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Western Nebraska Health Information Exchange Network
Public Health Reporting- Schematics and Matrix

May 17, 2007

The University of Nebraska Public Policy Center
www.ppc.nebraska.edu

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Table of Contents

Introduction.……4

Summary Schematic……5-6

Communicable Disease Schematic.…….7-8
Reportable Disease, Poisonings, & Organisms Form..……...9
Lab Reportable Disease, Poisonings, & Organisms Form..…….10

HIV/AIDS Schematic……...……11-12
Pediatric Form……..13-15
Adult Form……...16-17

Nebraska Newborn Screening Program Schematic……..18-19
Collecting and Reporting Form…….20

Newborn Hearing Screening Schematic……...21-22
Screen prints of Hearing Screening Module…….23-26

Chronic Disease Schematic……..27-28

Nebraska Cancer Registry Schematic……..29-30
Physician Reporting Form…….31

Nebraska Trauma Registry Schematic…….32-33
NARSIS Reporting Form…….34-36
e-NARSIS Screen prints……...37-38
NTRACS Required Data Template……..39-40

Immunization Schematic……..41-42

Matrix……...43-51

Introduction

This report documents the flow of health information for public health reporting specifically from the perspective of Western Nebraska providers and organizations.

The schematics attempt to outline the steps of different reporting processes. The steps are depicted by basic flowchart shapes and icons. A box with special comments and a key with icons are displayed in the lower right corner of each schematic.

The reporting processes presented are:

- Summary (overview of all public health reporting)
- Communicable Disease
- HIV/AIDS
- Nebraska Newborn Screening Program
- Newborn Hearing Screening
- Chronic Disease
- Nebraska Cancer Registry
- Nebraska Trauma Registry
- Immunization

The first schematic that is presented is the Summary Schematic which begins with each reporting entity and what health conditions or test they report. From there, the schematic shows how the health information is reported, to whom it is reported, and how the data are reported back to the community.

The following schematics that are presented include specific reporting processes. These schematics first indicate the initial health condition or test and then who is reporting. The next steps that are displayed include to whom the health information is reported, how it is reported, and how the data are reported back to the community.

The matrix reiterates the flow of health information from healthcare providers to the state and national programs. Information is displayed by columns that include which health information is reported, for whom the health condition is reported, who reports the required information, who receives the information, how it must be reported, how often is it sent, who reports the information to the partners, how the information is relayed back to the community, and what are the challenges to the reporting processes.

I. Summary of Reporting
A. Schematic

- Status:
  - Mandatory except for Immunization Reporting & Nebraska Hearing Screening Program

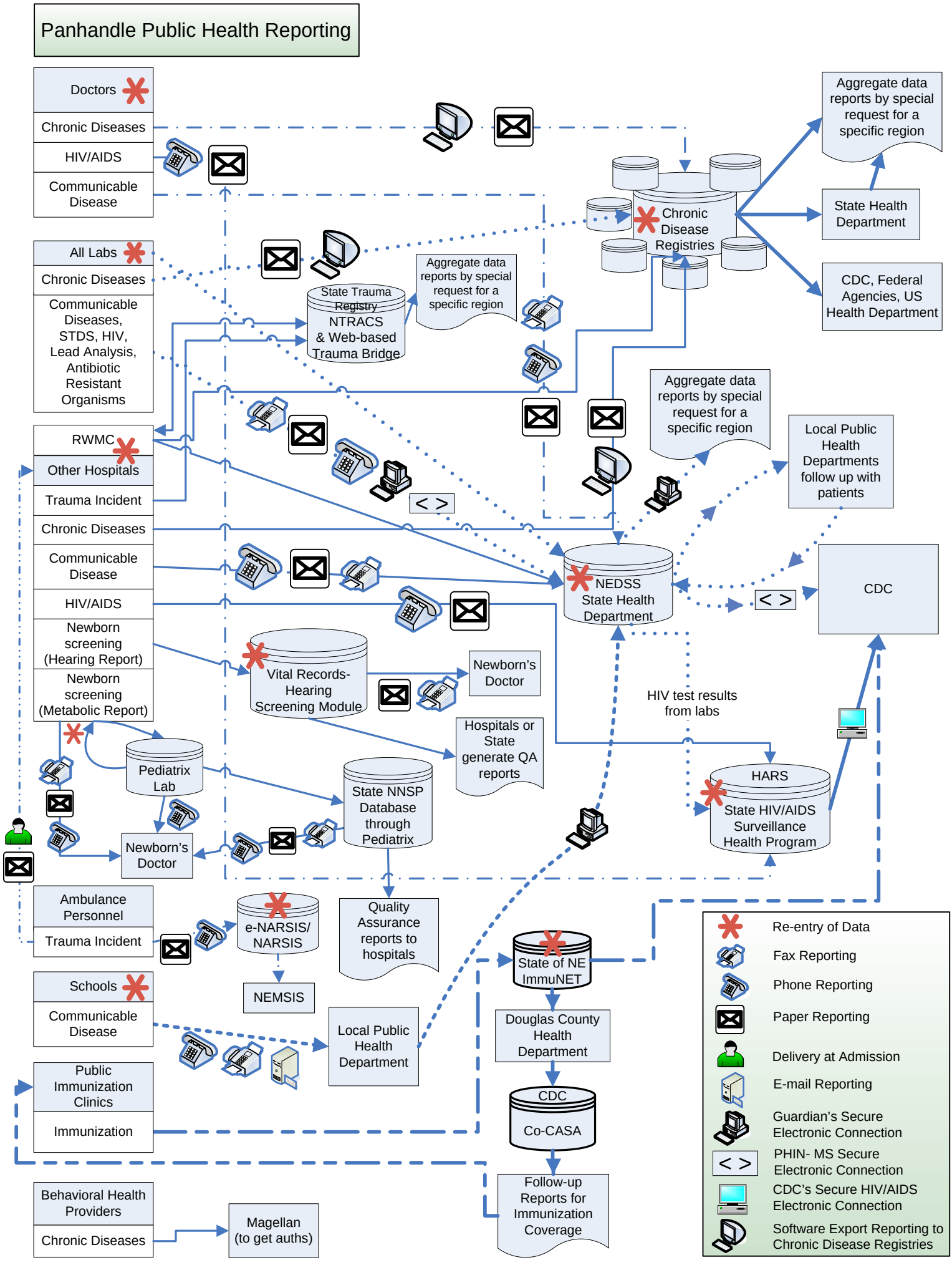
- Reporters:
  - Doctors
  - Labs
  - Regional West Medical Center
  - Other Hospitals
  - Ambulance Personnel
  - Schools
  - Public Immunization Clinics
  - Behavioral Health Providers

- Methods of Reporting:
  - Paper forms
  - Phone
  - Fax
  - Secure electronic connection (e.g., Guardian & PHIN- MS)
  - E-mail (schools)
  - Software exports (chronic disease registries)
  - Hand delivery at time of patient admission (Ambulance personnel)

