laboratory observation. LOINC applies universal code names and identifiers to medical terminology related to the electronic health record. The purpose is to assist in the electronic exchange and gathering of clinical results (e.g. laboratory tests, clinical observations, outcomes management, research). The LOINC database is developed and maintained by the Regenstrief Institute. The most current database can be downloaded from the Regenstrief Institute website available at http://www.regenstrief.org/medinformatics/loinc/ or by written request to Regenstrief Institute, Inc., Health Informational and Translational Sciences Building, 410 West 10th Street, Suite 2000, Indianpolis, IN, 46202

3.2 SNOMED

SNOMED is a system of standardized medical terminology developed by the College of American Pathologists. It can be described as comprehensive clinical terminology covering diseases, clinical findings, and procedures, that allows for a consistent way of indexing, storing, retrieving and aggregating clinical data across specialties and sites of care. SNOMED helps provide structure and computerize the medical record, reducing the variability in the way data is captured, encoded and used for clinical care of patients and research. For additional explanational please refer to the following document available at http://www.snomed.org/documents/snomed_overview.pdf.

A complete list of SNOMED codes is available at http://www.snomed.org/ or by written request to SNOMED Customer Service, SNOMED International, 325 Waukegan Road, Northfield, IL, 60093.
In addtion a subset for the notifiable diseases is available at the CDC website, available at http://www.cdc.gov/phin/vocabulary/ncmt.html.
CDC is also working to distribute the SNOMED codes through their PHIN Vocabulary Authoring and Distribution System (VADS) in the near future.

4. Mode of Electronic Transmission

NJDHSS will work with individual laboratories to set up Secure File Transfer Protocol (SFTP) connections to transmit data. Additional technologies like Virtual Private Networks (VPN), if available, may be considered.

SFTP is a program that uses the secure shell (SSH) program to transfer files. Unlike standard FTP, it encrypts both commands and data, preventing passwords and sensitive information from being transmitted in the clear over the network.

VPN is a network that is constructed by using the Internet to connect nodes (NJDHSS and lab server). This will allow the data to be encrypted and provide other security mechanisms to ensure that only authorized users can access the network and that the data cannot be intercepted.

5. Test Plan

All electronic interfaces will be tested by NJDHSS and the appropriate laboratory staff before being sent to the production system. The test phase will only be initiated once laboratories provide evidence that they have a complete list of diseases that they would be reporting and the accompanying LOINC and SNOMED tables required to map these diseases and conditions.
In the first phase of testing, the laboratories can provide test data files to OITS staff to process into our test environment. Once approved, the second phase of testing can be initialized, where the laboratories will provide their production data, which will be processed into NJDHSS test environment. Laboratories will also provide hard copies of all test results (as they appear at the physicians' office) to CDS staff. During this phase intense quality testing and assurance will be conducted to verify that all information on the hard copy result is captured accurately in the electronic transmission. Upon completion of phase II testing, data will be processed into production, but hard copies might still be requested by CDS staff, for another few months. Hard copy of results can be discontinued upon agreement by both CDS and the specific laboratory.

6. Contact Information

Mail: Communicable Disease Service, PO Box 369, Trenton, NJ, 08625-0369
Phone: (609) 588 7500

7. References

http://www.hl7.org/
http://www.cdc.gov/phin/phin_news.html#hl7

APPENDIX B

Quarantine and Isolation – Model Rules for Local Boards of Health

1.1 Applicability

The provisions of the model rules are applicable in jurisdictions in which the local board of health has adopted the model rules by reference in accordance with New Jersey law, but no local board of health is required to adopt the model rules.

1.2 Definitions

“Board” means [insert the name of the county, municipal or regional board].

“Department” means the New Jersey Department of Health and Senior Services.

"Isolation" means the physical separation and confinement of an individual or groups of individuals who are infected or reasonably believed to be infected, based on signs, symptoms or laboratory analysis, with a contagious or possibly contagious disease from non-isolated individuals, to prevent or limit the transmission of the disease to non-isolated individuals.

“Quarantinable disease” means any communicable disease which presents a risk of serious harm to public health and which may require isolation or quarantine to prevent its spread.

1. The Department’s lists of reportable communicable diseases are set forth at N.J.A.C. 8:57-1.5.

"Quarantine" means the physical separation and confinement of an individual or groups of individuals, who are or may have been exposed to a communicable or possibly communicable disease and who do not show signs or symptoms of a communicable

disease, from unexposed individuals, to prevent or limit the transmission of the disease to unexposed individuals.

1.3 General provisions

(a) Prior to instituting mandatory isolation or quarantine pursuant to this rule, the board may request that an individual or group of individuals voluntarily confine themselves to a private home or other facility.

(b) The board is authorized to impose and enforce quarantine and isolation restrictions, but the board shall rarely impose quarantine and isolation restrictions.

1. If a quarantinable disease occurs in New Jersey, the board may isolate or quarantine individuals with a suspected or active quarantinable disease and their contacts as the particular situation requires.

2. The board shall complete any quarantine or isolation in accordance with this rule and N.J.A.C. 8:57-1.11.

3. Upon the declaration of a public health emergency, the board shall comply with the isolation and quarantine procedures established in the Emergency Health Powers Act, N.J.S.A. 26:13-1 et seq.

(c) The board shall notify, consult, and work cooperatively with the New Jersey Department of Agriculture on issues relating to isolation and quarantine of potentially infected livestock under the authority of the New Jersey Department of Agriculture pursuant to the provisions of Title 4 of the Revised Statutes and the New Jersey Department of Environmental Protection on issues relating to isolation and quarantine of wildlife under the authority of the New Jersey Department of Environmental Protection

pursuant to the provisions of Title 23 of the Revised Statues, where illness could potentially impact human health.

1.4 Conditions and principles

(a) The board shall adhere to all of the following conditions and principles when isolating or quarantining individuals or a group of individuals:

1. The isolation or quarantine shall be by the least restrictive means necessary to prevent the spread of a communicable or possibly communicable disease to others and may include, but is not limited to, confinement to private homes, other private premises, or public premises.

2. Isolated individuals shall be confined separately from quarantined individuals.

3. The health status of isolated or quarantined individuals shall be monitored regularly to determine if the individuals require further or continued isolation or quarantine.

4. If a quarantined individual subsequently becomes infected or is reasonably believed to have become infected with a communicable or possibly communicable disease, the individual shall be promptly removed to isolation.

5. Isolated or quarantined individuals shall be immediately released when the board determines that the individuals pose no substantial risk of transmitting a communicable or possibly communicable disease.

6. The board shall address the needs of isolated or quarantined individuals in a systemic and competent fashion including, but not limited to, providing adequate food;

clothing; shelter; means of communicating with those in and outside of isolation or quarantine; medication; and competent medical care.

7. The premises used for isolation or quarantine shall be maintained in a safe and hygienic manner and shall be designed to minimize the likelihood of further transmission of infection or other harm to isolated or quarantined individuals.

8. To the extent possible, the board shall consider cultural and religious beliefs in addressing the needs of individuals in isolation and quarantine.

1.5 Isolation or quarantine premises

(a) The board shall prominently identify sites of isolation or quarantine with isolation or quarantine signs posted on all sides of the building wherever access is possible.

(b) An individual subject to isolation or quarantine shall obey the rules and orders of the board and shall not go beyond the isolation or quarantine premises without appropriate authorization and only while using appropriate infection control precautions to protect unexposed individuals.

(c) The Department or the board may authorize physicians, health care workers, or others access to individuals in isolation or quarantine as necessary to meet the needs of isolated or quarantined individuals.

(d) No individual, other than an individual authorized by the Department or the board, shall enter isolation or quarantine premises.

1. If the Department or the board has requested the assistance of law enforcement in enforcing the isolation or quarantine, the department or the board shall provide law

enforcement personnel with a list of individuals authorized to enter the isolation or quarantine premises.

(e) Any individual entering an isolation or quarantine premises with or without authorization of the Department or the board may be isolated or quarantined pursuant to this rule and N.J.A.C. 8:57-1.11.

1.6 Isolation and quarantine

(a) The board may:

1. Isolate individuals who are presumably or actually infected with a quarantinable disease;

2. Quarantine individuals who have been exposed to a quarantinable disease;

3. Establish and maintain places of isolation and quarantine; and

4. Adopt emergency rules and issue orders as necessary to establish, maintain, and enforce isolation or quarantine.

(b) The board may temporarily isolate or quarantine an individual or groups of individuals through an verbal order, without notice, only if delay in imposing the isolation or quarantine would significantly jeopardize the board's ability to prevent or limit the transmission of a communicable or possibly communicable disease to others.

1. If the board imposes temporary isolation or quarantine of an individual or groups of individuals through a verbal order, the board shall issue a written order as soon as is reasonably possible and in all cases within 24 hours of issuance of the verbal order if continued isolation or quarantine is necessary to prevent or limit the transmission of a communicable or possibly communicable disease.

(c) The board may isolate or quarantine an individual or groups of individuals through a written order issued pursuant to this rule.

1. The written order shall include all of the following:

i. The identity of the individual, individuals, or groups of individuals subject to isolation or quarantine;

ii. The premises subject to isolation or quarantine;

iii. The date and time at which isolation or quarantine commences;

iv. The suspected communicable disease;

v. A description of the less restrictive alternatives that the board attempted without success, or the less restrictive alternatives considered and rejected, and the reasons the board rejected such alternatives;

vi. A statement of compliance with the conditions and principles for isolation and quarantine specified in section 1.4;

vii. The legal authority under which the board requested the order;

viii. The medical basis upon which isolation or quarantine is justified;

ix. A statement advising the individual, individuals, or groups of individuals of the right to appeal the written order pursuant to section 1.7 and the rights of individuals and groups of individuals subject to quarantine and isolation as listed in section 1.8; and

x. A copy of this rule.

2. The board shall provide a copy of the written order to the individual to be isolated or quarantined within 24 hours of issuance of the order in accordance with any applicable process authorized by New Jersey law.

i. If the order applies to a group or groups of individuals and it is impractical to provide individual copies, the board may post the order in a conspicuous place in the isolation or quarantine premises.

1.7 Appeal from order imposing isolation or quarantine

(a) The subject of a board order imposing isolation or quarantine may appeal a written order by submitting a written appeal within ten days of receipt of the written order.

1. The subject shall address the appeal to [insert name of board and board address].

2. Unless stayed by order of the board or court with jurisdiction, the written order for quarantine or isolation shall remain in force and effect until the appeal is finally determined and disposed of upon its merits.

(b) The appeal proceeding shall be conducted in accordance with this rule [or insert specific board rule governing appeal proceedings].

1. The board shall hold the proceeding as soon as is practicable, and in no case later than ten days from the date of receipt of the appeal.

2. The board may hold the hearing by telephonic or other electronic means if necessary to prevent additional exposure to the person with the communicable or possibly communicable disease.

3. In extraordinary circumstances and for good cause shown, the board may continue the proceeding date for up to ten days, giving due regard to the rights of the

affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence.

4. At the appeal proceedings, the subject of the appeal shall have the right to introduce evidence on all issues relevant to the order.

5. The board, by majority vote, may modify, withdraw, or order compliance with the order under appeal.

(c) The aggrieved party to the final decision of the board may petition for judicial review of that action by filing an action in the appropriate court with jurisdiction.

1. Petitions for judicial review shall be filed within 30 days after the decision becomes final.

(d) The board acknowledges that in certain circumstances the subject or subjects of a board order may desire immediate judicial review of a board order in lieu of proceeding with the board's appeal process.

1. The board may consent to immediate jurisdiction of a court with jurisdiction when requested by the subject or subjects of a board order and justice so requires.

2. Unless stayed by order of the board or a court with jurisdiction, the written order for quarantine or isolation shall remain in force and effect until the judicial review is finally determined and disposed of upon its merits.

1.8 Rights of individuals and groups of individuals subject to isolation or quarantine

(a) Any individual or group of individuals subject to isolation or quarantine shall have the following rights:

1. The right to be represented by legal counsel;

2. The right to be provided with prior notice of the date, time, and location of any hearing;

3. The right to participate in any hearing, which could be by telephonic or electronic means;

4. The right to respond and present evidence and argument on the individual's own behalf in any hearing;

5. The right to cross-examine witnesses who testify against the individual; and

6. The right to view and copy all records in the possession of the board which relate to the subject of the written order.

