



State of Connecticut

Reportable Disease Confidential Case Report Form PD-23

(rev. 01/01/2022)

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

For information or weekday disease reporting call 860-509-7994. For reporting on evenings, weekends, and holidays call 860-509-8000.

Instructions for Submitting the PD-23

The Commissioner of the Department of Public Health (DPH) is required to declare an annual list of Reportable Diseases, Emergency Illnesses and Health Conditions, which has two parts: (A) reportable diseases; and (B) reportable emergency illnesses and conditions as required under Sections 19a-36-A3 and 19a-36-A4 (see back of form) of the Public Health Code and Sections 19a-2a and 19a-215 of the Connecticut General Statutes. Fillable PDF forms are found at: <https://portal.ct.gov/DPH/Communications/Forms/Form>. A three-part form for reporting of the reportable diseases can be requested. Mail or fax the white copy to the Connecticut Department of Public Health, Epidemiology and Emerging Infections Program at the address above. Mail the canary copy to the Director of Health of the patient's town of residence. Retain the pink copy in the patient's medical record. Mail reports in envelopes marked "Confidential."

Use of Other Forms or Methods to Report

Epidemiology and Emerging Infections Program 860-509-7994

Confidential Case Report Form PD-23 FAX 860-920-3131
Hospitalized and Fatal Cases of Influenza Case Report Form FAX 860-920-3131

Healthcare-associated Infections 860-509-7995 Use the National Healthcare Safety Network (NHSN)

HIV/AIDS and Viral Hepatitis 860-509-7900

Adult HIV Confidential Case Report Form or Viral Hepatitis PD-23 FAX 860-509-8237

Injury and Violence Surveillance Unit 860-509-8251

E-cigarette or vaping product use associated lung injury (EVALI) Case Report Form FAX 860-706-1262

Immunization Program 860-509-7929

Chickenpox (Varicella) Case Report Form FAX 860-707-1905

Occupational Diseases 860-509-8251

Physician's Report Form FAX 860-730-8424

Sexually Transmitted Diseases 860-509-7920

STD-23 Form FAX 860-730-8380

Tuberculosis Control Program 860-509-7722

Tuberculosis Surveillance Report Form FAX 860-730-8271

Category 1 Diseases: Report immediately by telephone (860-509-7994) on the day of recognition or strong suspicion of disease for those diseases marked with a telephone (☎). On evenings, weekends, and holidays call 860-509-8000. These diseases must also be reported by mail within 12 hours.

Category 2 Diseases: All other diseases not marked with a telephone must be reported by mail (or fax) within 12 hours of recognition or strong suspicion.