- Report To/Into:
  - Local Public Health Department
  - NEDSS (State Health Department)
  - Chronic Disease Registries
  - Vital Records- Hearing Screening Module
  - Nebraska Newborn Screening Program Database
  - HIV/AIDS Reporting System Database
  - e-NARSIS/NARSIS (Emergency Medical Services Database)
  - NTRACS (State Trauma Registry)
  - ImmuNET Database
  - Centers for Disease Control and Prevention
  - Federal Agencies & US Health Department

- Re-entry of Data:
  - Reporting sites
  - NEDSS (State Health Department)
  - Chronic Disease Registries
  - Vital Records- Hearing Screening Module
  - HIV/AIDS Reporting System
  - e-NARSIS/NARSIS
  - ImmuNET Database

- Reporting Back:
  - Aggregate data reports to region or county
  - Quality Assurance Reports for Newborn Hearing, Metabolic Screening, Trauma Registry Data
  - Follow-up reports for Immunization Coverage


Panhandle Public Health Reporting
Doctors
Chronic Diseases
HIV/AIDS
Communicable Disease
All Labs
Chronic Diseases
Communicable Diseases, STDS, HIV, Lead Analysis, Antibiotic Resistant Organisms
RWMC
Other Hospitals
Trauma Incident
Chronic Diseases
Communicable Disease
HIV/AIDS
Newborn screening (Hearing Report)
Newborn screening (Metabolic Report)
Ambulance Personnel
Trauma Incident
Schools
Communicable Disease
Public Immunization Clinics
Immunization
Behavioral Health Providers
Chronic Diseases
Chronic Disease Registries
Aggregate data reports by special request for a specific region
State Health Department
CDC, Federal Agencies, US Health Department
State Trauma Registry
NTRACS & Web-based Trauma Bridge
Aggregate data reports by special request for a specific region
Aggregate data reports by special request for a specific region
Local Public Health Departments follow up with patients
NEDSS State Health Department
CDC
Vital Records- Hearing Screening Module
Newborn's Doctor
Hospitals or State generate QA reports
HIV test results from labs
Pediatrix Lab
State NNSP Database through Pediatrix
Newborn's Doctor
HARS
State HIV/AIDS Surveillance Health Program
e-NARSIS/ NARSIS
Quality Assurance reports to hospitals
NEMSIS
Local Public Health Department
State of NE ImmuNET
Douglas County Health Department
CDC
Co-CASA
Follow-up Reports for Immunization Coverage
Magellan (to get auths)
Re-entry of Data
Fax Reporting
Phone Reporting
Paper Reporting
Delivery at Admission
E-mail Reporting
Guardian's Secure Electronic Connection
PHIN- MS Secure Electronic Connection
CDC's Secure HIV/AIDS Electronic Connection
Software Export Reporting to Chronic Disease Registries

II. Communicable Disease Reporting
A. Schematic
B. Reportable Disease, Poisonings, & Organisms Form
C. Lab Reportable Disease, Poisonings, & Organisms Form

- Status:
  - Mandatory

- Reporters:
  - Schools
  - Doctors
  - Labs at the Doctors' Offices and Hospitals
  - Other Labs
  - Regional West Medical Center
  - Other Hospitals

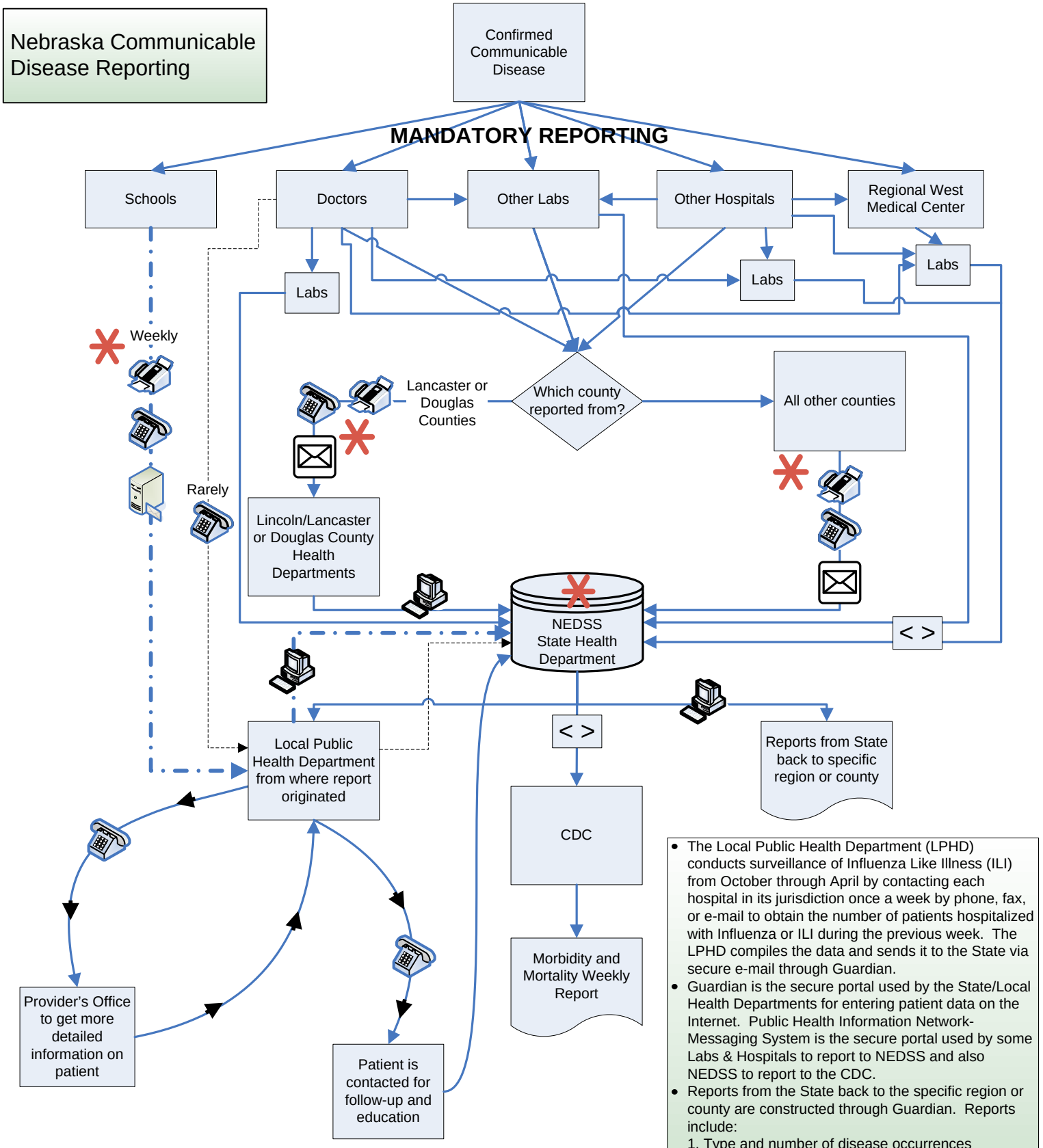
- Methods of Reporting:
  - Paper forms
  - Phone
  - Fax
  - Secure electronic connection (Guardian & PHIN- MS)
  - E-mail (schools only)