1.9 Consolidation of claims

(a) In any proceeding brought pursuant to this rule, to promote the fair and efficient operation of justice and having given due regard to the rights of the affected individuals, the protection of the public's health, and the availability of necessary witnesses and evidence, the board or court with jurisdiction may order the consolidation of individual claims into group claims, if all of the following conditions exist:

1. The number of individuals involved or to be affected is large enough that consolidation would be best use of resources;

2. There are questions of law or fact common to the individual claims or rights to be determined;

3. The group claims or rights to be determined are typical of the affected individuals' claims or rights; and

4. The entire group will be adequately represented in the consolidation.

1.10 Implementation and enforcement of isolation and quarantine

(a) The Department has primary jurisdiction to isolate or quarantine individuals or groups of individuals if the communicable disease has affected more than one county or has multicounty, statewide, interstate or public health emergency implications.

1. If the Department imposes isolation or quarantine, the board may not alter, amend, modify, or rescind the isolation or quarantine order.

(b) If the Department imposes isolation or quarantine the local boards of health and the local health departments in the affected areas shall assist in the implementation of the isolation or quarantine order.

(c) Any individual who violates a lawful board or Department order for isolation or quarantine, whether written or verbal, shall be subject to a penalty pursuant to N.J.S.A. 26:4-129.

(d) The board may file a civil action in accordance with New Jersey law in a court with jurisdiction to enforce a board order for isolation or quarantine.

New Jersey Department of Health and Senior Services

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(FOR PATIENTS ≥13 YEARS OF AGE AT TIME OF DIAGNOSIS)

(IMPORTANT: Fields which are "shaded" are required fields and MUST be completed.)

Date Received at NJDHSS

PATIENT NAME AND ADDRESS

Patient Name (Last, First, MI)	Alias	Telephone No.	
Address	City	State	Zip Code
County / Date Form Completed	Prisoner Number	CTS Number	Medical Record Number

NJDHSS USE ONLY

Soundex Code	Reporting Health Department-State	State Patient Number
Surveillance Method ☐A ☐F ☐P ☐R ☐U	Reporting Health Department-City/County	
Document Source	Or Source Code A __ __ . __ __ . __ __	
Did this Report initiate a new case investigation? ☐Yes ☐No	Report Medium ☐Field Visit ☐Mailed ☐Telephone ☐SDN	

DEMOGRAPHIC INFORMATION

Diagnostic Status at Report	Date of Birth (Month/Day/Year)	Alias Date of Birth (Month/Day/Year)	Sex at Birth	Country of Birth
☐HIV Infection (not AIDS) ☐AIDS	__ __ / __ __ / __ __	__ __ / __ __ / __ __	☐Male ☐Female	☐U.S. ☐Other, Specify:

Ethnicity *(Select One)*	Race *(Select one or more)*		
☐Hispanic ☐Not Hispanic ☐Unknown	☐Amer. Indian/Alaska Native ☐Asian	☐Black/African American ☐Native Hawaiian or Other Pac. Isl.	☐White ☐Unknown

Current Status	Date of Death	State/Territory of Death
☐Alive ☐Dead	__ __ / __ __ / __ __	

RESIDENCE AT DIAGNOSIS

City	County	State/Country	Zip Code
			__ __ __ __ __-__ __ __ __

FACILITY/PROVIDER OF DIAGNOSIS

Name of Facility/Provider			Name of Contact Person
Facility/Provider Full Address			Name of Person Completing Form
City	State	Zip Code	Main Telephone Number

Facility Setting *(Check one)*	Facility Type *(Check one)*
☐Public ☐Private ☐Federal ☐Unknown	☐Physician, HMO ☐Hospital, Inpatient ☐Other, Specify:

PATIENT HISTORY

Yes	No	Unk	
☐	☐	☐	Sex with male
☐	☐	☐	Sex with female
☐	☐	☐	Injected nonprescription drugs
			HETEROSEXUAL relations with any of the following:
☐	☐	☐	Intravenous/injection drug user
☐	☐	☐	Bisexual male
☐	☐	☐	Person with hemophilia/coagulation disorder
☐	☐	☐	Transfusion recipient with documented HIV infection
☐	☐	☐	Transplant recipient with documented HIV infection
☐	☐	☐	Person with AIDS or documented HIV infection, risk not specified
☐	☐	☐	Perinatal infection

Yes	No	Unk	
☐	☐	☐	Received clotting factor for hemophilia/coagulation disorder - specify disorder: ☐Factor VIII (Hemophilia A) ☐Factor IX (Hemophilia B) ☐Other, Specify:
☐	☐	☐	Received transfusion of blood/blood components (other than clotting factor) First (Mo/Yr): __ __ / __ __ Last (Mo/Yr): __ __ / __ __
☐	☐	☐	Received transplant of tissue/organs or artificial insemination
☐	☐	☐	Worked in a health-care or clinical laboratory setting; -specify occupation:

CLINICAL STATUS

Clinical Record Reviewed?	Co-Infection:	Date Patient was Diagnosed as **Asymptomatic** (including acute retroviral syndrome and persistent generalized lymphadenopathy):	Date Patient was Diagnosed as **Symptomatic** (not AIDS):
☐Yes ☐No	☐Hepatitis B ☐Hepatitis C ☐STD (Specify): _____	___ ___ / ___ ___	___ ___ / ___ ___

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT (Continued)

LABORATORY DATA

HIV Antibody Tests at Diagnosis

HIV-1 Western Blot	☐Pos	☐Neg	___/___/___
Rapid _____	☐Pos	☐Neg	___/___/___
Rapid _____	☐Pos	☐Neg	___/___/___
HIV-1 EIA	☐Pos	☐Neg	___/___/___
HIV-1/2 EIA	☐Pos	☐Neg	___/___/___
HIV-2 EIA	☐Pos	☐Neg	___/___/___
HIV-2 Western Blot	☐Pos	☐Neg	___/___/___

Positive HIV Detection Test (Record Earliest Test)

☐Culture ☐Antigen ☐PCR, DNA or RNA probe ___/___/___

☐Other (Specify): _____ ___/___/___

Viral Load Test (Earliest and Most Recent Tests)

Test Type	Copies/ml or Undetectable	Earliest Date
☐NASBA		___/___/___
☐RT-PCR		___/___/___
☐bDNA		___/___/___

Test Type	Copies/ml or Undetectable	Most Recent Date
☐NASBA		___/___/___
☐RT-PCR		___/___/___
☐bDNA		___/___/___

Date of last documented Negative HIV test (specify type):

_____ ___/___/___

IF HIV lab tests were not documented, is HIV diagnosis documented by a physician? ☐Yes ☐No ☐Unk.

If yes, provide date of documentation by physician: ___/___/___

Prior Tests

No. of HIV tests in 2 years before first positive: _____

Immunologic Lab Tests

At or closest to current diagnostic status:

CD4 Count ..... _____ cells/∝L ___/___/___

CD4 Percent ..... _____ % ___/___/___

First <200 ∝L or 14%

CD4 Count ..... _____ cells/∝L ___/___/___

CD4 Percent ..... _____ % ___/___/___

Genotype Testing

☐Yes ☐No Lab: _____ Date: ___/___/___

AIDS INDICATOR DISEASES

AIDS Indicator Disease	Initial Diag. Def.*	Initial Diag. Pres.*	Initial Date (Month/Year)
Candidiasis, bronchi, trachea, or lungs		N/A	___ / ___
Candidiasis, esophageal			___ / ___
Carcinoma, invasive cervical		N/A	___ / ___
Coccidioidomycosis, disseminated or extrapulmonary		N/A	___ / ___
Cryptococcosis, extrapulmonary		N/A	___ / ___
Cryptosporidiosis, chronic intestinal (>1 mo. Duration)		N/A	___ / ___
Cytomegalovirus disease (other than in liver, spleen, or nodes)		N/A	___ / ___
Cytomegalovirus retinitis (with loss of vision)		N/A	___ / ___
HIV encephalopathy		N/A	___ / ___
Herpes simplex: chronic ulcer(s) (>1 mo. Duration), or bronchitis, pneumonitis or esophagitis		N/A	___ / ___
Histoplasmosis, disseminated or extrapulmonary		N/A	___ / ___
Isosporiasis, chronic intestinal (>1 mo. Duration)		N/A	___ / ___
Kaposi's sarcoma			___ / ___

AIDS Indicator Disease	Initial Diag. Def.*	Initial Diag. Pres.*	Initial Date (Month/Year)
Lymphoma, Burkitt's (or equivalent term)		N/A	___ / ___
Lymphoma, immunoblastic (or equivalent term)		N/A	___ / ___
Lymphoma, primary in brain		N/A	___ / ___
Mycobacterium avium complex or *M. kansasii*, disseminated or extrapulmonary			___ / ___
M. tuberculosis, pulmonary **			___ / ___
M. tuberculosis, disseminated or extrapulmonary **			___ / ___
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary			___ / ___
Pneumocystis carinii pneumonia			___ / ___
Pneumonia, recurrent, in 12 mo. Period			___ / ___
Progressive multifocal leukoencephalopathy		N/A	___ / ___
Salmonella septicemia, recurrent		N/A	___ / ___
Toxoplasmosis of brain			___ / ___
Wasting syndrome due to HIV		N/A	___ / ___

* Def. = Definitive Diagnosis Pres. = Presumptive Diagnosis

** RVCT Case No.: _____

TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? ☐Yes ☐No ☐Unknown	Number of patient's sex or needle sharing partners:	Number of patient's partners notified about their HIV exposure by provider:

Is this patient receiving or has been referred for:
HIV related medical services? ☐Yes ☐No ☐Unknown

Substance abuse treatment services?
☐Yes ☐No ☐Not Applicable ☐Unknown

This patient has been enrolled at (clinical trial)?
☐NIH Sponsored ☐Other ☐None ☐Unknown

This patient received or is receiving:
Antiretroviral therapy? ☐Yes ☐No ☐Unknown

PCP prophylaxis?
☐Yes ☐No ☐Unknown

This patient has been enrolled at (clinic)?
☐HRSA Sponsored ☐Other ☐None ☐Unknown

At time of HIV/AIDS diagnosis, medical treatment primarily reimbursed by:
☐Medicaid ☐Private Insurance/HMO ☐No Coverage ☐Other Public Funding ☐Clinical Trial/Government Program ☐Unknown

FOR MEN:
Is this patient circumcised?
☐Yes ☐No ☐Unknown
If Yes, patient's age at circumcision:
_____

FOR WOMEN:
This patient is receiving or has been referred for gynecological or obstetrical services: ☐Yes ☐No ☐Unknown
Is this patient currently pregnant? ☐Yes ☐No ☐Unknown
Has this patient delivered live-born infants since 1989? ☐Yes *(If yes, provide birth information below.)* ☐No ☐Unknown

Child's DOB (Mo/Day/Yr.)	Name of Child	Hospital	City	State	Child's Soundex	Child's State No.

Comments

New Jersey Department of Health and Senior Services
Surveillance Unit
PO Box 363
Trenton, NJ 08625-0363

CONFIDENTIAL LABORATORY REPORT

PATIENT INFORMATION

Name of Patient (Last, First, MI)				Date of Report
Patient Street Address	City	County	State	Zip Code

Patient Identifiers:	Medical Record Number	Prison ID Number	Patient ID Number	Social Security Number

Sex	Patient Birthdate	Ethnicity (Select One)	Race (Select one or more)	
☐ Male ☐ Female	___ / ___ / _____	☐ Hispanic ☐ Not Hispanic ☐ Unknown	☐ Amer. Indian/Alaska Native ☐ Asian ☐ White	☐ Black/African American ☐ Native Hawaiian or Other Pac. Isl. ☐ Unknown

NAME OF FACILITY OR PROVIDER PRACTICE THAT ORDERED TESTS

Name of Facility/Provider			Name of Contact Person
Facility/Provider Full Address			
City	State	Zip Code	Main Telephone Number

NAME OF LABORATORY

Name of Laboratory			CLIA Code
Street Address			Name of Contact Person
City	State	Zip Code	Telephone Number

LABORATORY TEST RESULTS

Antibody Tests (Positive Results Only)	**Accession Number**	**Date Collected**	**Date Tested**	**Manufacturer**	**Specimen Type (Blood Saliva, Urine, Other, Unk)**	**Sent to Ref. Lab**
HIV-1 EIA						
HIV-1/2 EIA						
HIV-2 EIA						
HIV-1 Western Blot						
HIV-2 Western Blot						
HIV-1 IFA						
Rapid #1						
Rapid #2						
Other:						

HIV Detection Tests	**Accession Number**	**Date Collected**	**Date Tested**	**Results (Pos./Neg.)**	**Manufacturer**	**Specimen Type (Blood Saliva, Urine, Other, Unk)**	**Sent to Ref. Lab**
HIV-1 Proviral DNA (Qual)							
HIV-1 RNA-PCR (Qual)							
HIV-1 P24 Antigen							
HIV-1 Culture							
HIV-2 Culture							
Other:							

HIV Viral Load Tests	**Accession Number**	**Date Collected**	**Date Tested**	**# of Copies/ml**	**Interpretation (Det./Undet.)**	**Manufacturer**	**Specimen Type (Blood Saliva, Urine, Other, Unk)**	**Sent to Ref. Lab**
HIV-1 RNA RT-PCR (Standard)								
HIV-1 RNA RT-PCR (Ultrasensitive)								
HIV-1 bDNA								
HIV-1 RNA NASBA								
HIV-1 RNA Other:								

Immunologic Tests (CD4 <200 cells/mm3 or CD4% <14)	**Accession Number**	**Date Collected**	**Date Tested**	**Results**	**Manufacturer**	**Specimen Type (Blood Saliva, Urine, Other, Unk)**	**Sent to Ref. Lab**
CD4 Count							
CD4 Percent							

Distribution: Original-NJDHSS Copy-Laboratory

New Jersey Department of Health and Senior Services

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT

(FOR PATIENTS <13 YEARS OF AGE AT TIME OF DIAGNOSIS)

Date Received at NJDHSS

(IMPORTANT: Fields which are "shaded" are required fields and MUST be completed.)

