WASHOE COUNTY HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

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EPI-NEWS

Public Health

Serving Reno, Sparks and all of Washoe County, Nevada
Telephone: 775-328-2447 | Fax: 775-328-3764 | EpiCenter@washoecounty.us | washoecounty.us/health

IN THIS ISSUE: CD Annual Report, Reporting of Additional Communicable Diseases & Epi-News Topic Index

2018 Communicable Disease Annual Report

Communicable diseases are a continuing threat to all people, regardless of age, gender, lifestyle, ethnic background or socioeconomic status. They cause illness, suffering and even death, and place an enormous financial burden on society. Indeed, Joshua Lederberg, Nobel laureate once commented "We live in evolutionary competition with microbes – bacteria and viruses. There is no guarantee that we will be the survivors." Although some communicable diseases have been controlled by modern advances, new ones are constantly emerging. The Washoe County Health District (WCHD) relies on healthcare providers, laboratories, and others to report the occurrence of notifiable diseases. Without such data, trends cannot be accurately monitored, unusual occurrences of diseases (such as outbreaks) might not be detected or appropriately investigated, and the effectiveness of control and prevention activities cannot be easily evaluated.

The **Communicable Disease Annual Summary** is a compilation of communicable disease surveillance data in Washoe County.

Reportable Disease List

Reporting of specific communicable diseases to Washoe County Health District (WCHD) is mandated by Nevada Administrative Code (NAC) 441A.225. WCHD has updated the **Reportable Disease List** for your convenience.

Newly Reportable Diseases by Nevada Law

NAC regulations added certain communicable diseases to the list of diseases considered reportable in Nevada, as follows:

1) **Chikungunya virus disease**
2) **Dengue**
3) *Enterobacteriaceae, Carbapenem-resistant (CRE), including Carbapenem-resistant Enterobacter spp., Escherichia coli and Klebsiella spp.*
4) **Poliomyelitis**
5) **Saint Louis encephalitis virus (SLEV)**
6) **Zika virus disease**

Epi-News 2009-2019 Topic Index

Epi-News has been archived on the Washoe County Health District's (WCHD) website at http://tinyurl.com/WashoeEpiNews since 2001. For your convenience we have compiled an Epi-News Topic Index of the subjects addressed in the Epi-News during the past 10 years in a table format with links to respective issues. If you would like to be added to the Epi-News distribution list, please send your email address to EpiCenter@washoecounty.us.

Reporting Forms

Reports of illness can be faxed to 775-328-3764 or called in to our Communicable Disease Line at 775-328-2447. Please report using one of the three attached forms:

1. **CD Confidential Case Report** (CCR) for general communicable diseases, updated 10/2019.
2. **STD Confidential Case Report** for sexually transmitted diseases (i.e., chlamydia, gonorrhea, syphilis, and HIV), updated 10/2019.
3. **Animal Bite Report** to report an animal bite from a rabies susceptible animal updated 10/2019.

Please print these three forms and the Reportable Disease List and make copies for your staff. Take a moment to review them and make sure that you are using the most current form. Please discard all old reporting forms and reportable disease lists.

Correction

In the August 29, 2019 edition of the Epi-News, Syphilis and Congenital Syphilis, the frequency of HIV testing post syphilis treatment was erroneously stated. The HIV status of a person with syphilis should be determined through history or through additional testing. If a person with primary or secondary syphilis is co-infected with HIV, they should be evaluated clinically and serologically for treatment failure at 3, 6, 9, 12, and 24 months after therapy.

The Washoe County Health District (WCHD) would like to thank healthcare providers in the community for their dedication to communicable disease reporting and cooperation for communicable disease investigations. Our confidential reporting phone and fax numbers are ***775-328-2447 (Phone) and 775-328-3764 (Fax).***

REPORTING REQUIREMENTS
Updated October 2019
PLEASE FAX REPORTS TO (775) 328-3764

Physicians, laboratories, and other health care providers are required to report suspected and confirmed diagnoses of the following diseases and conditions to the Washoe County Health District, pursuant to Nevada Administrative Code Chapter 441A. Other persons with obligations to report suspected or confirmed disease include persons in charge of schools, child care facilities, or correctional facilities.

