



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. This three-part form is to be used for reporting of the reportable diseases in Part A, 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. Mail 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 Other Forms or Methods to Report

Epidemiology and Emerging Infections Program 860-509-7994
Confidential Case Report Form PD-23 FAX 860-509-7910
Hospitalized and Fatal Cases of Influenza Case Report Form
Healthcare-associated Infections 860-509-7995
Use the National Healthcare Safety Network (NHSN)
HIV/AIDS 860-509-7900
Adult HIV Confidential Case Report Form

Immunization Program 860-509-7929
Chickenpox (Varicella) Case Report Form
Occupational Diseases 860-509-7740
Physician's Report Form
Sexually Transmitted Diseases 860-509-7920
STD-23 Form
Tuberculosis 860-509-7722
Tuberculosis Surveillance Report Form

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 icon. 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 icon must be reported by mail 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
Carbon monoxide poisoning (3)
Chancroid
Chickenpox
Chickenpox-related death
Chikungunya
Chlamydia (C. trachomatis)(all sites)
Cholera
Cryptosporidiosis
Cyclosporiasis
Dengue
Diphtheria
Eastern equine encephalitis virus infection
Ehrlichia chaffeensis infection
Escherichia coli O157:H7 gastroenteritis
Gonorrhea
Group A Streptococcal disease, invasive (4)
Group B Streptococcal disease, invasive (4)
Haemophilus influenzae disease, invasive (4)
Hansen's disease (Leprosy)
Healthcare-associated infections (5)
Hemolytic-uremic syndrome (6)
Hepatitis A
Hepatitis B
acute infection (2)
HBsAg positive pregnant women
Hepatitis C
acute infection (2)
positive rapid antibody test result
HIV-1/HIV-2 infection in: (1)
persons with active tuberculosis disease
persons with a latent tuberculosis infection (history or tuberculin skin test >=5mm induration by Mantoux technique)
persons of any age
pregnant women
HPV: biopsy proven CIN 2, CIN 3, or AIS or their equivalent (1)
Influenza-associated death (7)
Influenza-associated hospitalization (7)
Legionellosis
Listeriosis
Lyme disease
Malaria
Measles
Meliodosis
Meningococcal disease
Mercury poisoning
Mumps
Neonatal bacterial sepsis (8)
Neonatal herpes (<= 60 days of age)
Occupational asthma
Outbreaks:
foodborne (involving >= 2 persons)
institutional
unusual disease or illness (9)
Pertussis
Plague
Pneumococcal disease, invasive (4)
Poliomyelitis
Powassan virus infection
Q fever
Rabies
Ricin poisoning
Rocky Mountain spotted fever
Rubella (including congenital)
Salmonellosis
SARS-CoV
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 (4, 10)
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. Includes persons being treated in hyperbaric chambers for suspect CO poisoning.
4. Invasive disease: from sterile fluid (blood, CSF, pericardial, pleural, peritoneal, joint or vitreous), bone, internal body site, or other normally sterile site including muscle.
5. 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:
http://www.portal.ct.gov/DPH/Infectious-Diseases/HAI/Healthcare-Associated-Infections-HAIs.
6. On request from the DPH and if adequate serum is available, send serum from patients with HUS to the DPH Laboratory for antibody testing.
7. Reporting requirements are satisfied by submitting the Hospitalized and Fatal Cases of Influenza-Case Report Form in a manner specified by the DPH.
8. Clinical sepsis and blood or CSF isolate obtained from an infant <= 72 hours of age.
9. Individual cases of "significant unusual illness" are also reportable.
10. Community-acquired: infection present on admission to hospital, and person has no previous hospitalizations or regular contact with the health-care setting.



State of Connecticut
Reportable Disease Confidential Case Report Form PD-23
 (rev. 01/01/2019)

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

Date Completed: _____

Check for additional PD-23 forms, or call 860-509-7994.

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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"/> Other specify: _____ <input type="checkbox"/> Unknown	Race (check all that apply) <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Unknown	<input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Other specify: _____	Hispanic/Latino <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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: _____				

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 Patient ID#

Viral Hepatitis

Symptoms: Yes No Onset date: _____
Jaundice: Yes No Onset date: _____
 ALT Result: _____ ALT date: _____
 AST Result: _____ AST date: _____
 IgM anti-HAV: Positive Negative Not Done
 HBsAg: Positive Negative Not Done
 IgM anti-HBc: Positive Negative Not Done
 Anti-HCV: Method: Rapid Serology
 Positive Negative Not Done
 HCV confirmed by: RNA Value: _____
 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
 Perinatal (infected mom to baby)
 Contact w/ infected person (household sexual)
 Blood Transfusion Incarcerated (present past)
 MSM (men who have sex with men) Other: _____

Lyme disease surveillance case definition signs and symptoms

When testing for Lyme disease consider testing for other tick-borne diseases.

Physician diagnosed EM rash ≥ 5cm Yes No Unknown
 Arthritis (objective joint swelling) Yes No Unknown
 Bell's palsy or other cranial neuritis Yes No Unknown
 Radiculoneuropathy Yes No Unknown
 Lymphocytic meningitis Yes No Unknown
 Encephalomyelitis Yes No Unknown
 If yes, is antibody to *B. burgdorferi* higher in CSF than serum Yes No Unknown
 2nd or 3rd degree atrioventricular block Yes No Unknown
 Was patient diagnosed with Lyme disease in current year? Yes No Unknown

Lyme disease laboratory results

EIA/IFA
 Positive Negative Unknown
Western Blot: IgM
 Positive Negative Unknown

Culture
 Positive Negative Unknown
Western Blot: IgG
 Positive Negative Unknown



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
in which the patient resides
(Canary copy) | AND | 2. Connecticut Department of Public Health
410 Capitol Avenue, MS#11FDS
P.O. Box 340308
Hartford, CT 06134-0308
(White copy) |
|--|-----|--|

(Retain Pink copy for patient's medical record.)

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