PATIENT NAME AND ADDRESS

Patient Name (Last, First, MI)	Alias		Telephone No.
Address	City	State	Zip Code
County	Date Form Completed	CTS Number	Medical Record Number

NJDHSS USE ONLY

Soundex Code	Reporting Health Department-State	State Patient Number
Surveillance Method ☐A ☐F ☐P ☐R ☐U	Reporting Health Department-City/County	
Document Source		Or Source Code **A** __ __ . __ __ . __ __
Did this Report initiate a new case investigation? ☐Yes ☐No	Report Medium ☐Field Visit ☐Mailed ☐Telephone ☐SDN ☐Internal Matching Program	

DEMOGRAPHIC INFORMATION

Diagnostic Status at Report	Date of Birth (Month/Day/Year)	Sex at Birth	Country of Birth
☐Perinatally HIV Exposed ☐AIDS ☐Confirmed HIV Infection (not AIDS) ☐Seroreverter	__ __ / __ __ / __ __	☐Male ☐Female	☐U.S. ☐Puerto Rico ☐Other, Specify:

Ethnicity *(Select One)*	Race *(Select one or more)*		
☐Hispanic ☐Not Hispanic ☐Unknown	☐Amer. Indian/Alaska Native ☐Asian	☐Black/African American ☐Native Hawaiian or Other Pac. Isl.	☐White ☐Unknown

Current Status	Date of Death	State/Territory of Death
☐Alive ☐Dead	__ __ / __ __ / __ __	

Date of Initial Evaluation for HIV Infection:	Date of Last Evaluation for HIV Infection:	Was the reason for initial HIV evaluation due to clinical signs and symptoms?
__ __ / __ __	__ __ / __ __	☐Yes ☐No ☐Unknown

RESIDENCE AT DIAGNOSIS

City	County	State/Country	Zip Code
			__ __ __ __ __-__ __ __ __

FACILITY OR PROVIDER PRACTICE

Name of Facility/Provider Practice	Name of Contact Person	Main Telephone Number
Full Address of Facility/Provider Practice	City	State/Country

Name of Person Completing Form	Telephone No. of Person Completing Form	Medical Record Number

Facility Setting *(Check one)*	Facility Type *(Check one)*
☐Public ☐Private ☐Federal ☐Unknown	☐Physician, HMO ☐Hospital, Inpatient ☐Other, Specify:

PATIENT HISTORY

Child's biological **mother's** HIV Infection Status *(Check one)*

☐Refused HIV Testing ☐Known to be Uninfected after this child's birth ☐HIV Status Unknown

Diagnosed with HIV infection/AIDS:

☐Before this child's pregnancy ☐At time of delivery ☐After the child's birth

☐During this child's pregnancy ☐Before child's birth, exact period unknown ☐HIV-infected, unknown when diagnosed

Date of **mother's** first positive HIV confirmatory test:	Mother was counseled about HIV testing during this pregnancy, labor or delivery?
__ __ / __ __	☐Yes ☐No ☐Unknown

PATIENT HISTORY, Continued

Yes	No	Unk	
☐	☐	☐	Mother perinatally infected
			After 1977, this child's biologic mother had:
☐	☐	☐	Injected nonprescription drugs
			HETEROSEXUAL relations with:
☐	☐	☐	Intravenous/injection drug user
☐	☐	☐	Bisexual male
☐	☐	☐	Male with hemophilia/coagulation disorder
☐	☐	☐	Transfusion recipient with documented HIV infection
☐	☐	☐	Transplant recipient with documented HIV infection
☐	☐	☐	Male with AIDS or documented HIV infection, risk not specified
☐	☐	☐	Received transfusion of blood/blood components (other than clotting factor)
☐	☐	☐	Received transplant of tissue/organs or artificial insemination

Before the diagnosis of HIV Infection/AIDS, this child had:

Yes	No	Unk	
☐	☐	☐	Received clotting factor for hemophilia/coagulation disorder - specify disorder: ☐Factor VIII (Hemophilia A) ☐Factor IX (Hemophilia B) ☐Other, Specify:
☐	☐	☐	Received transfusion of blood/blood components (other than clotting factor) First (Mo/Yr): __ __ / __ __ Last (Mo/Yr): __ __ / __ __
☐	☐	☐	Received transplant of tissue/organs
☐	☐	☐	Sexual contact with a male
☐	☐	☐	Sexual contact with a female
☐	☐	☐	Injected nonprescription drugs
☐	☐	☐	Other (alert State/City NIR Coordinator)

LABORATORY DATA

HIV Antibody Tests at Diagnosis

HIV-1 Western Blot	☐Pos	☐Neg	___/___/___
Rapid _____	☐Pos	☐Neg	___/___/___
Rapid _____	☐Pos	☐Neg	___/___/___
HIV-1 EIA	☐Pos	☐Neg	___/___/___
HIV-1/2 EIA	☐Pos	☐Neg	___/___/___
HIV-2 EIA	☐Pos	☐Neg	___/___/___
HIV-2 Western Blot	☐Pos	☐Neg	___/___/___

Positive HIV Detection Tests

☐Culture ☐Antigen ☐PCR, DNA or RNA probe ___/___/___

☐Other (Specify): _____ ___/___/___

Viral Load Test (Earliest and Most Recent Tests)

Test Type	Copies/ml or Undetectable	**Earliest** Date
☐NASBA		___/___/___
☐RT-PCR		___/___/___
☐bDNA		___/___/___

Test Type	Copies/ml or Undetectable	**Most Recent** Date
☐NASBA		___/___/___
☐RT-PCR		___/___/___
☐bDNA		___/___/___

If HIV tests were not positive or were not done, or the patient is less than 18 months of age, does this patient have an immunodeficiency that would disqualify the child from the HIV/AIDS definition?
☐Yes ☐No ☐Unknown

If HIV lab tests were not documented, is HIV diagnosis documented by a physician?
☐Yes ☐No ☐Unknown

If yes, provide date of documentation by physician: ___/___/___

Immunologic Lab Tests

At or closest to current diagnostic status:

CD4 Count ..... _____ cells/∝L ___/___/___

CD4 Percent ..... _____ % ___/___/___

First <200 ∝L or 14%

CD4 Count ..... _____ cells/∝L ___/___/___

CD4 Percent ..... _____ % ___/___/___

Genotype Testing

☐Yes ☐No Lab: _____ Date: ___/___/___

AIDS INDICATOR DISEASES

AIDS Indicator Disease	Initial Diag. Def.*	Initial Diag. Pres.*	Initial Date (Month/Year)
Bacterial infections, multiple or recurrent (including Salmonella septicemia)		N/A	___ / ___
Candidiasis, bronchi, trachea, or lungs		N/A	___ / ___
Candidiasis, esophageal			___ / ___
Coccidioidomycosis, disseminated or extrapulmonary		N/A	___ / ___
Cryptococcosis, extrapulmonary		N/A	___ / ___
Cryptosporidiosis, chronic intestinal (>1 mo. duration)		N/A	___ / ___
Cytomegalovirus disease (other than in liver, spleen, or nodes)		N/A	___ / ___
Cytomegalovirus retinitis (with loss of vision)		N/A	___ / ___
HIV encephalopathy		N/A	___ / ___
Herpes simplex: chronic ulcer(s) (>1 mo. duration), or bronchitis, pneumonitis or esophagitis onset at >1 month of age		N/A	___ / ___
Histoplasmosis, disseminated or extrapulmonary		N/A	___ / ___
Isosporiasis, chronic intestinal (>1 mo. duration)		N/A	___ / ___
Kaposi's sarcoma			___ / ___
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia			___ / ___
Lymphoma, Burkitt's (or equivalent term)		N/A	___ / ___
Lymphoma, immunoblastic (or equivalent term)		N/A	___ / ___
Lymphoma, primary in brain		N/A	___ / ___
Mycobacterium avium complex or *M. kansasii*, disseminated or extrapulmonary			___ / ___
M. tuberculosis, pulmonary **			___ / ___
M. tuberculosis, disseminated or extrapulmonary **			___ / ___
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary			___ / ___
Pneumocystis carinii pneumonia			___ / ___
Progressive multifocal leukoencephalopathy		N/A	___ / ___
Toxoplasmosis of brain			___ / ___
Wasting syndrome due to HIV		N/A	___ / ___
Has this child been diagnosed with pulmonary tuberculosis? ☐Yes ☐No ☐Unknown			___ / ___

* Def. = Definitive Diagnosis Pres. = Presumptive Diagnosis

BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: ☐Yes ☐No ☐Unknown ***If No or Unknown, proceed to Treatment/Services Referrals.***

Hospital at Birth

Hospital Name	City	State/Country

Residence at Birth

City	County	State/Country	Zip Code
			__ __ __ __ __-__ __ __ __

Birthweight (enter lbs/oz OR grams)
|___|___| lbs. / |___|___| ozs. OR |___|___|___|___| grams

Birth Type
☐Single ☐Twin ☐>2 ☐Unknown

Delivery
☐Vaginal ☐Elective Caesarean ☐Non-elective Caesarean ☐Caesarean, unknown type ☐Unknown

Birth Defects
☐Yes ☐No ☐Unknown

Specify Type(s): _____ Code: |___|___|___| . |___|___|___|

Neonatal Status ☐Full Term ☐Premature Weeks: |___|___| *99 = Unknown*	Month of pregnancy prenatal care began: Month: |___|___| *99 = Unknown 00 = None*	Total number of prenatal care visits: |___|___| *99 = Unknown 00 = None*
Did mother receive zidovudine (ZDV, AZT) during pregnancy? ☐Refused ☐Yes ☐No ☐Unknown	Did mother receive zidovudine (ZDV, AZT) during labor/delivery? ☐Refused ☐Yes ☐No ☐Unknown	Did mother receive any other Anti-retroviral medication during pregnancy? ☐Yes ☐No ☐Unknown If Yes, specify:
If yes, what week of pregnancy was zidovudine (ZDV, AZT) started? |___|___| Weeks *99 = Unknown*	Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy? ☐Yes ☐No ☐Unknown	Did mother receive any other Anti-retroviral medication during labor/delivery? ☐Yes ☐No ☐Unknown If Yes, specify:

MATERNAL DATA

Maternal Date of Birth:	Maternal Soundex:	Mother's Name:	Maternal State Patient No.:
__ __ / __ __ / __ __	|___|___|___|___|	_____	__ __ __ __ __ __ __ __ __ __

Birthplace of Biologic Mother:
☐U.S. ☐U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____
☐Other (specify): _____ ☐Unknown

TREATMENT/SERVICES REFERRALS

This child received or is receiving: Date Started

Neonatal zidovudine (ZDV, AZT) for HIV *prevention* ..... ☐Yes ☐No ☐Unknown ..... __ __ / __ __ / __ __
Other neonatal anti-retroviral medication for HIV *prevention* ..... ☐Yes ☐No ☐Unknown ..... __ __ / __ __ / __ __
If yes, specify: _____
Anti-retroviral therapy for HIV *treatment*..... ☐Yes ☐No ☐Unknown ..... __ __ / __ __ / __ __
PCP prophylaxis..... ☐Yes ☐No ☐Unknown ..... __ __ / __ __ / __ __