PART A: REPORTABLE DISEASES

- Acquired Immunodeficiency Syndrome (1,2)
- Acute flaccid myelitis
- ☎ Acute HIV infection
- ☎ Anthrax
- Babesiosis
- Borrelia miyamotoi* disease
- ☎ Botulism
- ☎ Brucellosis
- California group arbovirus infection
- Campylobacteriosis
- Candida auris*
- Chancroid
- Chickenpox
- Chickenpox-related death
- Chikungunya
- Chlamydia (*C. trachomatis*) (all sites)
- ☎ Cholera
- Coronavirus, COVID-19 (SARS-CoV-2)
- COVID-19 Hospitalizations
- Cryptosporidiosis
- Cyclosporiasis
- Dengue
- ☎ Diphtheria
- E-cigarette or vaping product use associated lung injury (EVALI)
- Eastern equine encephalitis virus infection
- Ehrlichia chaffeensis* infection
- Escherichia coli* O157:H7 gastroenteritis
- Gonorrhea
- Group A Streptococcal disease, invasive (3)
- Group B Streptococcal disease, invasive (3)
- Haemophilus influenzae* disease, invasive (3)
- Hansen's disease (Leprosy)
- Healthcare-associated infections (4)
- Hemolytic-uremic syndrome (5)
- Hepatitis A
- Hepatitis B
 - acute infection (2)
 - HBsAg positive pregnant women
- Hepatitis C
 - acute infection (2)
 - perinatal infection
 - positive rapid antibody test result
- HIV-1/HIV-2 infection in: (1)
 - persons with active tuberculosis disease
 - persons with latent tuberculosis infection
 - persons of any age
 - pregnant women
- HPV: biopsy proven CIN 2, CIN 3, or AIS or their equivalent (1)
- Influenza-associated death (6)
- Influenza-associated hospitalization (6)
- Legionellosis
- Listeriosis
- Lyme disease
- Malaria
- ☎ Measles
- ☎ Melioidosis
- ☎ Meningococcal disease
- Mercury poisoning
- Multisystem inflammatory syndrome in children
- Mumps
- Neonatal bacterial sepsis (7)
- Neonatal herpes (≤ 60 days of age)
- Occupational asthma
- ☎ Outbreaks:
 - foodborne (involving ≥ 2 persons)
 - institutional
 - unusual disease or illness (8)
- Pertussis
- ☎ Plague
- Pneumococcal disease, invasive (3)
- ☎ Poliomyelitis
- Powassan virus infection
- ☎ Q fever
- ☎ Rabies
- ☎ Ricin poisoning
- Rocky Mountain spotted fever
- Rubella (including congenital)
- Salmonellosis
- ☎ SARS-CoV-1
- Shiga toxin-related disease (gastroenteritis)
- Shigellosis
- Silicosis
- ☎ Smallpox
- St. Louis encephalitis virus infection
- ☎ Staphylococcal enterotoxin B pulmonary poisoning
- ☎ *Staphylococcus aureus* disease, reduced or resistant susceptibility to vancomycin (1)
- Staphylococcus aureus* methicillin-resistant disease, invasive, community acquired (3, 9)
- Staphylococcus epidermidis* disease, reduced or resistant susceptibility to vancomycin (1)
- Syphilis
- Tetanus
- Trichinosis
- ☎ Tuberculosis
- ☎ Tularemia
- Typhoid fever
- Vaccinia disease
- ☎ Venezuelan equine encephalitis virus infection
- Vibrio* infection (*parahaemolyticus*, *vulnificus*, other)
- ☎ Viral hemorrhagic fever
- West Nile virus infection
- ☎ Yellow fever
- Zika virus infection

FOOTNOTES

1. Report only to State.
2. As described in the CDC case definition.
3. Invasive disease: from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint or vitreous), bone, internal body site, or other normally sterile site including muscle.
4. Report HAIs according to current CMS pay-for-reporting or pay-for-performance requirements. Detailed instructions on the types of HAIs, facility types and locations, and methods of reporting are available on the DPH website: <https://portal.ct.gov/DPH/HAI/Healthcare-Associated-Infections-Reporting-Requirements>
5. On request from the DPH and if adequate serum is available, send serum from patients with HUS to the DPH State Laboratory for antibody testing.
6. Reporting requirements are satisfied by submitting the Hospitalized and Fatal Cases of Influenza-Case Report Form in a manner specified by the DPH.
7. Clinical sepsis and blood or CSF isolate obtained from an infant ≤ 72 hours of age.
8. Individual cases of "significant unusual illness" are also reportable.
9. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.



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(rev. 01/01/2022)

Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308

Date Completed: _____

For information or weekday disease reporting, call 860-509-7994.
 For reporting on evenings, weekends, and holidays, call 860-509-8000.

PLEASE PRINT

Disease & Patient Information				
Disease Name	Patient Name (Last, First, MI)	Age	Date of Birth	Parent or Guardian Name
Address (Street, City, State, Zip Code) _____				Phone _____
				<input type="checkbox"/> Cell <input type="checkbox"/> Home <input type="checkbox"/> Work
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Intersex <input type="checkbox"/> Unknown	Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Unknown	<input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other specify: _____ <input type="checkbox"/> Refused to Answer	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Refused to Answer	
Primary Language Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other: _____	Is Patient Pregnant <input type="checkbox"/> Yes – Due date: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	Did Patient Die of Illness <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Is Condition Work Related <input type="checkbox"/> Yes – Occupation: _____ <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Is patient a (please check) <input type="checkbox"/> Health care worker <input type="checkbox"/> Day care worker	<input type="checkbox"/> Student/Day care attendee <input type="checkbox"/> Food handler <input type="checkbox"/> LTC Facility resident	Did patient have recent international travel <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Country visited: _____ Dates visited from: _____ to: _____		
Name and address of workplace, school, day care or other facility (including prisons or jails): _____				
Clinical & Laboratory Information		Confirmatory information, include laboratory data, immunization status, dates, and specific comments:		
Onset Date _____	Diagnosis Date _____			
If specimen obtained, collection date: _____				
Provider/Reporter & Hospital Information				
Healthcare Provider _____	Phone _____	Facility Name _____	Address _____	
Person Completing Report _____	Phone _____	Fax _____	Report Date _____	Address (if different from above) _____
Hospital Name _____	City _____	State _____	Date Admitted _____	Date Discharged _____ PatientID# _____