- Report To/Into:
  - Local Public Health Departments
  - NEDSS (State Health Department)
  - Centers for Disease Control and Prevention

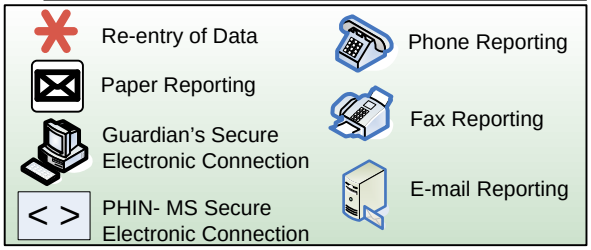
- Re-entry of Data:
  - Reporting sites
  - NEDSS (State Health Department)
  - Local Public Health Department

- Reporting Back:
  - Aggregate reports, generated in Guardian, to region or county

Nebraska Communicable Disease Reporting



- The Local Public Health Department (LPHD) conducts surveillance of Influenza Like Illness (ILI) from October through April by contacting each hospital in its jurisdiction once a week by phone, fax, or e-mail to obtain the number of patients hospitalized with Influenza or ILI during the previous week. The LPHD compiles the data and sends it to the State via secure e-mail through Guardian.
- Guardian is the secure portal used by the State/Local Health Departments for entering patient data on the Internet. Public Health Information Network-Messaging System is the secure portal used by some Labs & Hospitals to report to NEDSS and also NEDSS to report to the CDC.
- Reports from the State back to the specific region or county are constructed through Guardian. Reports include:
  1. Type and number of disease occurrences in each Health Department
  2. List of patients who have received follow-up in the specific jurisdiction



Cert.#_____

Nebraska Department of Health and Human Services
Regulation and Licensure

REPORTABLE DISEASES, POISONINGS AND ORGANISMS

Health Care Provider Confidential Communication

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES - DEPARTMENT OF REGULATION AND LICENSURE - DEPARTMENT OF FINANCE AND SUPPORT

Person Reporting: _____ Week Ending _____

Clinic/Institution: _____ Address/Box # _____ Fax # _____

Phone # _____

Town: _____ State _____ Zip Code _____

For Physician and Hospital Reporting — Patient Information

TODAY'S DATE _____ ATTENDING PHYSICIAN _____ DATE OF ONSET _____

PATIENT'S NAME: (Last) _____ (First) _____ (MI) _____

IF < 19, PARENT'S NAME: (Last) _____ (First) _____ (M) _____

ADDRESS: CITY/TOWN _____ COUNTY _____ STATE _____ ZIP _____

AGE _____ /DOB: _____ RACE ☐ White ☐ Black ☐ Am Indian ☐ Asian or Pacific Islander

SEX Male Female ETHNICITY ☐ Hispanic ☐ Non-Hispanic

PHONE _____ MARITAL STATUS ☐ Single ☐ Married ☐ Other

Disease: | Status: ☐ Case ☐ Suspected case ☐ Asympt. carrier

Check all of the following that apply

☐ Suspected food or waterborne illness.
☐ Patient is part of an outbreak.
☐ Patient was hospitalized.
☐ Patient died as a result of this illness.
☐ Blood level test result _____ µg/dL
☐ Patient has contact with children in day care.
☐ Patient is a foodhandler.

Treatment (drug, dosage, route, administration)

☐ **I request additional report forms. Please send _____ copies.**

HHS Regulation and Licensure Canary Copy - Health Care Provider

HHS-9-(DC) Rev. 1/01 (86009)
(Previous version 5/97 should **NOT** be used)

Confidential

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

Laboratory Summary of Reportable Diseases, Poisonings and Organisms (Including Sexually Transmitted Diseases) Nebraska Department of Health and Human Services

Submit on copy not later than Tuesday of each week to

Nebraska Department of Health and Human Services
Regulation and Licensure
Communicable Disease
P.O Box 95007
Lincoln, Nebraska 68509-5007

PATIENT'S NAME		ADDRESS	Date of		Name of			PHYSICIAN		
Last	First	Street, City, State, Zip	Birth/Age	Sex	Test	Result	Date	Name	Phone	City

This notification shall be sumitted weekly. If no reportable conditions have been detected, the notification should be submitted so indicating.

Name of Laboratory _____ Designated laboratory contact _____ Telephone: _____

For Week Ending _____ Date _____ Fax: _____

White copy - HHS - Regulation and Licensure

Canary copy - Laboratory

PRINTED WITH SOY INK

HHS-10-(DC) Rev. 1/01 (86010)
(Previous version 5/97 should **NOT** be used)

III. HIV/AIDS Reporting
A. Schematic
B. Pediatric Report Form
C. Adult Report Form

- Status:
  - Mandatory

- Reporters:
  - Doctors
  - Labs
  - Hospitals

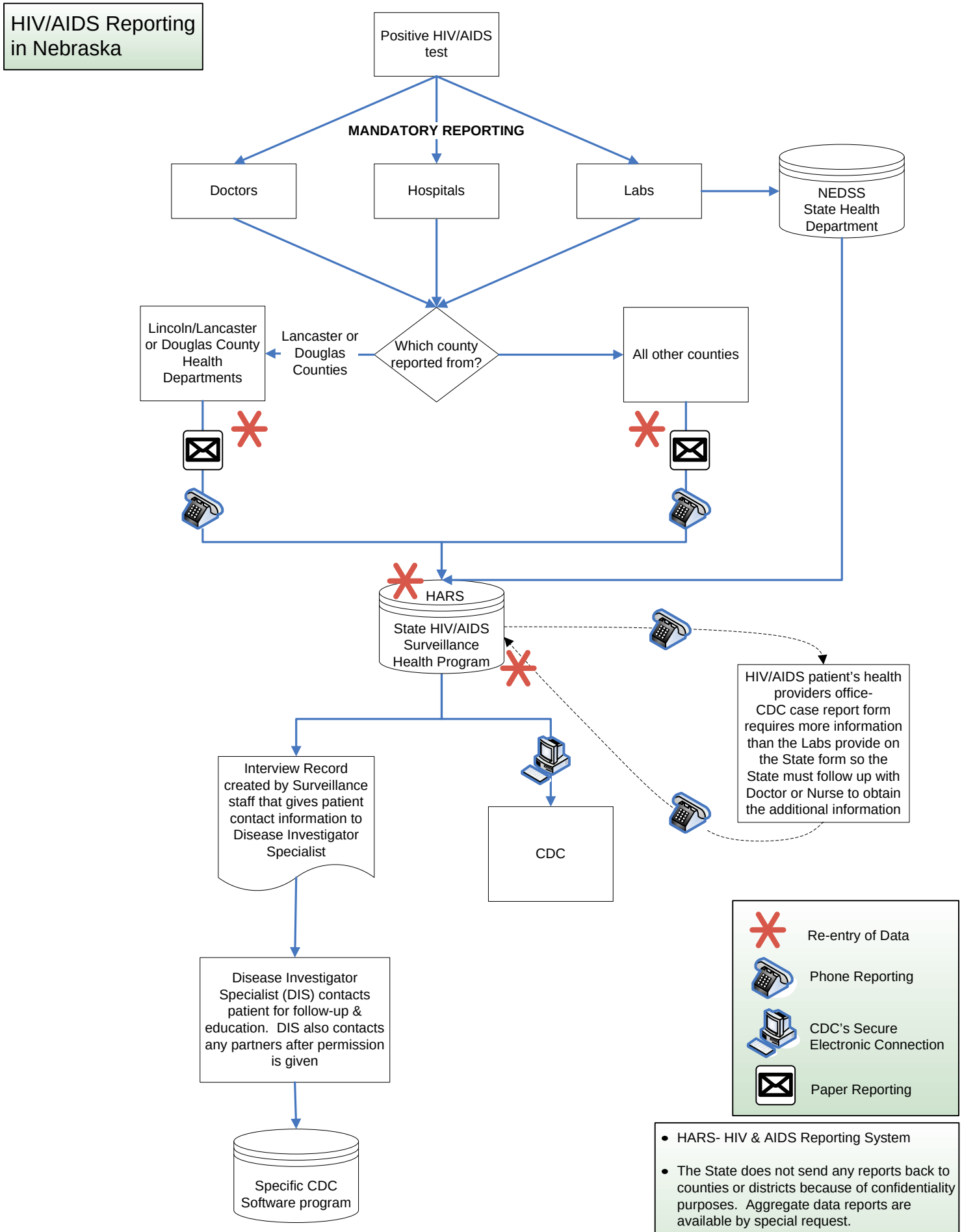
- Methods of Reporting:
  - Paper forms
  - Phone