Was child breastfed?
☐Yes ☐No ☐Unknown

This child has been enrolled at (clinical trial)?	This child has been enrolled at (clinic)?
☐NIH Sponsored ☐Other ☐None ☐Unknown	☐HRSA Sponsored ☐Other ☐None ☐Unknown

This child's medical treatment is primarily reimbursed by:
☐Medicaid ☐Private Insurance/HMO ☐No Coverage ☐Other Public Funding ☐Clinical Trial/Government Program ☐Unknown

This child's primary caretaker is:
☐Biologic parent(s) ☐Other relative ☐Foster/Adoptive parent, relative ☐Foster/Adoptive parent, unrelated
☐Social service agency ☐Other (specify in "Comments") ☐Unknown

	State Number	Date of Birth	Name
Father:	__ __ __ __ __ __ __ __ __ __	__ __ / __ __ / __ __	_____
Siblings:	__ __ __ __ __ __ __ __ __ __	__ __ / __ __ / __ __	_____
	__ __ __ __ __ __ __ __ __ __	__ __ / __ __ / __ __	_____
	__ __ __ __ __ __ __ __ __ __	__ __ / __ __ / __ __	_____
	__ __ __ __ __ __ __ __ __ __	__ __ / __ __ / __ __	_____
	__ __ __ __ __ __ __ __ __ __	__ __ / __ __ / __ __	_____

Comments

GENERAL INSTRUCTIONS FOR COMPLETING THE HIV TEST FORM

- This form is designed to be read by an Optical Character Recognition (OCR) scanner. The legibility of this form depends on the quality of the hand-written and selected information.
- Carefully separate the sheets at the perforations. If the form tears, it may not be readable by the scanner or operator.
- Each part has a top sheet and a bottom carbonless copy. The top copy (white) is the only sheet that should be scanned. The bottom copy (yellow) should **NOT** be scanned; rather it should be used for record keeping purposes.
- **DO NOT** use red ink. Blue or black ink is preferred.
- **DO NOT** fold, staple, wrinkle or tear form(s).
- **DO NOT USE WHITE OUT**. White out sometimes will cause a mis-read by the scanning software.
- **DO NOT** mark on the bar codes of the Form ID numbers. Marking on the Form ID numbers (barcode) may cause the wrong number to be scanned.
- **DO NOT** make any stray marks on the form(s), particularly in the fields where answers will appear.
- Part 1 is the only form with a pre-printed code. You must attach a form identification sticker (barcode) located on the back of the carbonless copy (yellow) to Part 2 and/or Part 3 in order to link a client's information.
    - Part 1 should be used for all testing events
    - Part 2 should be used to record referral data on **confirmed HIV positive** clients
    - Part 3 is used by jurisdictions funded to collect HIV Incidence data.

RESPONSE FORMATS

There are three different response formats on the form that you will use to record data: (1) text boxes, (2) check boxes, and (3) radio buttons. Instructions for each one of these formats are listed below.

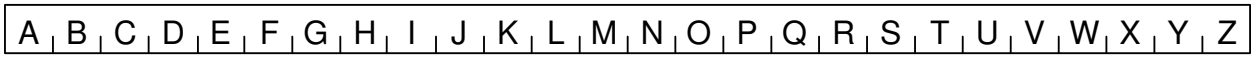
Text boxes

Text boxes are used to record handwritten information (e.g., codes, dates). When writing letters or numbers in the boxes:

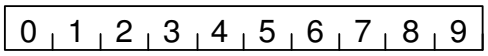
- use all capital letters and write neatly in your best penmanship. **DO NOT** use cursive.
- put only 1 letter or number per box and **DO NOT** have any part of the letter or number touch the edges of the box.

Here are examples of how to write letters and numbers:

LETTERS



NUMBERS



Check boxes

Check boxes are used to select all options that apply. For example, check boxes are used to record information about "Race."

- use an "X" instead of a check mark because the tail of the check mark might run over into another box.
- keep the "X" within the edges of the box.

Radio buttons

Radio buttons are ovals used to select only one option from among two or more options. For example, radio buttons are used to select "Current Gender." When selecting an option using a radio button:

- fill in the oval completely.
- **DO NOT** mark over area of the oval.

Printed Barcode

HIV TEST FORM

PART 1

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

CDC Centers for Disease Control and Prevention

Agency

Session Date (MMDDYYYY) | Unique Agency ID Number | Intervention ID

Site ID | Site Type (See codes on reverse) | Site Zip Code

Client

Client ID | Date of Birth (MMDDYYYY) | State | County | Zip Code

Ethnicity
- Hispanic or Latino
- Not Hispanic or Latino
- Don't know
- Declined

Race — *Check all that apply*
- American Ind./AK Native
- Asian
- Black/African American
- Native HI/Pac. Islander
- White
- Don't know
- Declined

Current Gender
- Male
- Female
- Transgender – M2F
- Transgender – F2M

Previous HIV Test?
- Yes
- No
- Don't know
- Declined
- Not asked

Self-Reported Result
- Positive
- Negative
- Prelim. Pos.
- Indeterminate
- Don't know
- Declined
- Not asked

Provide date of last test (MMYYYY)

HIV Test Information

	HIV TEST 1	HIV TEST 2	HIV TEST 3
Sample Date (MMDDYYYY)			
Worker ID			
Test Election	○ Tested anonymously ○ Tested confidentially ○ Declined testing	○ Tested anonymously ○ Tested confidentially ○ Declined testing	○ Tested anonymously ○ Tested confidentially ○ Declined testing
Test Technology	○ Conventional ○ Rapid ○ Other	○ Conventional ○ Rapid ○ Other	○ Conventional ○ Rapid ○ Other
Specimen Type	○ Blood: finger stick ○ Blood: venipuncture ○ Blood spot ○ Oral mucosal transudate ○ Urine	○ Blood: finger stick ○ Blood: venipuncture ○ Blood spot ○ Oral mucosal transudate ○ Urine	○ Blood: finger stick ○ Blood: venipuncture ○ Blood spot ○ Oral mucosal transudate ○ Urine
Test Result	○ Positive/Reactive ○ NAAT-pos ○ Negative ○ Indeterminate ○ Invalid ○ No result	○ Positive/Reactive ○ NAAT-pos ○ Negative ○ Indeterminate ○ Invalid ○ No result	○ Positive/Reactive ○ NAAT-pos ○ Negative ○ Indeterminate ○ Invalid ○ No result
Result Provided	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
Date Provided (MMDDYYYY)			
If results not provided, why?	○ Declined notification ○ Did not return/Could not locate ○ Obtained results from another agency	○ Declined notification ○ Did not return/Could not locate ○ Obtained results from another agency	○ Declined notification ○ Did not return/Could not locate ○ Obtained results from another agency
If rapid reactive, did client provide confirmatory sample?	○ Yes ○ Client declined confirmatory test ○ Did not return/Could not locate ○ Referred to another agency ○ Other	○ Yes ○ Client declined confirmatory test ○ Did not return/Could not locate ○ Referred to another agency ○ Other	○ Yes ○ Client declined confirmatory test ○ Did not return/Could not locate ○ Referred to another agency ○ Other

Risk Factors

Choose one if: ○ Client was not asked about risk factors ○ Client was asked, but no risk was identified ○ Client declined to discuss risk factors

If client risk factor information was discussed, please mark all that apply:

In past 12 months has client had:

Vaginal or Anal Sex — With Male ☐ With Female ☐

Oral Sex ☐

...without using a condom? ☐

...with person who is an IDU? ☐

...with person who is MSM? (Female Only) ☐

...with person who is HIV positive? ☐

Injection Drug Use (IDU)

Has client used injection drugs in past 12 months? ☐

↓ *if marked* ↓

Did client share drug injection equipment? ☐

Other Risk Factor(s) (see codes on reverse)

Session Activity

During this visit, was a risk reduction plan developed for the client? ○ Yes ○ No

Other Session Activities (see codes on reverse)

Local Use Fields

L1

L2

CDC Use Fields

C1

C2

Printed Barcode

HIV TEST FORM
PART 1

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

CDC Centers for Disease Control and Prevention

Agency

Session Date (MMDDYYYY) | Unique Agency ID Number | Intervention ID

Site ID | Site Type (See codes on reverse) | Site Zip Code

Client

Client ID | Date of Birth (MMDDYYYY) | State | County | Zip Code

Ethnicity
- ◯ Hispanic or Latino
- ◯ Not Hispanic or Latino
- ◯ Don't know
- ◯ Declined

Race — *Check all that apply*
- ☐ American Ind./AK Native
- ☐ Asian
- ☐ Black/African American
- ☐ Native HI/Pac. Islander
- ☐ White
- ☐ Don't know
- ☐ Declined

Current Gender
- ◯ Male
- ◯ Female
- ◯ Transgender – M2F
- ◯ Transgender – F2M

Previous HIV Test?
- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Declined
- ◯ Not asked

Self-Reported Result
- ◯ Positive
- ◯ Negative
- ◯ Prelim. Pos.
- ◯ Indeterminate
- ◯ Don't know
- ◯ Declined
- ◯ Not asked

Provide date of last test (MMYYYY)

HIV Test Information

	HIV TEST 1	HIV TEST 2	HIV TEST 3
Sample Date (MMDDYYYY)			
Worker ID			
Test Election	◯ Tested anonymously ◯ Tested confidentially ◯ Declined testing	◯ Tested anonymously ◯ Tested confidentially ◯ Declined testing	◯ Tested anonymously ◯ Tested confidentially ◯ Declined testing
Test Technology	◯ Conventional ◯ Rapid ◯ Other	◯ Conventional ◯ Rapid ◯ Other	◯ Conventional ◯ Rapid ◯ Other
Specimen Type	◯ Blood: finger stick ◯ Blood: venipuncture ◯ Blood spot ◯ Oral mucosal transudate ◯ Urine	◯ Blood: finger stick ◯ Blood: venipuncture ◯ Blood spot ◯ Oral mucosal transudate ◯ Urine	◯ Blood: finger stick ◯ Blood: venipuncture ◯ Blood spot ◯ Oral mucosal transudate ◯ Urine
Test Result	◯ Positive/Reactive ◯ NAAT-pos ◯ Negative ◯ Indeterminate ◯ Invalid ◯ No result	◯ Positive/Reactive ◯ NAAT-pos ◯ Negative ◯ Indeterminate ◯ Invalid ◯ No result	◯ Positive/Reactive ◯ NAAT-pos ◯ Negative ◯ Indeterminate ◯ Invalid ◯ No result
Result Provided	◯ Yes ◯ No	◯ Yes ◯ No	◯ Yes ◯ No
Date Provided (MMDDYYYY)			
If results not provided, why?	◯ Declined notification ◯ Did not return/Could not locate ◯ Obtained results from another agency	◯ Declined notification ◯ Did not return/Could not locate ◯ Obtained results from another agency	◯ Declined notification ◯ Did not return/Could not locate ◯ Obtained results from another agency
If rapid reactive, did client provide confirmatory sample?	◯ Yes ◯ Client declined confirmatory test ◯ Did not return/Could not locate ◯ Referred to another agency ◯ Other	◯ Yes ◯ Client declined confirmatory test ◯ Did not return/Could not locate ◯ Referred to another agency ◯ Other	◯ Yes ◯ Client declined confirmatory test ◯ Did not return/Could not locate ◯ Referred to another agency ◯ Other

Risk Factors

Choose one if: ◯ Client was not asked about risk factors ◯ Client was asked, but no risk was identified ◯ Client declined to discuss risk factors

If client risk factor information was discussed, please mark all that apply:

In past 12 months has client had:

	Vaginal or Anal Sex	Oral Sex
With Male	☐	☐
With Female	☐	☐

- ☐ ...without using a condom?
- ☐ ...with person who is an IDU?
- ☐ ...with person who is MSM?
- ☐ ...with person who is HIV positive?