REPORTABLE DISEASE LIST – Report within 24 hours unless otherwise noted below

Acquired immunodeficiency syndrome (AIDS)
Amebiasis
Animal bite from a rabies-susceptible animal
ANTHRAX*†¶
BOTULISM *†¶
Brucellosis¶
Campylobacteriosis¶
Carbapenem resistant organisms ▲§¶
CD4 lymphocyte counts▲
Chancroid
Chikungunya virus disease
Chlamydia trachomatis infection of the genital tract
Cholera
Coccidioidomycosis
Cryptosporidiosis
Dengue
Diphtheria†¶
Ehrlichiosis/anaplasmosis
Encephalitis
Enterobacteriaceae, Carbapenem-resistant (CRE), including carbapenem-resistant Enterobacter spp., *Escherichia coli* and *Klebsiella spp.*¶
EXTRAORDINARY OCCURRENCE OF ILLNESS (E.G., SMALLPOX, SARS)*†
Giardiasis
Gonococcal infection
Granuloma inguinale
Haemophilus influenza, type b invasive disease¶
Hansen's Disease (leprosy)
Hantavirus
Hemolytic-uremic syndrome (HUS)
Hepatitis A
Hepatitis B
Hepatitis C
Hepatitis Delta
Hepatitis E
Hepatitis, unspecified
Human immunodeficiency virus infection (HIV)
ILLNESS KNOWN OR SUSPECTED TO BE THE RESULT OF INTENTIONAL TRANSMISSION OR BIOTERRORISM*†
Influenza
Legionellosis¶
Leptospirosis
Listeriosis¶
Lyme disease
Lymphogranuloma venereum
Malaria¶
Measles (rubeola)†
Meningitis (specify type)
MENINGOCOCCAL DISEASE*†¶
Mumps
OUTBREAKS, ALL (E.G., FOODBORNE, HEALTHCARE-ASSOCIATED, NOROVIRUS) *†
Pertussis¶
PLAGUE*†¶
POLIOVIRUS INFECTION*
POLIOMYELITIS*†
Psittacosis
Q Fever¶
Rabies, animal
RABIES, HUMAN*†
Relapsing fever
Respiratory syncytial virus infection (RSV)
Rotavirus
Rubella (including congenital)†
Saint Louis encephalitis virus (SLEV)
Salmonellosis¶
Severe reaction to immunization
Shiga toxin-producing Escherichia coli¶
Shigellosis¶
Spotted fever riskettsioses (including RMSF)
Staphylococcus aureus (vancomycin-intermediate or vancomycin-resistant)¶
Streptococcus pneumoniae (invasive)
Syphilis (including congenital)
Tetanus¶
Toxic shock syndrome
Trichinosis
Tuberculosis†¶
TULAREMIA*†¶
Typhoid fever
Varicella (chickenpox)
Vibriosis¶
VIRAL HEMORRHAGIC FEVER*†
West Nile Virus
Yellow fever
Yersiniosis¶
Zika virus disease

*MUST REPORT IMMEDIATELY, anytime, day or night, including weekends and holidays, by calling (775) 328-2447
†Must report when suspect ▲Laboratories only must report ¶ Isolates must be submitted to Nevada State Public Health Lab
§Reporting of carbapenem-resistant Enterobacteriaceae (CRE), carbapenem-resistant pseudomonas aeruginosa (CRPA), and other carbapenem-resistant Gram negative bacilli (CRGNB) is now being requested pursuant to NAC 441A.235-3(a) from all hospital laboratories in Washoe County.

REQUIRED INFORMATION FOR REPORTS

- Disease or suspected disease
- Patient's full name
- Address
- Telephone number
- Date of birth (if known)
- Sex, Race (if known)
- Occupation, Employer (if known)
- Date of disease onset and diagnosis
- Health Care Provider's name & contact information
- Any other information requested by the health authority, if available.

CONTACTS FOR DISEASE SPECIFIC QUESTIONS

AIDS, HIV, CD4	Heather Holmstadt, RN, 328-6142 Jessica Conner, 328-6156, Jennifer Howell, 328-6147	Public Health Investigator Public Health Investigator, Program Coordinator
Sexually Transmitted Diseases	328-6161	On-duty Disease Intervention Specialist
TB	785-4785	On-duty Public Health Nurse
All other reportable diseases	328-2447	On-duty Public Health Investigator or Epidemiologist

WASHOE COUNTY
HEALTH DISTRICT
ENHANCING QUALITY OF LIFE

To: Washoe County Health District Communicable Disease Program
Confidential Fax (775) 328-3764

From: ______________________________ of ______________________________ Phone: ________________
Name of Person Faxing / Name of Healthcare Provider/Facility
Fax: ____________________

Re: Reportable Communicable Disease ______ Number of Pages Faxed

*** * * Please fax copies of client's face sheet & pertinent lab results if available. * * ***

* * Additional information may be requested as needed to complete the investigation (per NAC 441A.230). * *