- Report To/Into:
  - NEDSS (Labs can directly enter data into this system.)
  - HIV/AIDS Reporting System
  - Centers for Disease Control and Prevention

- Re-entry of Data:
  - Reporting sites
  - HIV/AIDS Reporting System

- Reporting Back:
  - Aggregate reports are available by special request due to confidentiality reasons

HIV/AIDS Reporting in Nebraska



- HARS- HIV & AIDS Reporting System
- The State does not send any reports back to counties or districts because of confidentiality purposes. Aggregate data reports are available by special request.
- An Interview Record is only created after approval from physician has been given.

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

– Patient identifier information is not transmitted to CDC! –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

PEDIATRIC HIV/AIDS CONFIDENTIAL CASE REPORT
(Patients <13 years of age at time of diagnosis)

CDC Centers for Disease Control and Prevention

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

II. HEALTH DEPARTMENT USE ONLY

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

SOUNDEX CODE:

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT: State: _____ City/County: _____

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one) 3 Perinatally HIV Exposed; 4 Confirmed HIV Infection (not AIDS); 5 AIDS; 6 Seroreverter

DATE OF LAST MEDICAL EVALUATION: Mo. Yr.

DATE OF BIRTH: Mo. Day Yr.

AGE AT DIAGNOSIS: Years Months — HIV Infection (not AIDS) ... ; AIDS .....

CURRENT STATUS: 1 Alive; 2 Dead; 9 Unk.

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

DATE OF INITIAL EVALUATION FOR HIV INFECTION: Mo. Yr.

Was reason for initial HIV evaluation due to clinical signs and symptoms? Yes 1 No 0 Unk. 9

SEX: 1 Male; 2 Female

ETHNICITY: (select one) 1 Hispanic; 2 Not Hispanic or Latino; 9 Unk.

RACE: (select one or more) American Indian/Alaska Native; Native Hawaiian or Other Pacific Islander; Asian; White; Black or African American; Unk

COUNTRY OF BIRTH: 1 U.S.; 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): _____; 8 Other (specify): _____; 9 Unk.

RESIDENCE AT DIAGNOSIS:
City: _____ County: _____ State/Country: _____ Zip Code: _____

IV. FACILITY OF DIAGNOSIS

Facility Name: _____ City: _____ State/Country: _____

FACILITY SETTING (check one) 1 Public; 2 Private; 3 Federal; 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO; 31 Hospital, Inpatient; 88 Other (specify): _____

V. PATIENT/MATERNAL HISTORY *(Respond to ALL categories)*

• Child's biologic mother's HIV Infection Status: (check one)

1 Refused HIV testing; 2 Known to be uninfected after this child's birth; 9 HIV status unknown

Diagnosed with HIV Infection/AIDS:

3 Before this child's pregnancy; 4 During this child's pregnancy; 5 At time of delivery; 6 Before child's birth, exact period unknown; 7 After the child's birth; 8 HIV-infected, unknown when diagnosed

• Date of mother's first positive HIV confirmatory test: ..... Mo. Yr.

• Mother was counseled about HIV testing during this pregnancy, labor or delivery? ..... Yes 1 No 0 Unk. 9

After 1977, this child's biologic mother had:

	Yes	No	Unk.
• Injected nonprescription drugs	1	0	9
• *HETEROSEXUAL* relations with:			
- Intravenous/injection drug user	1	0	9
- Bisexual male	1	0	9
- Male with hemophilia/coagulation disorder	1	0	9
- Transfusion recipient with documented HIV infection	1	0	9
- Transplant recipient with documented HIV infection	1	0	9
- Male with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9

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

	Yes	No	Unk.
• Received clotting factor for hemophilia/coagulation disorder	1	0	9
(specify disorder): 1 Factor VIII (Hemophilia A); 2 Factor IX (Hemophilia B); 8 Other (specify): _____			
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
First: Mo. Yr. Last: Mo. Yr.			
• Received transplant of tissue/organs	1	0	9
• Sexual contact with a male	1	0	9
• Sexual contact with a female	1	0	9
• Injected nonprescription drugs	1	0	9
• Other (Alert State/City NIR Coordinator)	1	0	9

VI. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Physician identifier information is not transmitted to CDC! –

VII. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Record all tests, include earliest positive)

	Positive	Negative	Indeterminate	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV–1 EIA	1	0	–	9		
• HIV–1 EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify): _____	1	0	8	9		

2. HIV DETECTION TESTS:
(Record all tests, include earliest positive)

	Positive	Negative	Not Done	TEST DATE Mo.	TEST DATE Yr.
• HIV culture	1	0	9		
• HIV culture	1	0	9		
• HIV antigen test	1	0	9		
• HIV antigen test	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV DNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• HIV RNA PCR	1	0	9		
• Other, specify _____	1	0	9		

3. HIV VIRAL LOAD TEST: (Record all tests, include earliest detectable)

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

Test type*	Detectable Yes	Detectable No	Copies/ml	Test Date Mo.	Test Date Yr.
	1	0			
	1	0			

4. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

		Mo.	Yr.
• CD4 Count	cells/∝L		
• CD4 Count	cells/∝L		
• CD4 Percent	%		
• CD4 Percent	%		

5. 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 him/her from the AIDS case definition? ..... Yes 1 No 0 Unk. 9

6. If laboratory tests were not documented, is patient confirmed by a physician as:

	Yes	No	Unk.	Date of Documentation Mo.	Date of Documentation Yr.
• HIV-infected	1	0	9		
• Not HIV-infected	1	0	9		