Injection Drug Use (IDU)

Has client used injection drugs in past 12 months? ☐ *if marked* → Did client share drug injection equipment? ☐

Other Risk Factor(s) (see codes on reverse)

Session Activity

During this visit, was a risk reduction plan developed for the client? ◯ Yes ◯ No

Other Session Activities (see codes on reverse)

Local Use Fields

L1

L2

CDC Use Fields

C1

C2

Client Identifying Data (Optional)

Name: _____

Address:_____

Phone: _____ Other: _____

Codes for Site Type

F01	Inpatient Facility
F01.01	Inpatient Hospital
F01.50	Inpatient- Drug / Alcohol Treatment
F01.88	In patient Facility- Other
F01.99	Inpatient Facility- Unknown
F02	Outpatient facility
F02.03	Outpatient- Private Medical Practice
F02.04	Outpatient- HIV Specialty Clinic
F02.10	Outpatient- Prenatal/ OBGYN Clinic
F02.12	Outpatient- TB Clinic
F02.12	Outpatient- Drug / Alcohol Treatment Clinic
F02.19	Outpatient- Family Planning
F02.20	Outpatient- Community Mental Health
F02.30	Outpatient- Community Health Clinic
F02.58	Outpatient- School/University Clinic
F02.60	Outpatient- Health Department/Public Health Clinic
F02.61	Outpatient- Health Department/Public Health Clinic-HIV
F02.62	Outpatient- Health Department/Public Health Clinic-STD
F02.88	Outpatient Facility- Other
F02.99	Outpatient Facility- Unknown
F03	Emergency Room
F04.01	Blood Bank, Plasma Center
F04.05	HIV Counseling and Testing Site
F06	Community Setting
F06.01	Community Setting – AIDS Service Organization – non clinical
F06.02	Community Setting – School/Education Facility
F06.03	Community Setting – Church/Mosque/Synagogue/Temple
F06.04	Community Setting – Shelter/Transitional housing
F06.05	Community Setting – Commercial
F06.06	Community Setting – Residential
F06.07	Community Setting – Bar/Club/Adult Entertainment
F06.08	Community Setting – Public Area
F06.09	Community Setting – Workplace
F06.10	Community Setting – Community Center
F06.88	Community Setting – Other
F07	Correctional Facility
F88	Facility – Other

Codes for Other Risk factor(s)

01	Exchange sex for drugs/money/or something they need
02	While intoxicated and/or high on drugs
05	With person of unknown HIV status
06	With person who exchanges sex for drugs/money
08	With anonymous partner
09	With person who has hemophilia or transfusion/transplant recipient
11	Sex with transgender

Codes for Other Session Activities

03.00	HIV Testing
04.00	Referral
05.00	Personalized Risk assessment
06.00	Elicit Partners
07.00	Notification of exposure
08.01	Information – HIV/AIDS transmission
08.02	Information-Abstinence/postpone sexual activity
08.03	Information-Other sexually transmitted diseases
08.04	Information-Viral hepatitis
08.05	Information – Availability of HIV/STD counseling and testing
08.06	Information-Availability of partner notification and referral services
08.07	Information – Living with HIV/AIDS
08.08	Information – Availability of social services
08.09	Information – Availability of medical services
08.10	Information – Sexual risk reduction
08.11	Information – IDU risk reduction
08.12	Information – IDU risk free behavior
08.13	Information – Condom/barrier use
08.14	Information – Negotiation / Communication
08.15	Information – Decision making
08.16	Information – Disclosure of HIV status
08.17	Information – Providing prevention services
08.18	Information – HIV testing
08.19	Information – Partner notification
08.20	Information – HIV medication therapy adherence
08.21	Information – Alcohol and drug use prevention
08.22	Information – Sexual health
08.23	Information – TB testing
08.66	Information – Other
09.01	Demonstration – Condom/barrier use
09.02	Demonstration – IDU risk reduction
09.03	Demonstration – Negotiation / Communication
09.04	Demonstration – Decision making
09.05	Demonstration – Disclosure of HIV status
09.06	Demonstration – Providing prevention services
09.07	Demonstration – Partner notification
09.66	Demonstration – Other
10.01	Practice – Condom/barrier use
10.02	Practice – IDU risk reduction
10.03	Practice – Negotiation / Communication
10.04	Practice – Decision making
10.05	Practice – Disclosure of HIV status
10.06	Practice – Providing prevention services
10.07	Practice – Partner notification
10.66	Practice – Other
11.01	Discussion – Sexual risk reduction
11.02	Discussion – IDU risk reduction
11.03	Discussion – HIV testing
11.04	Discussion – Other sexually transmitted diseases
11.05	Discussion – Disclosure of HIV status
11.06	Discussion – Partner notification
11.07	Discussion – HIV medication therapy adherence
11.08	Discussion – Abstinence/postpone sexual activity
11.09	Discussion – IDU risk free behavior
11.10	Discussion – HIV/AIDS transmission
11.11	Discussion – Viral hepatitis
11.12	Discussion – Living with HIV/AIDS
11.13	Discussion – Availability of HIV/AIDS counseling testing
11.14	Discussion – Availability of partner notification and referral services
11.15	Discussion – Availability of social services
11.16	Discussion – Availability of medical services
11.17	Discussion – Condom/barrier use
11.18	Discussion – Negotiation / Communication
11.19	Discussion – Decision making
11.20	Discussion – Providing prevention services
11.21	Discussion – Alcohol and drug use prevention
11.22	Discussion – Sexual health
11.23	Discussion – TB testing
11.66	Discussion – Other
12.01	Other testing – Pregnancy
12.02	Other testing – STD
12.03	Other testing – Viral hepatitis
12.04	Other testing – TB
13.01	Distribution – Male condoms
13.02	Distribution – Female condoms
13.03	Distribution – Safe sex kits
13.04	Distribution – Safer injection / bleach kits
13.05	Distribution – Lubricants
13.06	Distribution – Education materials
13.07	Distribution – Referral lists
13.08	Distribution – Role model stories
13.66	Distribution – Other
14.01	Post-intervention follow up
14.02	Post-intervention booster session
15.00	HIV Testing History Survey
88	Other

Form ID stickers
(n=8)

Place Barcode Sticker Here

HIV TEST FORM

PART 2

Form Approved: OMB No. 0920-0696, Exp. Date 08/31/2010

CDC requires the following information on **confirmed positives**

Referrals

Was client referred to medical care?

- ○ Yes → If yes, did client attend the first appointment?
  - ○ Yes
  - ○ No
  - ○ Don't know
- ○ No → If no, why?
  - ○ Client already in care
  - ○ Client declined care

Was client referred to HIV Prevention services?

- ○ Yes
- ○ No

Was client referred to PCRS?

- ○ Yes
- ○ No

If female, is client pregnant?

- ○ Yes → If yes, in prenatal care?
  - ○ Yes
  - ○ No → If no, was client referred for prenatal care?
    - ○ Yes → If yes, did client attend first prenatal care appointment?
      - ○ Yes
      - ○ No
      - ○ Don't know
    - ○ No
  - ○ Don't know
  - ○ Declined
  - ○ Not asked
- ○ No
- ○ Don't know
- ○ Declined
- ○ Not asked

Local Use Fields

L3		L8		L13	
L4		L9		L14	
L5		L10		L15	
L6		L11		L16	
L7		L12		L17	

CDC Use Fields

C3		C6	
C4		C7	
C5		C8	

Notes (Print Only)

Place Barcode Sticker Here

HIV TEST FORM

PART 2

Form Approved: OMB No. 0920-0696, Exp. Date 08/31/2010

CDC requires the following information on **confirmed positives**

Referrals

Was client referred to medical care?

- ○ Yes → If yes, did client attend the first appointment?
  - ○ Yes
  - ○ No
  - ○ Don't know
- ○ No → If no, why?
  - ○ Client already in care
  - ○ Client declined care

Was client referred to HIV Prevention services?

- ○ Yes
- ○ No

Was client referred to PCRS?

- ○ Yes
- ○ No

If female, is client pregnant?

- ○ Yes → If yes, in prenatal care?
  - ○ Yes
  - ○ No → If no, was client referred for prenatal care?
    - ○ Yes → If yes, did client attend first prenatal care appointment?
      - ○ Yes
      - ○ No
      - ○ Don't know
    - ○ No
  - ○ Don't know
  - ○ Declined
  - ○ Not asked
- ○ No
- ○ Don't know
- ○ Declined
- ○ Not asked

Local Use Fields

L3		L8		L13	
L4		L9		L14	
L5		L10		L15	
L6		L11		L16	
L7		L12		L17	

CDC Use Fields

C3		C6	
C4		C7	
C5		C8	

Notes (Print Only)

WHITE COPY = Scan

YELLOW COPY = Record Keeping

Place Barcode Sticker Here

HIV TEST FORM

PART 3

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

HIV Incidence

Date information collected? (MMDDYYYY)

Date first positive HIV test: (MMDDYYYY)

Has client ever tested negative?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Declined

Date last negative HIV test: (MMDDYYYY)

Number of tests in the two years before the current (or first positive) test. Include the current (or first positive) test.

1 (Current (or 1st positive) test) + [ ] (# of tests in the 2 years before the current (or 1st positive) test) = [ ]

Has client used or is client currently using antiretroviral medication (ARV)?

- ◯ Yes → If yes, specify antiretroviral medication? → [ ] [ ] [ ] [ ]
- ◯ No
- ◯ Don't know
- ◯ Declined

(See codes on reverse)

Date ARV began? (MMDDYYYY)

Date of last ARV use? (MMDDYYYY)

Place Barcode Sticker Here

HIV TEST FORM

PART 3

Form Approved: OMB No. 0920-0696, Exp. Date: 08/31/2010

HIV Incidence

Date information collected? (MMDDYYYY)

Date first positive HIV test: (MMDDYYYY)

Has client ever tested negative?
- Yes
- No
- Don't know
- Declined

Date last negative HIV test: (MMDDYYYY)

Number of tests in the two years before the current (or first positive) test. Include the current (or first positive) test.

1 (Current (or 1st positive) test) + [ ] (# of tests in the 2 years before the current (or 1st positive) test) = [ ]

Has client used or is client currently using antiretroviral medication (ARV)?
- Yes → If yes, specify antiretroviral medication? → [ ] [ ] [ ] [ ]
- No
- Don't know
- Declined

(See codes on reverse)

Date ARV began? (MMDDYYYY)

Date of last ARV use? (MMDDYYYY)

Codes for Antiretroviral (ARV) medication(s)

22 Agenerase (amprenavir)
30 Aptivus (tipranavir, TPV)
32 Atripla (efavirenz/emtricitabine/tenofovir DF)
24 Combivir (lamivudine/ zidovudine, 3TC/AZT)
06 Crixivan (indinavir, IDV)
11 Emtriva (emtricitabine, FTC)
03 Epivir (lamivudine, 3TC)
28 Epzicom (abacavir/lamivudine, ABC/3TC)
25 Fortovase (saquinavir, SQV)
10 Fuzeon (enfuvirtide, T20)
19 Hepsera (adefovir)
02 Hivid (zalcitabine, ddC)
23 Hydroxyurea
18 Invirase (saquinavir, SQV)
16 Kaletra (lopinavir/ ritonavir)
31 Lexiva (fosamprenavir, 908)
07 Norvir (ritonavir, RTV)
33 Prezista (darunavir, DRV)
09 Rescriptor (delavirdine, DLV)
26 Retrovir (zidovudine, ZDV, AZT)
15 Reyataz (atazanavir, ATV)
08 Saquinavir (Fortavase, Invirase)
21 Sustiva (efavirenz, EFV)
13 Trizivir (abacavir/lamivudine/zidovudine, ABC/3TC,AZT)
27 Truvada (tenofovir DF/emtricitabine, TDF/FTC)
01 Videx (didanosine, ddl)
14 Videx EC (didanosine, ddl)
17 Viracept (nelfinavir, NFV)
05 Viramune (nevirapine, NVP)
12 Viread (tenofovir DF, TDF)
04 Zerit (stavudine, d4T)
21 Ziagen (abacavir, ABC)

88 Other
99 Unspecified

APPENDIX E

New Jersey Department of Health and Senior Services
Division of HIV/AIDS Services
Epidemiologic Services

Instructions on HIV Reporting Using the HIV Test Form

A. Purpose

The purpose of these instructions is to describe the required procedures for medical providers and responsible parties on the submission of HIV specimens to the State Public Health and Environmental Laboratories (SPHL) from Counseling and Testing agencies that are funded by the New Jersey Department of Health and Senior Services (Department).

B. Completion of Form

1. Medical providers and responsible parties shall be required to use the HIV Test Form for reporting HIV cases as well as submitting HIV specimens to the SPHL.

2. Medical providers and responsible parties shall be required to complete the HIV Test Form in accordance with N.J.A.C. 8:57-2 and the Department's instructions.