CONFIDENTIAL CASE REPORT—REPORTABLE COMMUNICABLE DISEASE

Patient's Last Name:	**First:**	**Initial:**	**DOB:** ____/____/____

Sex:	**Race (✓ one):**	**Ethnicity (✓ one):**	**Address:**		**Phone #:**
☐ M ☐ F	☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black ☐ White ☐ Other: ______________ ☐ Unknown	☐ Hispanic ☐ Non-Hispanic ☐ Unknown	**City:**	**State:**	**Zip:**
		Country of Birth: ☐ US ☐ Other: ________	**Occupation:**	**Employer:**	

Disease:	**Onset Date:**
Comments: Lab Results, Tests, Symptoms, Treatment:	**Date of Diagnosis:**

Is client pregnant?	**If pregnant:**
☐ Yes ☐ No ☐ N/A	EDC: ____/____/____ Delivery Hospital: ☐ RRMC ☐ SMRMC ☐ Other: _________

LIST OF REPORTABLE DISEASES AND CONDITIONS

AIDS
Amebiasis
Animal bite from a rabies susceptible animal*
Anthrax*†¶
Botulism*†¶
Brucellosis¶
Campylobacteriosis¶
Carbapenemase-resistant organisms ▲§
CD4 lymphocyte counts▲
Chancroid
Chikunguyna
Chlamydia
Cholera
Coccidioidomycosis
Cryptosporidiosis
Dengue
Diphtheria†¶
Ehrlichiosis/Anaplasmosis
Encephalitis
Enterobacteriaceae, Carbapenem-resistant (CRE), including Carbapenem-resistant *Enterobacter spp.*,
Escherichia coli and *Klebsiella spp.* ¶
Extraordinary occurrence of illness (e.g. Smallpox, SARS)*†
Giardiasis
Granuloma inguinale
Haemophilus influenza, type b (invasive disease)¶
Hansen's Disease (leprosy)
Hantavirus
Hemolytic uremic syndrome (HUS)
Hepatitis A, B, C, delta, E, unspecified
HIV infection
Illness known or suspected to be the result of intentional transmission or bioterrorism*†
Influenza
Legionellosis¶
Leptospirosis
Listeriosis¶
Lyme disease
Lymphogranuloma venereum
Malaria¶
Measles (rubeola)†
Meningitis (specify type)
Meningococcal disease*†¶
Mumps
Outbreaks, all (e.g., foodborne, healthcare-associated, Norovirus)*†
Pertussis¶
Plague*†¶
Poliomyelitis*†
Poliomyelitis*†
Psittacosis
Q Fever¶
Rabies (human or animal)*†
Relapsing Fever
Respiratory Syncytial Virus (RSV)
Rotavirus
Rubella (including congenital)†
Saint Louis encephalitis virus (SLEV)
Salmonellosis¶
Severe Reaction to Immunization
Shiga toxin-producing *Escherichia coli*¶
Shigellosis¶
Spotted fever rickettsioses (including RMSF)
Staph aureus, vancomycin-intermediate or resistant¶
Strep pneumo (invasive)¶
Syphilis (including congenital)
Tetanus¶
Toxic Shock Syndrome
Trichinosis
Tuberculosis†¶
Tularemia*†¶
Typhoid Fever
Vibriosis¶
Viral hemorrhagic fever *†
West Nile Virus
Yellow Fever
Yersiniosis¶
Zika virus disease

***Must report immediately** **†Must report when suspect** **▲Laboratories only must report**

¶ Isolates must be submitted to Nevada State Public Health Lab

§Reporting of carbapenem-resistant Enterobacteriaceae (CRE), carbapenem-resistant pseudomonas aeruginosa (CRPA), and other carbapenem-resistant Gram negative bacilli (CRGNB) is now being requested pursuant to NAC 441A.235-3(a) from all hospital laboratories in Washoe County.

WASHOE COUNTY HEALTH DISTRICT
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Date:______/_____/ _____

To: Washoe County Health District Sexual Health program
Confidential Fax **(775) 328-3764**

Facility: ________________________ Phone: ________________ Fax:______________

Sender: ________________________

Re: SEXUALLY TRANSMITTED DISEASES / HIV ______Number of Pages Faxed

**** Fax fully completed form, with client's face sheet, provider notes and lab results * ***

**Additional information may be requested as needed to complete the investigation (per NAC 441A.230). **

CONFIDENTIAL CASE REPORT— SEXUALLY TRANSMITTED DISEASES / HIV

Patient's Last Name:	**First:**	**Initial:**	**DOB:** ____/____/_____	**Age:**

Sex: ☐ M ☐ F **Pregnant:** ☐ Yes ☐ No # wks:	**Race (Please ✓ one):** ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Black ☐ White ☐ Other: ____________ ☐ Unknown	**Ethnicity (✓ one):** ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Marital Status:**	**Address:** **City:** **State:** **Zip:** **Patient Phone # (home/cell):**