VIII. CLINICAL STATUS

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Bacterial infections, multiple or recurrent (including Salmonella septicemia)	1	NA		
Candidiasis, bronchi, trachea, or lungs	1	NA		
Candidiasis, esophageal	1	2		
Coccidioidomycosis, disseminated or extrapulmonary	1	NA		
Cryptococcosis, extrapulmonary	1	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	1	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes) onset at >1 mo. of age	1	NA		
Cytomegalovirus retinitis (with loss of vision)	1	2		
HIV encephalopathy	1	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis, onset at >1 mo. of age	1	NA		
Histoplasmosis, disseminated or extrapulmonary	1	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA		
Kaposi's sarcoma	1	2		
Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia	1	2		
Lymphoma, Burkitt's (or equivalent term)	1	NA		
Lymphoma, immunoblastic (or equivalent term)	1	NA		
Lymphoma, primary in brain	1	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	1	2		
M. tuberculosis, disseminated or extrapulmonary*	1	2		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	1	2		
Pneumocystis carinii pneumonia	1	2		
Progressive multifocal leukoencephalopathy	1	NA		
Toxoplasmosis of brain, onset at >1 mo. of age	1	2		
Wasting syndrome due to HIV	1	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

Has this child been diagnosed with pulmonary tuberculosis?* 1 Yes 0 No 9 Unk. If yes, initial diagnosis and date: 1 Definitive 2 Presumptive Mo. Yr. *RVCT CASE NO.:

IX. BIRTH HISTORY (for PERINATAL cases only)

Birth history was available for this child: [1] Yes [0] No [9] Unk. ***If No or Unknown, proceed to Section X.***

HOSPITAL AT BIRTH:

Hospital:_____ City:_____ State:_____ Country:_____

RESIDENCE AT BIRTH:

City:_____ County:_____ State/ Country:_____ Zip Code:_____

BIRTHWEIGHT: (enter lbs/oz OR grams)

____ lbs. ____ oz

____ grams

BIRTH: **Type:** .... [1] Single [2] Twin [3] >2 [9] Unk.

Delivery: ..... [1] Vaginal [2] Elective Caesarean [3] Non-elective Caesarean [4] Caesarean, unk. type [9] Unk.

Birth Defects: .... [1] Yes [0] No [9] Unk.

Specify type(s):_____ **Code:** ____.____

NEONATAL STATUS:

[1] Full term

[2] Premature

Weeks ____ 99 = Unk.

PRENATAL CARE:

Month of pregnancy prenatal care began: ____ mos. 99 = Unk. 00 = None

Total number of prenatal care visits: ____ 99 = Unk. 00 = None

- **Did mother receive zidovudine (ZDV, AZT) during pregnancy?** Refused [8] Yes [1] No [0] Unk. [9]
- **Did mother receive zidovudine (ZDV, AZT) during labor/delivery?** Refused [8] Yes [1] No [0] Unk. [9]
- **If yes, what week of pregnancy was zidovudine (ZDV, AZT) started?** Weeks: ____ 99 = Unk.
- **Did mother receive zidovudine (ZDV, AZT) prior to this pregnancy?** Yes [1] No [0] Unk. [9]
- **Did mother receive any other Anti-retroviral medication during pregnancy?** Yes [1] No [0] Unk. [9] If yes, specify:_____
- **Did mother receive any other Anti-retroviral medication during labor/delivery?** Yes [1] No [0] Unk. [9] If yes, specify:_____

Maternal Date of Birth Mo. Day Yr. ____

Maternal Soundex: ____ _____

Maternal State Patient No. _____

Birthplace of Biologic Mother:

[1] U.S. [7] U.S. Dependencies and Possessions (including Puerto Rico) (specify):_____

[8] Other (specify):_____ [9] Unk.

X. TREATMENT/SERVICES REFERRALS

This child received or is receiving:

	Yes	No	Unk.	DATE STARTED Mo. Day Yr.
• Neonatal zidovudine (ZDV, AZT) for HIV *prevention*	1	0	9	____ ____ ____
• Other neonatal anti-retroviral medication for HIV *prevention*	1	0	9	____ ____ ____
• Anti-retroviral therapy for HIV *treatment*	1	0	9	____ ____ ____
• PCP prophylaxis	1	0	9	____ ____ ____

If yes, specify:_____

Was child breastfed? Yes [1] No [0] Unk. [9]

This child has been enrolled at:

Clinical Trial: [1] NIH-sponsored [2] Other [3] None [9] Unk.

Clinic: [1] HRSA-sponsored [2] Other [3] None [9] Unk.

This child's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO [3] No coverage [4] Other Public Funding [7] Clinical trial/government program [9] Unk.

This child's primary caretaker is:

[1] Biologic parent(s) [2] Other relative [3] Foster/Adoptive parent, relative [4] Foster/Adoptive parent, unrelated [7] Social service agency [8] Other (specify in Section XI.) [9] Unk.

XI. COMMENTS:

(XI. COMMENTS CONTINUED ON THE BACK)

This report to the Centers for Disease Control and Prevention (CDC) is authorized by law (Sections 304 and 306 of the Public Health Service Act, 42 USC 242b and 242k). Response in this case is voluntary for federal government purposes, but may be mandatory under state and local statutes. Your cooperation is necessary for the understanding and control of HIV/AIDS. Information in CDC's HIV/AIDS surveillance system that would permit identification of any individual on whom a record is maintained, is collected with a guarantee that it will be held in confidence, will be used only for the purposes stated in the assurance on file at the local health department, and will not otherwise be disclosed or released without the consent of the individual in accordance with Section 308(d) of the Public Health Service Act (42 USC 242m).

Public reporting burden of this collection of information is estimated to average 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0009). **Do not send the completed form to this address.**

I. STATE/LOCAL USE ONLY

Patient's Name: _____ Phone No.: ( ) _____
(Last, First, M.I.)

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

– Patient identifier information is not transmitted to CDC! –

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention

ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

CDC Centers for Disease Control and Prevention

Form Approved OMB No. 0920-0573 Exp Date 11/30/2005

II. HEALTH DEPARTMENT USE ONLY

DATE FORM COMPLETED: Mo. Day Yr.

REPORT SOURCE:

SOUNDEX CODE:

REPORT STATUS: 1 New Report 2 Update

REPORTING HEALTH DEPARTMENT: State: City/County:

State Patient No.:

City/County Patient No.:

III. DEMOGRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT (check one): 1 HIV Infection (not AIDS) 2 AIDS

AGE AT DIAGNOSIS: Years Years

DATE OF BIRTH: Mo. Day Yr.

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Mo. Day Yr.

STATE/TERRITORY OF DEATH:

SEX: 1 Male 2 Female

ETHNICITY: (select one) 1 Hispanic 9 Unk 2 Not Hispanic or Latino

RACE: (select one or more) American Indian/Alaska Native; Black or African American; Asian; Native Hawaiian or Other Pacific Islander; White; Unk

COUNTRY OF BIRTH: 1 U.S. 7 U.S. Dependencies and Possessions (including Puerto Rico) (specify): 8 Other (specify): 9 Unk

RESIDENCE AT DIAGNOSIS: City: County: State/Country: Zip Code:

IV. FACILITY OF DIAGNOSIS

Facility Name

City

State/Country

FACILITY SETTING (check one) 1 Public 2 Private 3 Federal 9 Unk.