3. Medical providers and responsible parties shall be required to write the name, address and telephone number of any person confirmed as testing HIV positive on the back of the yellow copy of Part I, in the spaces provided.

4. Medical providers and responsible parties shall be required to write the name and telephone number of the person completing the form on the back of the yellow copy of Part I, in the space marked "other."

5. Medical providers and responsible parties shall be required to make a photocopy of the back of the yellow copy of Part I.

6. Medical providers and responsible parties shall be required to complete Parts II and III.

C. Mailing Instructions

1. Mail the white copy of Parts I, II, and III along with the photocopy of the yellow copy of Part I to the Surveillance Unit of the Division of HIV/AIDS Services (DHAS) in envelopes supplied by the DHAS, which may be obtained by calling (609) 984-5940.

2. The completed form shall be marked confidential and treated as such.

3. The completed form is <u>not</u> to be sent to the DHAS along with routine HIV Test Forms completed for clients testing HIV negative.

APPENDIX F

New Jersey Department of Health and Senior Services
Division of HIV/AIDS Services, Epidemiologic Services

Instructions for Submission of Positive HIV Diagnostic Specimens

A. Purpose

The purpose of these guidelines is to describe the procedures for the care, handling and submission of serum specimens from positive HIV diagnostic specimens. These serum specimens shall be tested using the Serologic Testing Algorithm for Recent HIV Seroconversion (STARHS). Results from these tests will allow the New Jersey Public Health and Environmental Laboratory (PHEL) to distinguish whether an HIV infection is recent or has been ongoing, thus allowing for the determination of incidence i.e., the number of new or recent infections in a given population.

Surplus serum from the positive HIV diagnostic specimens shall be collected and frozen using vials and mailing labels supplied by the Division of HIV/AIDS Services (DHAS). Ideally, a minimum of 0.5 mls should be collected for each aliquot. The frozen serum specimen shall be sent to the PHEL for processing and testing with the STARHS.

B. Materials

The materials used for submission of specimens include:

1. Cryogenic vials – supplied by the DHAS.
2. Specimen labels – supplied by the DHAS. The label shall be used to identify the sample (barcode, number etc).
3. Cardboard storage boxes for cryogenic vials shall be supplied by the DHAS if requested.
4. Freezer – samples can be refrigerated at 2 to 8 degrees centigrade, but for long term storage and shipping samples should be frozen at minus 20 degrees centigrade.
5. A supply of dry ice in pellet form.
6. Insulated shipping containers certified to ship frozen diagnostic specimens (HIV positive serum and dry ice) should be used.
7. A temperature log sheet should be kept to ensure that the freezer is operating properly.

C. Specimen Collection, Storage and Processing

1. Aliquot the serum (0.5 mls per cryogenic vial). Use a label to identify the specimen.
2. Store the aliquot specimen in the refrigerator if being shipped within 1 week of aliquoting or place in the freezer if being shipped later than 1 week.

D. Specimen Shipping

1. All specimens shall be sent to the PHEL at the following address:
   New Jersey Department of Health and Senior Services
   369 South Warren Street
   Health & Agriculture Building
   John Fitch Plaza
   Trenton, NJ 08625-0363

2. Specimens shall be accepted Monday through Friday during the hours of 8:30 AM to 4:00 PM.

E. Contact Information

Questions about these guidelines may be directed to the Division of HIV/AIDS Services, Epidemiologic Services, PO Box 363, Trenton, NJ 08625-0363
Phone: (609) 984-5940

A. Purpose

The purpose of these instructions is to describe the required procedures for medical providers and responsible parties on the submission of HIV specimens to the State Public Health and Environmental Laboratories (SPHL) from Counseling and Testing agencies that are funded by the New Jersey Department of Health and Senior Services (Department).

B. Completion of Form

1. Medical providers and responsible parties shall be required to use the HIV Test Form for reporting HIV cases as well as submitting HIV specimens to the SPHL.

2. Medical providers and responsible parties shall be required to complete the HIV Test Form in accordance with N.J.A.C. 8:57-2 and the Department's instructions.

3. Medical providers and responsible parties shall be required to write the name, address and telephone number of any person confirmed as testing HIV positive on the back of the yellow copy of Part I, in the spaces provided.

4. Medical providers and responsible parties shall be required to write the name and telephone number of the person completing the form on the back of the yellow copy of Part I, in the space marked "other."

5. Medical providers and responsible parties shall be required to make a photocopy of the back of the yellow copy of Part I.

6. Medical providers and responsible parties shall be required to complete Parts II and III.

C. Mailing Instructions

1. Mail the white copy of Parts I, II, and III along with the photocopy of the yellow copy of Part I to the Surveillance Unit of the Division of HIV/AIDS Services (DHAS) in envelopes supplied by the DHAS, which may be obtained by calling (609) 984-5940.

2. The completed form shall be marked confidential and treated as such.

3. The completed form is <u>not</u> to be sent to the DHAS along with routine HIV Test Forms completed for clients testing HIV negative.

A. Purpose

The purpose of these instructions is to describe the required procedures for medical providers and responsible parties on the submission of HIV specimens to the State Public Health and Environmental Laboratories (SPHL) from Counseling and Testing agencies that are funded by the New Jersey Department of Health and Senior Services (Department).

B. Completion of Form

1. Medical providers and responsible parties shall be required to use the HIV Test Form for reporting HIV cases as well as submitting HIV specimens to the SPHL.

2. Medical providers and responsible parties shall be required to complete the HIV Test Form in accordance with N.J.A.C. 8:57-2 and the Department's instructions.

3. Medical providers and responsible parties shall be required to write the name, address and telephone number of any person confirmed as testing HIV positive on the back of the yellow copy of Part I, in the spaces provided.

4. Medical providers and responsible parties shall be required to write the name and telephone number of the person completing the form on the back of the yellow copy of Part I, in the space marked "other."

5. Medical providers and responsible parties shall be required to make a photocopy of the back of the yellow copy of Part I.

6. Medical providers and responsible parties shall be required to complete Parts II and III.

C. Mailing Instructions

1. Mail the white copy of Parts I, II, and III along with the photocopy of the yellow copy of Part I to the Surveillance Unit of the Division of HIV/AIDS Services (DHAS) in envelopes supplied by the DHAS, which may be obtained by calling (609) 984-5940.

2. The completed form shall be marked confidential and treated as such.

3. The completed form is <u>not</u> to be sent to the DHAS along with routine HIV Test Forms completed for clients testing HIV negative.

APPENDIX G

New Jersey Department of Health and Senior Services
Division of HIV/AIDS Services, Epidemiologic Services

Instructions for Electronic Submission of Laboratory Results Indicative of HIV Infection

A. Data Standards

The following standards shall apply to the submission of electronic data.

All records will end with a carriage return.
Blanks fields shall be accepted for non-required fields.
Dates shall be formatted as YYYYMMDD.
Include hyphens for phone numbers and zip codes.
Social security numbers (SSN optional) may not contain any spaces, dashes, or hyphens. National codes shall be used as applicable Health Level (HL)7v2x**,** Federal Information Processing Standards (FIPS), Logical Observation Identifier Names and Codes (LOINC), Systematized Nomenclature for Human and Veterinary Medicine (SNOWMED) and United States Postal Service (USPS).

B. File Formats

One of the following file formats shall be used for submission of electronic data.
1. HL 7 formats

The following fields are required.

Date Definitions	**HL7 V2.4Field**	**HLT V2.3z Field**
Name of sending Lab or reporting site	MSH0401 SendingFac_Namespace	MSH0401 SendingFac_Namespace
Reporting Sending Lab CLIA number	MSH0402 SendingFac_UnivID	MSH0402 SendingFac_UnivID
Date message generated by reporting/sending lab	MSH0701 Date Time of Message	MSH0701 Date Time of Message
Patient Medical Record # (Unique identifier used by reporting facility if different from ordering facility)	PID0301 Patient ID_Internal	PID0301 Patient ID_Internal
Patient Current surname (last name)	PID0501 Patient_Family Name	PID0501 Patient_Family Name
Patient Current first name (given name)	PID0502 Patient_Given Name	PID0502 Patient_Given Name
Patient Date of Birth	PID0701 Date Time of Birth	PID0701 Date Time of Birth
Patient Current street address	PID1101 Patient Address_Street	PID1101 Patient Address_Street
Patient Current City of residence/location	PID1103 Patient Address _City	PID1103 Patient Address _City
Patient Current state/territory of residence/location	PID1104 Patient Address_State	PID1104 Patient Address_State
Patient Current zip code of residence	PID1105 Patient Address_ Zip Code	PID1105 Patient Address_ Zip Code

Ordering facility name	ORC2101 Order Fac Name_Name	ORC2101 Order Fac Name_Name
Ordering facility phone number	ORC2301 Order Fac Phone_No	ORC2301 Order Fac Phone_No
Lab specimen accession number	OBR0301 Filler Order Number	OBR0301 Filler Order Number
Specimen type (blood-include if Capillary or Venous for lead test, tissue)	ORB150102 Spec Source _Test	ORB150102 Spec Source-Test
Body site coding system	OBR150403 Spec Srce Body Site_NCS	OBR150403 Spec Srce Body Site_NCS
Alternate test code	OBX0304 Obsvl DAltTxt	OBX0304 Obsvl DAltTxt
Alternate code	OBX0305 Obsvl DAltTxt	OBX0305 Obsvl DAltTxt
Lab test result – need specific and complete info	OBX0502 Text_CE	OBX0502 Text_CE
Date of observation/test	OBX1401 Obsv DtTm	OBX1401 Obsv DtTm

The remaining HL-7 fields are recommended.

a. HL 7 version 2.4. The preferred format for electronic transmission of laboratory reports is HL 7 version 2.4 as supplemented and implemented and as specified by the Centers of Disease Control and Prevention standards. These standards can be found at the http://www.cdc.gov, National Electronic Disease Surveillance System.

b. HL 7 v2.3z will also be acceptable. File specification of HL 7 version 2.3z can be found at: http://www.cdc.gov.

2. American Standard Code for Information Interchange (ASCII). The following ASCll format is acceptable.

Column Starts	Column Ends	Field Length	Field Description	Required Field	Coding Information
1	30	30	Person Last Name	Yes	
31	60	30	Person First Name	Yes	
61	70	10	Person Middle Name		
71	75	5	Person Name Suffix		
76	90	15	Patient Identifier #1		
91	105	15	Patient Medical Record Number		
106	120	15	Prison Number		

121	135	15	Accession Number	Yes	
136	144	9	Person SSN		
145	152	8	Person Date of Birth	Yes	YYYYMMDD
153	153	1	Sex		1=Male, 2=Female, 9=Unk
154	155	2	Age of Person in Years		
156	156	1	Hispanic Ethnicity		1=Yes, 2=No, 9=Unk
157	157	1	Race: Ameri.Indian/Alaska Native		1=Yes
158	158	1	Race: Asian		1=Yes
159	159	1	Race: Black		1=Yes
160	160	1	Race: Pacific Islander		1=Yes
161	161	1	Race: White		1=Yes
162	162	1	Race: Unknown		1=Yes
163	197	35	Person Address #1		
198	232	35	Person Address #2		
233	267	35	Person City		
268	282	15	Person County		
283	284	2	Person State	Yes	
285	294	10	Person Zip Code		
295	344	50	Facility Name	Yes	
345	356	12	Facility Main Phone Number	Yes	
357	391	35	Facility Street Address #1		
392	426	35	Facility Street Address #2		
427	461	35	Facility City		
462	476	15	Facility County		
477	478	2	Facility State		
479	488	10	Facility Zip Code		
489	528	40	Facility Contact Person		
529	578	50	Laboratory Name	Yes	
579	588	10	Laboratory CLIA Code	Yes	
589	600	12	Laboratory Phone Number	Yes	
601	635	35	Laboratory Street Address #1		
636	670	35	Laboratory Street Address #2		
671	705	35	Laboratory City		
706	707	2	Laboratory State		
708	717	10	Laboratory Zip Code		