Provider's Name:	**Provider's Phone #:**

Disease: ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ HIV **Date of Diagnosis:** ______________________	**Specimen Collection Date:** ______/______/_______	
Treatment: ☐ Azithromycin 1g ☐ Ceftriaxone/Rocephin 250 mg IM ☐ L-A Bicillin 2.4 mu IM ☐ Other________________________________	**Tx Date:** ___/____/____	**Tx administered:** Dr.'s office/Prescription

Please complete the following for ALL cases

Sex with: ☐Male ☐ Female ☐ Both **HIV status:** ☐Pos ☐ Neg ☐ Unk **Date last tested:** ______________ **If + In Care? Where?**	**Partner info:** Name:____________ DOB: ___________ Age: Tel#:_______ Last sex when?____________ ☐ Steady ☐ 1x-only ☐ on/off # Partners in last 3 mos?__ ☐ Partner F/U: ☐ Hopes ☐ HD ☐ PMD ☐ Other______☐ Epi-treated?

Please complete the following if reporting Syphilis

Symptoms? ☐ No ☐ Yes-how long? _____________ If Yes, ☐ Chancre ☐ Rash ☐ Other_____________ Where? ☐ Genital ☐ Oral ☐ Hands ☐ Feet ☐ Body Neurological Involvement? ☐ No ☐Yes Describe: Previous Hx of Syphilis? ☐ No ☐ Yes If Yes, City/State treated _______________ Year _______ Treated with: ☐ Shots ☐ Pills Previous Syphilis Test? ☐ No ☐ Yes If Yes, Date: _________ Results: RPR ☐ Negative ☐ Positive If positive, RPR titer: _________ FTA/TPPA: _________	**Provider Diagnosis:** ☐ Primary Syphilis ☐ Secondary Syphilis ☐ Early Latent ☐ Late Latent ☐ Old previously treated ☐ BFP – (False Positive) *Please include copy of any NR confirmatory tests* **Plan**: ☐ Treated on day of visit. ☐ Not treated yet. Appt on: ____________ ☐ Previously treated. Repeat titer ______ ☐ Unable to contact. Reason: ___________

Note: To speak with the on-duty Disease Intervention Specialist, contact (775) 328-6161.
For HIV Disease Investigators, contact (775) 328-6142, (775) 328-6147, or (775) 328-6156.

Last date revised: 10/11/2019

PLEASE PRINT CLEARLY

WASHOE COUNTY
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FAX COMPLETED REPORTS TO:
(775) 328-3764

ANIMAL BITE REPORT – To Be Completed By Health Care Provider

INSTRUCTIONS FOR COMPLETING FORM:	**This form should be completed by the health care provider, unless the person bitten did not seek medical care.** Complete all sections in full. **Fax completed form as soon as possible to Washoe County Health District at 328-3764.** This allows the local rabies control authority to evaluate & monitor the biting animal and fulfills the health care provider's requirement to report animal bites under Nevada Administrative Code 441A. The original form should stay with the patient's chart. Questions? Please call 328-2447.

Today's Date: ____/____/____ **Name of Hospital/ Urgent Care/Clinic:** ____________________

Exposed Person

Age: _______ □ Months □ Years

Name: ______________________ Date of Birth: ____/____/____

Parent/Guardian's Name if patient is a minor: ______________________

Street Address: ______________________ City: __________ State: ________ Zip: ________

Phone: Home: ______________ Work: ______________ Cell: ______________

Bite

Date of Bite: ______________ Time ____________ ☐ AM ☐ PM

Where on body bitten? ______________________ Skin Broken? ☐ Yes ☐ No

☐ **If bite occurred at exposed person's address, check this box and skip to Animal Information. If not, complete the following:** Address/place where bite occurred: ______________________

Street Address: ______________________ City: __________ State: ________ Zip: ________

Animal Information

Species: ☐ Dog ☐ Cat ☐ Ferret ☐ Other: ______________________

Age: ______ Breed: ______________ Color: __________ Name of Animal (if known) ______________

Owner's Name: ______________________

☐ **If owner is exposed person, check this box & skip to Medical care obtained. If not, complete the following:**

Street Address: ______________________ City: ______________ Zip: __________

Phone: Home: ______________ Work: ______________ Cell: ______________

Medical care obtained? ☐ Yes ☐ No If yes, complete the following:

Health care provider: ______________________ Hospital/Urgent Care/Clinic: ______________________

Explain circumstances of bite incident: ______________________

____

____

____

This information is accurate to the best of my knowledge.

Signature of Person Bitten or Parent/Guardian: ______________________