FACILITY TYPE (check one) 01 Physician, HMO 31 Hospital, Inpatient 88 Other (specify):

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V. PATIENT HISTORY

AFTER 1977 AND PRECEDING THE FIRST POSITIVE HIV ANTIBODY TEST OR AIDS DIAGNOSIS, THIS PATIENT HAD (Respond to **ALL** Categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (specify):

• *HETEROSEXUAL* relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9
• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting	1	0	9

First Mo. Yr. Last Mo. Yr.

(specify occupation):

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos	Neg	Ind	Not Done	TEST DATE Mo.	Yr.
• HIV–1 EIA	1	0	–	9		
• HIV–1/HIV–2 combination EIA	1	0	–	9		
• HIV–1 Western blot/IFA	1	0	8	9		
• Other HIV antibody test (specify):	1	0	8	9		

2. POSITIVE HIV DETECTION TEST: (Record earliest test) Mo. Yr.

culture antigen PCR, DNA or RNA probe

• Other (specify):

3. DETECTABLE VIRAL LOAD TEST: (Record most recent test)

Test type* COPIES/ML Mo. Yr.

*Type: 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA(Chiron) 18. Other

• Date of last documented negative HIV test (specify type): Mo. Yr.

• If HIV laboratory tests were not documented, is HIV diagnosis documented by a physician? Yes 1 No 0 Unk. 9

If yes, provide date of documentation by physician Mo. Yr.

4. IMMUNOLOGIC LAB TESTS:

AT OR CLOSEST TO CURRENT DIAGNOSTIC STATUS Mo. Yr.

• CD4 Count cells/µL

• CD4 Percent %

First <200 µL or <14% Mo. Yr.

• CD4 Count cells/µL

• CD4 Percent %

VII. STATE/LOCAL USE ONLY

Physician's Name: _____ Phone No.: ( ) _____ Medical Record No. _____
(Last, First, M.I.)

Hospital/Facility: _____ Person Completing Form: _____ Phone No.: ( ) _____

– Patient identifier information is not transmitted to CDC! –

VIII. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS: Asymptomatic (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo. Yr. Symptomatic (not AIDS): Mo. Yr.

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Candidiasis, bronchi, trachea, or lungs	[1]	NA		
Candidiasis, esophageal	[1]	[2]		
Carcinoma, invasive cervical	[1]	NA		
Coccidioidomycosis, disseminated or extrapulmonary	[1]	NA		
Cryptococcosis, extrapulmonary	[1]	NA		
Cryptosporidiosis, chronic intestinal (>1 mo. duration)	[1]	NA		
Cytomegalovirus disease (other than in liver, spleen, or nodes)	[1]	NA		
Cytomegalovirus retinitis (with loss of vision)	[1]	[2]		
HIV encephalopathy	[1]	NA		
Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	[1]	NA		
Histoplasmosis, disseminated or extrapulmonary	[1]	NA		
Isosporiasis, chronic intestinal (>1 mo. duration)	[1]	NA		
Kaposi's sarcoma	[1]	[2]		

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Initial Date Yr.
Lymphoma, Burkitt's (or equivalent term)	[1]	NA		
Lymphoma, immunoblastic (or equivalent term)	[1]	NA		
Lymphoma, primary in brain	[1]	NA		
Mycobacterium avium complex or *M.kansasii*, disseminated or extrapulmonary	[1]	[2]		
M. tuberculosis, pulmonary*	[1]	[2]		
M. tuberculosis, disseminated or extrapulmonary*	[1]	[2]		
Mycobacterium, of other species or unidentified species, disseminated or extrapulmonary	[1]	[2]		
Pneumocystis carinii pneumonia	[1]	[2]		
Pneumonia, recurrent, in 12 mo. period	[1]	[2]		
Progressive multifocal leukoencephalopathy	[1]	NA		
Salmonella septicemia, recurrent	[1]	NA		
Toxoplasmosis of brain	[1]	[2]		
Wasting syndrome due to HIV	[1]	NA		

Def. = definitive diagnosis Pres. = presumptive diagnosis

* RVCT CASE NO.: _____

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

IX. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:
[1] Health department [2] Physician/provider [3] Patient [9] Unknown

This patient is receiving or has been referred for:

	Yes	No	NA	Unk.
• HIV related medical services	[1]	[0]	–	[9]
• Substance abuse treatment services	[1]	[0]	[8]	[9]

This patient received or is receiving:

	Yes	No	Unk.
• Anti-retroviral therapy	[1]	[0]	[9]
• PCP prophylaxis	[1]	[0]	[9]

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:
[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

FOR WOMEN:
- This patient is receiving or has been referred for gynecological or obstetrical services: [1] Yes [0] No [9] Unknown
- Is this patient currently pregnant? [1] Yes [0] No [9] Unknown
- Has this patient delivered live-born infants? [1] Yes (if delivered after 1977, provide birth information below for the most recent birth) [0] No [9] Unknown

CHILD'S DATE OF BIRTH: Mo. Day Yr.

Hospital of Birth: _____
City: _____ State: _____

Child's Soundex:

Child's State Patient No.

X. COMMENTS: _____

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IV. Newborn Metabolic Reporting
A. Schematic
B. Collection and Reporting Form