Viral Hepatitis

Perinatal:

HBV: Yes No
 HCV: Yes No
 Symptoms: Yes No Onset Date: _____
 Jaundice: Yes No Onset Date: _____
 ALT Result: _____ Test Date: _____
 Bilirubin Result: _____ Test Date: _____
 IgM anti-HAV: Pos Neg Test Date: _____
 HBsAg: Pos Neg Test Date: _____
 IgM anti-HBc: Pos Neg Test Date: _____

Anti-HCV: Method: Rapid Serology
 Pos Neg Test Date: _____
 HCV confirmed by: RNA Value: _____ Test Date: _____
 HCV negative antibody test within the last 12 months
 HBV Chronic/Carrier: Yes No Unknown
Risk Factors: IDU Non-injection street drugs
 Hemodialysis Multiple sex partners
 Contact w/ infected person (household sexual)
 Blood Transfusion Incarcerated (present past)
 MSM (men who have sex with men) Other:



Pursuant to Connecticut General Statutes (CGS) § 19a-2a and § 19a-215 and to the Regulations of Connecticut State Agencies Section 19a-36-A3 and Section 19a-36-A4, the requested information is required to be provided to the Department of Public Health (DPH)

Please note that CGS § 52-146o(b)(1) authorizes the release of these records to the Department without the patient's consent. Additionally, the federal Privacy Regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) also authorize you, as a provider, to release this information without an authorization, consent, release, opportunity to object by the patient, as information (i) required by law to be disclosed [HIPAA Privacy regulation, 45 CFR § 164.512(a)] and (ii) as part of the Department's public health activities (HIPAA Privacy regulation, 45 CFR § 165.512(b)(1)(i)). The requested information is what is minimally necessary to achieve the purpose of the disclosure, and you may rely upon this representation in releasing the requested information, pursuant to 45 CFR § 164.514(d)(3)(iii)(A) of the HIPAA Privacy regulations.

PHC Section 19a-36-A4 - Content of report and reporting of reportable diseases and laboratory findings.

Each report should include: 1) name, address, and phone number of the person reporting and of the physician attending; 2) name, address, date of birth, age, sex, race/ethnicity, and occupation of person affected; and 3) the diagnosed or suspected disease, and date of onset.

Reports must be mailed in envelopes marked "CONFIDENTIAL" within 12 hours of recognition or strong suspicion to the:

- | | |
|--|--|
| 1. Local Director of Health of the town AND
in which the patient resides
(Canary copy)

(Retain Pink copy for patient's medical record.) | 2. Connecticut Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308
(White copy) |
|--|--|

If using the fillable pdf to report, please make copies to send to the local health director and DPH. Reports can also be faxed to DPH using the numbers noted on the first page of this form. A separate report must be sent to the local director of health.

PHC Section 19a-36-A3 - Persons required to report reportable diseases and laboratory findings.

1. Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report the case to the local director of health or other health authority within whose jurisdiction the patient resides and to the DPH.
2. If the case or suspected case of reportable disease is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and DPH. The person in charge shall designate appropriate infection control or record keeping personnel for this purpose.
3. If the case or suspected case of reportable disease is not in a health care facility, and if a health care provider is not in attendance or is not known to have made a report within the appropriate time, such report of reportable diseases shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and DPH by:
 - a. the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease;
 - b. the person in charge of any camp;
 - c. the master or any other person in charge of any vessel lying within the jurisdiction of the state;
 - d. the master or any other person in charge of any aircraft landing within the jurisdiction of the state;
 - e. the owner or person in charge of any establishment producing, handling, or processing dairy products, other food, or non-alcoholic beverages for sale or distribution;
 - f. morticians and funeral directors