718	767	50	Laboratory Contact Person	Yes	
768	768	1	Specimen Sent to Reference Lab	Yes	1=Yes, 2=No
769	793	25	Test Code #1	Yes	* See Below
794	818	25	Test Manufacturer #1	Yes	
819	827	9	Test Result #1	Yes	Pos, Neg, High, Low, Detected, Undetected
828	837	10	Test Value #1	Yes	Quantity if applicable
838	845	8	Date Specimen Collected #1	Yes	YYYYMMDD
846	853	8	Date Specimen Tested #1	Yes	YYYYMMDD
854	863	10	Type of Specimen #1	Yes	Blood, Saliva, Urine, Other, Unknown
864	888	25	Test Code #2	Yes, if done	* See Below
889	913	25	Test Manufacturer #2	Yes, if done	
914	922	9	Test Result #2	Yes, if done	Pos, Neg, High, Low, Detected, Undetected
923	932	10	Test Value #2	Yes, if done	Quantity if applicable
933	940	8	Date Specimen Collected #2	Yes, if done	YYYYMMDD
941	948	8	Date Specimen Tested #2	Yes, if done	YYYYMMDD
949	958	10	Type of Specimen #2	Yes, if done	Blood, Saliva, Urine, Other, Unknown
959	983	25	Test Code #3	Yes, if done	* See Below
984	1008	25	Test Manufacturer #3	Yes, if done	
1009	1017	9	Test Result #3	Yes, if done	Pos, Neg, High, Low, Detected, Undetected
1018	1027	10	Test Value #3	Yes, if done	Quantity if applicable
1028	1035	8	Date Specimen Collected #3	Yes, if done	YYYYMMDD
1036	1043	8	Date Specimen Tested #3	Yes, if done	YYYYMMDD
1044	1053	10	Type of Specimen #3	Yes, if done	Blood, Saliva, Urine, Other, Unknown
1054	1078	25	Test Code #4	Yes, if	* See Below

				done	
1079	1103	25	Test Manufacturer #4	Yes, if done	
1104	1112	9	Test Result #4	Yes, if done	Pos, Neg, High, Low, Detected, Undetected
1113	1122	10	Test Value #4	Yes, if done	Quantity if applicable
1123	1130	8	Date Specimen Collected #4	Yes, if done	YYYYMMDD
1131	1138	8	Date Specimen Tested #4	Yes, if done	YYYYMMDD
1139	1148	10	Type of Specimen #4	Yes, if done	Blood, Saliva, Urine, Other, Unknown
1149	1173	25	Test Code #5	Yes, if done	* See Below
1174	1198	25	Test Manufacturer #5	Yes, if done	
1199	1207	9	Test Result #5	Yes, if done	Pos, Neg, High, Low, Detected, Undetected
1208	1217	10	Test Value #5	Yes, if done	Quantity if applicable
1218	1225	8	Date Specimen Collected #5	Yes, if done	YYYYMMDD
1226	1233	8	Date Specimen Tested #5	Yes, if done	YYYYMMDD
1234	1243	10	Type of Specimen #5	Yes, if done	Blood, Saliva, Urine, Other, Unknown

*** Examples of Test Codes:**

HIV Antibodies:	HIV-1 EIA, HIV-1/2 EIA, HIV-2 EIA, HIV-1 Western Blot, HIV-2 Western Blot, HIV-1 IFA, Rapid #1, Rapid #2, Other
HIV Detection:	HIV-1 Proviral DNA, HIV-1RN-PCR (Qualitative), P24 Antigen, HIV-1 Culture, HIV-2 Culture, Other
HIV Viral Loads:	RNA RT-PCR (Standard), RN RT-PCR (Ultra sensitive), bDNA, RNA NASBA, RNA Other
Immunologic:	CD4 Absolute, CD4 Percent

3. Other Formats

Other formats may be accepted on a case-by-case basis with the approval of Epidemiologic Services. Questions regarding data standards may addressed by contacting Epidemiologic Services at (609) 984-5940 or PO Box 363, Trenton, NJ 08625-0363

Phone: (609) 984-5940

C. Mode of Electronic Transmission

The Department will work with individual laboratories to establish Secure File Transfer Protocol (SFTP) connections to transmit data. Other technologies such as Virtual Private Networks may be considered.

The Secure File Transfer Protocol is a program that uses the secure shell (SSH) program to transfer files. Unlike standard file transfer protocol, it encrypts both commands and data, thus preventing passwords and sensitive information from being transmitted in the clear over the network.

The Virtual Private Network is a network that is constructed by using the internet to connect nodes (Department and Laboratory Server). This will allow the data to be encrypted as well as ensure that only authorized users access the secure network.

All electronic interfaces shall be tested by the Department's laboratory staff prior to being sent to the production system. The test phase shall only be initiated once the laboratories have provided evidence that they have completed a list of diseases that they will be reporting along with the required LOINC and SNOMED tables.

During the first phase of testing, the laboratories can provide test data files to the Office of Information Technology Services to process into our test environment. Upon approval, the second phase of testing can be initialized by the laboratories to allow for the production and processing of data into the Department's test environment. Laboratories will provide hard copies of all test results (as they appear at the physicians' offices) to Epidemiologic Services. During this testing phase quality assurance will be conducted to verify the accuracy of the electronic data transmission. Upon completion of phase II testing, data will be put into production. However, hard copies may still be requested by Epidemiologic Services for a few months. Hard copy results can be discontinued if agreement is obtained by Epidemiologic Services and the specific Laboratory.

D. Contact Information

Division of HIV/AIDS Services
Epidemiologic Services
PO Box 363
Trenton, NJ 08625-0363

Phone: (609) 984-5940

E. References

http://www.h17org
http://www.cdc.gov/phin/phin_news.html#h17

PLEASE PRINT OR TYPE ALL INFORMATION!

NJDHSS USE ONLY:	Date Counted: _____	Final Dx (Check one): ☐ + Sputum Smear ☐ Neg. Sputum Smear/+ Sputum Culture ☐ Pulm-Other-Cul ☐ Pulm-Clinical ☐ Extra-Pulm

New Jersey Department of Health and Senior Services
TB Program
PO Box 369, Trenton, NJ 08625-0369

RECORD OF CONTACT INTERVIEW

☐ **Contact ID** ☐ **Eval** ☐ **Final**
☐ **No Contacts Identified** ☐ **Interview Not Done**

TB-70 #

Date Reported

Name: Last	First	MI	Street Address	
City	County	Zip Code	Date of Birth	Telephone Number
Name of Employer/School/Congregate Setting			Address	
Telephone Number of Employer/School/Congregate Setting			Occupation	
Date of Interview	Date of Reinterview	Infectious Period: From: To:	Reason for Interview ☐Case ☐Suspect ☐Child <5 Years Old	

CONTACT INFORMATION					EXAMINATION RESULTS					
Last Name, First Name Address/Telephone Number	**Nature of Contact (Codes 1-8)**	**DOB and/or Age**	**Sex**	**For-eign Born**	**Last Exposure Date**	**1st Test Date Done Results**	**2nd Test Date Done Results**	**X-Ray Date Results**	**Therapy Date Meds (K-P)**	**Completed Rx Date or Incomplete Code A-G**	**Remarks**
	☐☐☐☐		☐M ☐F	☐Y ☐N		_____ mm	_____ mm	_____	_____		
	☐☐☐☐		☐M ☐F	☐Y ☐N		_____ mm	_____ mm	_____	_____		
	☐☐☐☐		☐M ☐F	☐Y ☐N		_____ mm	_____ mm	_____	_____		
	☐☐☐☐		☐M ☐F	☐Y ☐N		_____ mm	_____ mm	_____	_____		
	☐☐☐☐		☐M ☐F	☐Y ☐N		_____ mm	_____ mm	_____	_____		

Name and Title of Interviewer		Agency Name	
Signature	Date Submitted	Agency Telephone Number	Reviewed by NJDHSS (Initials and Date)

NATURE OF CONTACT: 1-Household 2-Worksite 3-School 4-Jail/Prison 5-Health Care Facility 6-Social 7-Shelter 8-Other
MEDS: K-INH L-RIF M-INH or RIF Intermittent N-Special Regimen (MDR) O-Other LTBI Rx P-Rx for TB Case/Suspect
RX INCOMPLETE: A-Death B-Moved C-Active TB D-Adverse Effects E-Refused F-Lost G-Provider Decision

RECORD OF CONTACT INTERVIEW, Continued

TB-70 #

Name: Last	First	MI	County

CONTACT INFORMATION						EXAMINATION RESULTS					
Last Name, First Name Address/Telephone Number	Nature of Contact (Codes 1-8)	DOB and/or Age	Sex	For-eign Born	Last Exposure Date	1st Test Date Done / Results	2nd Test Date Done / Results	X-Ray Date / Results	Therapy Date / Meds (K-P)	Completed Rx Date or Incomplete Code A-G	Remarks
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				
			☐M ☐F	☐Y ☐N		mm	mm				

NATURE OF CONTACT: 1-Household 2-Worksite 3-School 4-Jail/Prison 5-Health Care Facility 6-Social 7-Shelter 8-Other

MEDS: K-INH L-RIF M-INH or RIF Intermittent N-Special Regimen (MDR) O-Other LTBI Rx P-Rx for TB Case/Suspect

RX INCOMPLETE: A-Death B-Moved C-Active TB D-Adverse Effects E-Refused F-Lost G-Provider Decision

New Jersey Department of Health and Senior Services **NO.**

TUBERCULOSIS CASE, SUSPECT AND STATUS REPORT

SHADED AREAS ARE FOR STATE USE ONLY; LEAVE BLANK.

Report Date: _____

Patient's Name: _____ **ID No.:** _____

5. ***REPORT DATE*** ____/____/____

TYPE OF REPORT ☐Initial ☐Reinstate ☐Current Status

2. ***PATIENT ID NUMBER***

1. LAST ***NAME*** FIRST MI

MEDICAID NO.

3 & 6. ***SUBMITTED*** ____/____/____

ADDRESS ☐Check if New

HOMELESS ☐Yes ☐No

TELEPHONE NUMBER ( )

COUNTY

7. ***DATE OF BIRTH*** ____/____/____

Apt. #

4. CITY

STATE

ZIP CODE

8. ***SEX***
1 ☐ Male
2 ☐ Female

9. ***RACE***
1 ☐ White 2 ☐ Black
3 ☐ Native American 4 ☐ Asian

10. ***HISPANIC***
1 ☐ Yes
2 ☐ No

11. COUNTRY OF ORIGIN ☐☐ _____

12. **ARRIVED IN USA** Mo. _____ Yr. _____

13. **STATUS**
1 ☐ Alive
2 ☐ Dead

14. ***PREVIOUS*** TB DIAGNOSIS
1 ☐ Yes – If yes, list year __ __ __ __ 2 ☐ No ☐ Check here if more than one episode

15-16. ***CURRENT DIAGNOSIS***
☐ TB Suspect 00 ☐ Pulmonary ☐ Non-Pulmonary TB Site(s) _____ ☐☐ Code

If more than one additional site, check here: ☐ 88 ☐☐ Code ☐☐ Code

BACTERIOLOGY

Specimen Taken 1 ☐ Yes 2 ☐ No Date Collected _____/_____/_____

Lab Name _____ Lab Slip No. _____

Specimen: ***17-18*** ☐ ***Sputum*** ***19-20*** ☐ Other _____ ☐☐ Code

Smear: 1 ☐ AFB Present 2 ☐ Negative 3 ☐ Not Done 9 ☐ UNK ☐☐ Code

Culture: 1 ☐ M.tb 2 ☐ Negative 3 ☐ Not Done 9 ☐ UNK ☐ M._____

BACTERIOLOGY

Specimen Taken 1 ☐ Yes 2 ☐ No Date Collected _____/_____/_____

Lab Name _____ Lab Slip No. _____

Specimen: ***17-18*** ☐ ***Sputum*** ***19-20*** ☐ Other _____ ☐☐ Code

Smear: 1 ☐ AFB Present 2 ☐ Negative 3 ☐ Not Done 9 ☐ UNK ☐☐ Code

Culture: 1 ☐ M.tb 2 ☐ Negative 3 ☐ Not Done 9 ☐ UNK ☐ M._____

X-RAY

Date _____/_____/_____

21 ☐ ***Chest***

☐ Other _____

1 ☐ Normal
2 ☐ Abnormal
3 ☐ Not Done
9 ☐ UNK

If Abnormal:
1 ☐ Cavitary
2 ☐ Noncavitary/TB
3 ☐ Not TB

1 ☐ Stable
2 ☐ Worsening
3 ☐ Improving
9 ☐ UNK

22. ***TUBERCULIN TEST***

☐ Mantoux ☐ Other _____ Date Read: Mo._____ Day _____ Yr._____ **Result** _____ mm