- Status:
  - Mandatory

- Reporters:
  - Hospitals

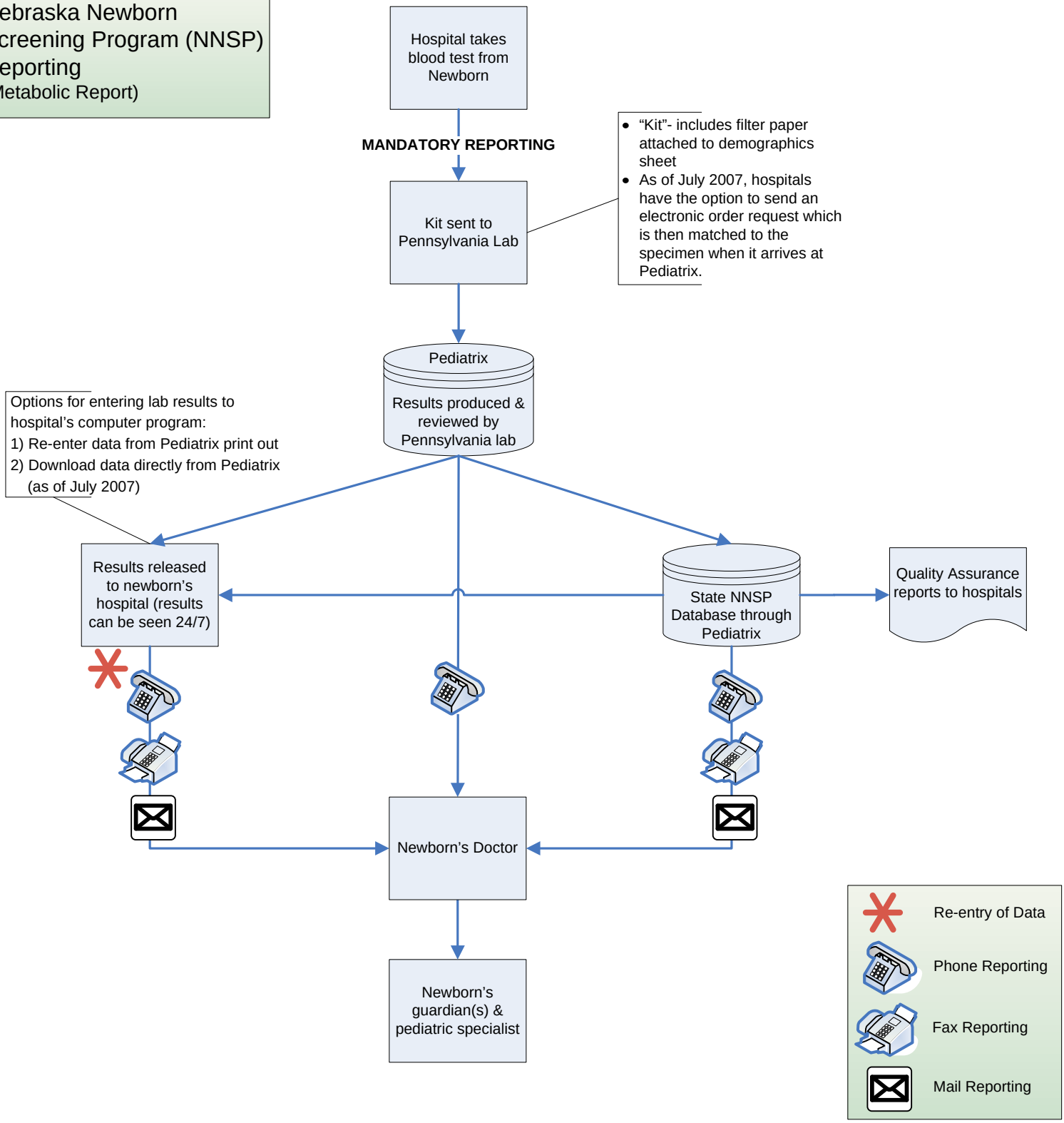
- Methods of Reporting:
  - Paper forms
  - Fax
  - Phone

- Report To/Into:
  - Pediatrix
  - Results sent to hospital & State's customized Database through the Pediatrix Lab
  - Newborn's Doctor
  - Newborn's Guardian

- Re-entry of Data:
  - Hospital- After receiving results from the Pediatrix Lab

- Reporting Back:
  - Quality Assurance Reports for Hospitals

Nebraska Newborn Screening Program (NNSP) Reporting
(Metabolic Report)



- Newborn's Doctor contacted by Pediatrix Lab and/or the State for the following reasons:
  1. Positive results
  2. Inconclusive results
  3. Unsatisfactory specimens
  4. Specimens drawn too early
- Reports from the State back to submitting hospitals:
  1. Quarterly Quality Assurance reports
     - Individual hospital's data compared to the State data
  2. Specific variable reports i.e.:
     - Turnaround Time for lab results
     - Rates for unsatisfactory specimens
- For clarification, the data are located in the Pediatrix database, and the State accesses it via a secure Internet connection. The State has some ability to edit the data, but it is primarily entered, edited, and maintained by the Pennsylvania lab. Also, the follow-up tracking reports and quality assurance reports are customized for the State.

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

COLLECTION AND REPORTING (CARE) FORM – *NEBRASKA NEWBORN SCREENING PROGRAM*

REPORTED

Birth: Date:___/___/___Time:___:___(Military)
Collection: Date:___/___/___Time:____(Military)
Collector's initials:___ Initialo Repeat o
o Specimen collected prior to 24 hours
o Transfused prior to specimen collected
If 4'd specify type:_____date:____time:___
o TPN o Baby on antibiotics o Meconium Ileus
Gestational age_____(wks) Birth weight:_____

NEWBORN'S INFORMATION:

Name_____
Last First Middle
Patient Record Number:_____
Place of Birth:_____
Home Birth: Yes o No o Sex: M o

MOTHER'S INFORMATION:

Name_____
Last First Middle
Address_____
_____
Telephone (___)___-_____Birthdate___/___/___

SUBMITTER'S INFORMATION;

Name_____
Address:_____
_____
Telephone(___)_____-_____

RECEIVED

SERIAL # 1234567

NEWBORN'S PHYSICIAN INFORMATION

SERIAL # 1234567

Name_____
Last First
Telephone (_____)_____-_____

Serial # 1234567

BEFORE SUBMITTING SPECIMEN TO SCREENING LAB. MUST COMPLETE:

Parent **consents** to optional/supplemental testing
o (Signed Consent on file at hospital)
Parent **dissents** from optional/supplemental testing
o (Signed Dissent on file at hospital)

TESTING LAB REQUIRED DATA

SATISFACTORY SPECIMEN? Yes o No o
IF NO, WHY:_____

TEST RESULTS:

	Normal / Abnormal
Biotinidase Deficiency:	_____ / _____
Congenital Adrenal Hyperplasia	_____ / _____
Congenital Primary Hypothyroidism: T4_____ TSH_____	_____ / _____
Cystic Fibrosis (CF)	_____ / _____
Galactosemia	_____ / _____
Hemoglobinopathies: Result___	_____ / _____
MCAD	_____ / _____
PKU	_____ / _____