Induration: 1 ☐ Positive 2 ☐ Negative 3 ☐ Not Done 9 ☐ UNK If Negative, was patient anergic? 1 ☐ Yes 2 ☐ No 9 ☐ UNK

23. ***Z STATUS***
0 ☐ Negative
1 ☐ Positive
2 ☐ Indeterminate
3 ☐ Refused
4 ☐ Not Offered
5 ☐ Test Done, Results Unknown
9 ☐ UNK

☐☐☐☐☐☐☐☐☐☐

If Positive, based on:
1 ☐ Medical Documentation 2 ☐ Patient History 9 ☐ UNK

EVIDENCE **OF ACTIVE TB**
☐ Clinical Response
☐ X-Ray Change
☐ Epidemiologic Link
☐ Pathological Evidence

24. ***HOMELESS WITHIN THE PAST YEAR***
0 ☐ No 1 ☐ Yes 9 ☐ UNK

25. ***CORRECTIONAL FACILITY RESIDENT*** AT TIME OF DIAGNOSIS
0 ☐ No 1 ☐ Yes 9 ☐ UNK
If yes, indicate facility: _____
1 ☐ Federal Prison 2 ☐ State Prison 3 ☐ Local Jail 4 ☐ Juvenile Correctional Facility 5 ☐ Other 9 ☐ UNK

26. ***LONG TERM CARE FACILITY*** RESIDENT AT TIME OF DIAGNOSIS
0 ☐ No 1 ☐ Yes 9 ☐ UNK
If yes, indicate facility: _____
1 ☐ Nursing Home 2 ☐ Hospital Based Facility 3 ☐ Residential Facility 4 ☐ Mental Health Residential Facility
5 ☐ Alcohol or Drug Treatment Facility 6 ☐ Other Long Term Care Facility 9 ☐ UNK

27. ☐ ***CURRENT CHEMOTHERAPY***

Date: _____/_____/_____

☐ Isoniazid..... _____ mg ☐ Ethionamide..... _____ mg ☐ Amikacin ..... _____ mg
☐ Rifampin..... _____ mg ☐ Kanamycin..... _____ mg ☐ Rifabutine..... _____ mg
☐ Pyrazinamide..... _____ ***gm*** ☐ Cycloserine..... _____ mg ☐ Ciprofloxacin..... _____ mg
☐ Ethambutol ..... _____ mg ☐ Capreomycin ..... _____ mg ☐ Ofloxacin..... _____ mg
☐ Streptomycin..... _____ ***gm*** ☐ Para-Amino Salicylic Acid ..... _____ mg ☐ Other: _____ ..... _____ mg

☐ Not Prescribed ☐ Interrupted TB Chemotherapy, Specify: _____

28. ☐ ***INITIAL CHEMOTHERAPY***

Date: _____/_____/_____ Directly Observed Therapy (DOT) ☐ Yes ☐ No Patient's Weight: _____ lbs.

WITHIN THE PAST YEAR

29. INJECTING DRUG USE 0 ☐ No 1 ☐ Yes 9 ☐ UNK

30. NON-INJECTING DRUG USE 0 ☐ No 1 ☐ Yes 9 ☐ UNK

31. EXCESS ALCOHOL USE 0 ☐ No 1 ☐ Yes 9 ☐ UNK

32. ***OCCUPATION*** (CHECK ALL THAT APPLY WITHIN THE ***PAST 24 MONTHS***)
1 ☐ Health Care Worker
2 ☐ Correctional Employee
3 ☐ Migratory Agricultural Worker
4 ☐ Other Occupation
5 ☐ Not Employed within Past 24 Months
9 ☐ UNK
Specify: _____

SUSCEPTIBILITY STUDIES
33 ☐ Initial ☐ Other 40 ☐ Final 0 ☐ Not Done 1 ☐ Done 9 ☐ UNK Date Collected: _____/_____/_____
(1=Resistant 2=Sensitive)
34. INH____ RIF____ PZA____ EMB____ SM____ ETH____ KM____ CYC____ CAP____ PAS____ AK____ RBT____ CIP____ OFL____ OTHER____

35. SPUTUM CULTURE ***CONVERSION***
0 ☐ No 1 ☐ Yes 9 ☐ UNK
If Yes, Date of Initial Positive Culture: _____/_____/_____ If Yes, Date of First Consistently Negative Culture: _____/_____/_____

HOSPITALIZATION
Name _____
MR# _____ Admission _____/_____/_____ Discharge _____/_____/_____

DIAGNOSING PHYSICIAN
Name _____ License No. _____
Telephone No. _____ City _____ State _____ Zip Code _____

CASE MANAGER
Name _____ Telephone No. _____ ☐☐☐

38. ***SUPERVISION IS NOW BEING PROVIDED BY***
1 ☐ Health Department 2 ☐ Private / Hospital / Hospital Clinic / Institution 3 ☐ Both Health Department and Private
Name _____ License No. _____
Telephone No. _____ City _____ State _____ Zip Code _____

39. ***DIRECTLY OBSERVED THERAPY*** (UPON COMPLETION OF THERAPY)
0 ☐ None 1 ☐ Yes, Totally Directly Observed 2 ☐ Yes, Both Directly Observed and Self Administered 9 ☐ UNK
If yes, give (site(s) of DOT:
1 ☐ In clinic or other facility 2 ☐ In the field 3 ☐ Both in facility and in the field 9 ☐ UNK
***No. of Weeks on DOT** ☐☐☐

TERMINATION
36. Date Therapy Stopped _____/_____/_____
37. 1 ☐ Completed Therapy
2 ☐ Moved (specify): _____
3 ☐ Whereabouts Unknown
4 ☐ Uncooperative or Refused
5 ☐ Diagnosis Changed (specify): _____
6 ☐ Died (MM/DD/YY): _____/_____/_____
7 ☐ Other (specify): _____

REPORT PREPARED BY
_____
Telephone: _____

STATE FIELD CHECK
☐☐ Initial _____/_____/_____ Date

REMARKS
_____
_____
_____
_____

New Jersey Department of Health and Senior Services
Vaccine Preventable Disease Program
P.O. Box 369
Trenton, NJ 08625-0369

ANNUAL COLLEGE IMMUNIZATION STATUS REPORT – FALL 2008

Submit complete report by December 1, 2008 to the address listed above.

Name of Institution of Higher Education	Report Year
Address	Total University/College Fall 2008 Enrollment (head count)
Town/Municipality	Zip Code
Name and Title of Person(s) responsible for implementing immunization requirements	Telephone Number
Name and Title of Person(s) responsible for maintaining immunization records	Telephone Number

A. MEASLES, MUMPS, AND RUBELLA REQUIREMENT	
a. Number of incoming students:	
b. Number of incoming students in non-degree status **not subject** to regulations:	
c. Number of incoming students born before 1957 **not subject** to regulations:	
d. For 2-year colleges **ONLY**: Number of incoming students with less than 12 credit hours **not subject to regulations**:	
e. Number of students subject to regulations [a – (b + c + d) = e]:	

Number of students meeting the MMR* Requirement	Number of students with Provisional Status	Number of students with Medical Exemptions	Number of students with Religious Exemptions

* *For incoming students, two doses of a measles containing vaccine, preferably MMR given on or after the first birthday separated by at least one month or laboratory evidence of immunity to these diseases.*

Does your institution require any additional immunizations other than two doses of measles, and one dose of mumps and rubella vaccines?

☐ Yes ☐ No

If "Yes," specify vaccines and the number of doses required:

Does your institution offer immunization services for MMR vaccine through your own student health center or contract with another organization?

☐ Own ☐ Contracted ☐ Do not offer immunizations

Name of contracting organization(s) (if applicable):

ANNUAL COLLEGE IMMUNIZATION STATUS REPORT (CONTINUED)

B. MENINGOCOCCAL MENINGITIS EDUCATION AND VACCINATION REQUIREMENT (4-YEAR INSTITUTIONS ONLY)

Number of new students provided Meningococcal Information	Number of students' responses collected by, or returned to, the college	Number of students' responses indicating previous vaccination	Number of new students first vaccinated by college/student health services

NOTE: The section below applies to ONLY New Students living in a campus dormitory:

Number of new students residing in a Campus Dormitory for the first time in Fall 2008.	Number of new students meeting the Meningococcal Vaccination Requirement	Number of students with Provisional Status	Number of students with Medical Exemptions	Number of students with Religious Exemptions

Does your institution offer Meningococcal vaccination services through its own student health service or contract with another organization?

☐ Own ☐ Contracted

Name of contracting organization(s) (if applicable):

C. HEPATITIS B VACCINE REQUIREMENT (NEW STUDENTS WITH 12 OR MORE CREDIT HOURS)

Number of new students meeting the Hepatitis B requirement	Number of students with Provisional Status	Number of students with Medical Exemptions	Number of students with Religious Exemptions

Does your institution offer Hepatitis B vaccination services through its own student health service or contract with another organization?

☐ Own ☐ Contracted

Name of contracting organization(s) (if applicable):

Name or Person Reporting/Submitting Report	Title	
Signature	Telephone Number	Date Submitted

New Jersey Department of Health and Senior Services
Occupational Health Service
P.O. Box 360
Trenton, NJ 08625-0360

OCCUPATIONAL AND ENVIRONMENTAL DISEASE, INJURY,OR POISONING REPORT BY HEALTH CARE PROVIDER

*INSTRUCTIONS: In accordance with N.J.A.C. 8:58-1.5, health care providers must report any patient who is ill or diagnosed with any disease, injury, or poisoning listed below within 30 days after the disease, injury, or poisoning has been diagnosed or treated. In addition, suspect cases or patients with other occupational diseases may be reported. All information **MUST** be completed. Mail **complete** report to above address or fax to (609) 292-5677. Additional information, report forms, or business reply envelopes may be obtained from the above address, or by calling (609) 984-1863. This form is also available online in Microsoft Word and in PDF format at www.nj.gov/health/eoh/survweb.*

Date

PATIENT INFORMATION

Name of Patient (Print) _____ (First) _____ (MI) _____ (Last)

Date of Birth

Street Address

Age (If DOB Unavailable)

City | State | Zip Code

Home Telephone Number ( )

Sex ☐Male ☐Female

Race ☐White ☐Black ☐Am. Ind./ Alaskan Native ☐Asian/Pacific Islander ☐Other

Hispanic Origin ☐Yes ☐No ☐Unknown

DIAGNOSTIC INFORMATION

Date of Onset of Disease, Injury, or Poisoning ____ / ____ / _____

Diagnosis:

☐Work-Related Asthma
- ☐Possible
- ☐Probable
- ☐Confirmed

☐Extrinsic Allergic Alveolitis
☐Silicosis
☐Asbestosis
☐Pneumoconiosis, Other and Unspecific
☐Occupational Dermatitis
☐Other Occupational Disease - Specify: _____

☐Work-Related Fatal Injury
☐Work-Related Injury in Children (Under Age 18)
☐Work-Related Carpal Tunnel Syndrome
☐Poisoning Caused by Known or Suspected Occupational Exposure
☐Pesticide Toxicity

☐Lead Toxicity, Adult
(Blood ≥ 25 μg/dl; Urine ≥ 80 μg/L)
Blood = _____ μg/dL
Urine = _____ μg/L

☐Arsenic Toxicity, Adult
(Blood ≥ .07 μg/mL; Urine ≥ 100 μg/L)
Blood = _____ μg /mL
Urine = _____ μg /L

☐Mercury Toxicity, Adult
(Blood ≥ 2.8 μg/dL; Urine ≥ 20 μg/L)
Blood = _____ μg/dL
Urine = _____ μg/L

☐Cadmium Toxicity, Adult
(Blood ≥ 5 μg/L whole blood;
Urine ≥ 3 μg/gram creatinine)
Blood = _____ μg/L whole blood
Urine = _____ μg/gram creatinine

Name and Address of Laboratory Which Performed the Testing, If Applicable

Laboratory Name _____
Street Address _____
City _____ State _____ Zip _____

PLACE OF EXPOSURE / INJURY

Company Where Exposure/Injury Occurred

Name _____
Street Address _____ Phone No. _____
City _____ State _____ Zip _____

Job Title or Type of Work Performed by Patient

Patient-Reported Cause of Symptoms

HEALTH CARE PROVIDER INFORMATION

Name of Health Care Provider (Print)

Telephone Number ( )

Address

Facility Name _____
Street Address _____
City _____ State _____ Zip _____

Indicate Any Reasons Why the Patient Should NOT be Contacted

Comments by Health Care Provider, if Any