V. Newborn Hearing Screening Reporting
A. Schematic
B. Screen print

- Status:
  - Nonmandatory

- Reporters:
  - Hospitals

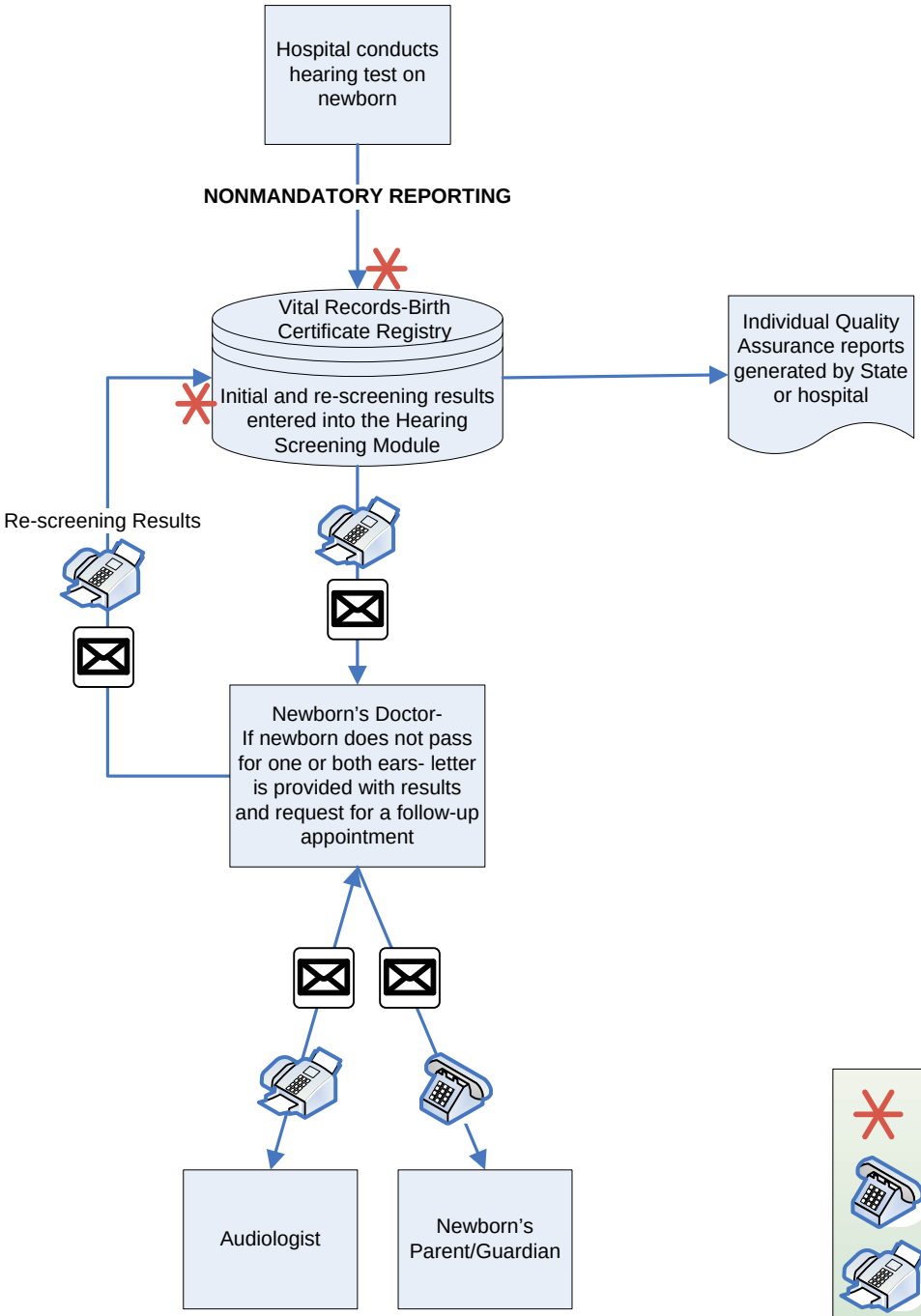
- Methods of Reporting:
  - Paper forms
  - Fax

- Report To/Into:
  - Vital Records- Hearing Screening Module
  - Newborn's Doctor
  - Audiologist
  - Newborn's Parent/Guardian

- Re-entry of Data:
  - Vital Records- Hearing Screening Module

- Reporting Back:
  - Quality Assurance Reports for Hospitals

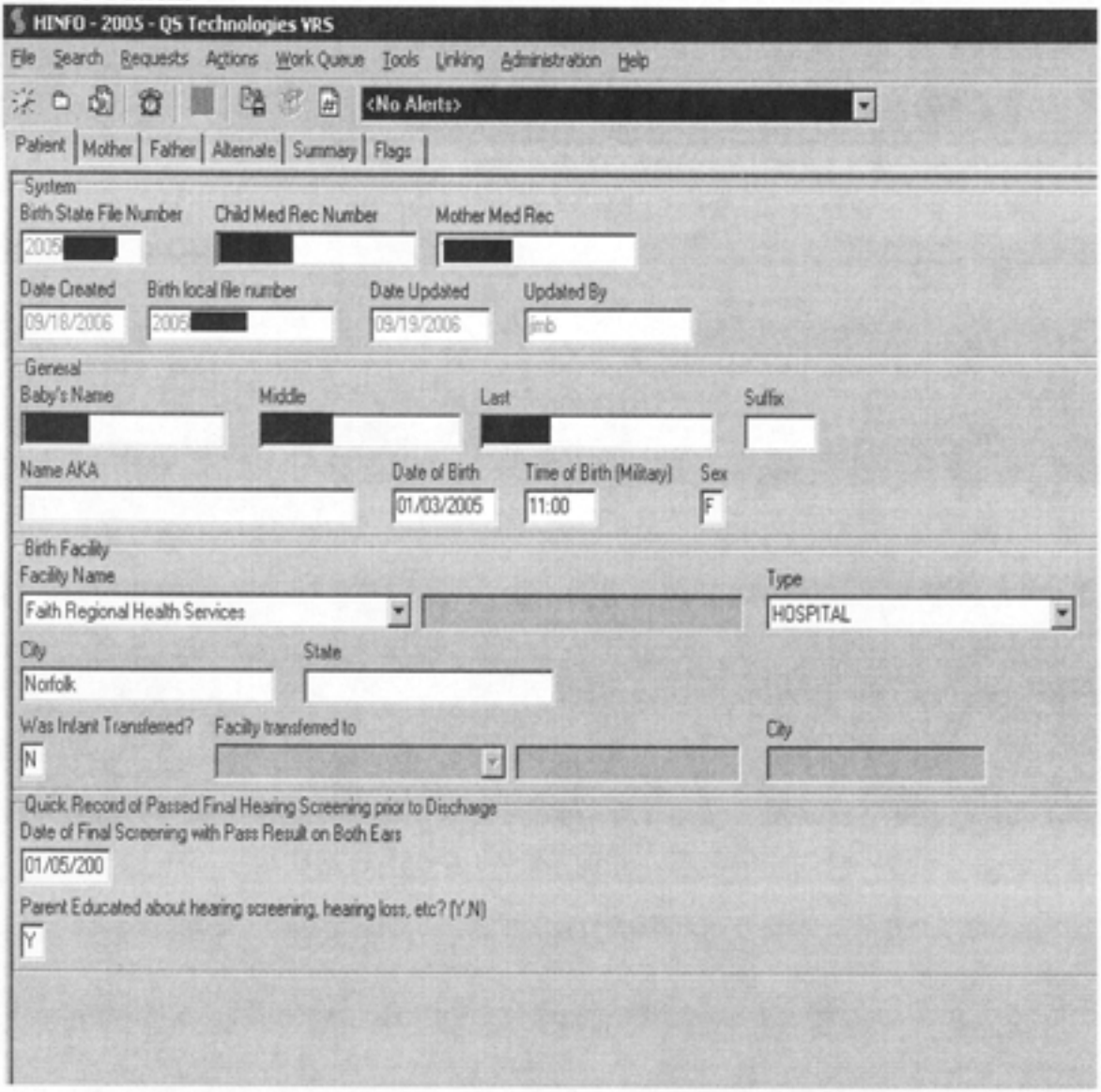
Nebraska Newborn Hearing Screening Reporting



- The electronic system connection between the Hearing Screening Module and the Vital Records-Birth Certificate Registry for birthing facilities in the Panhandle which are in Scottsbluff, Chadron, Sidney, Alliance, and Gordon was implemented in January 2007.
- Birthing Facilities and the State of NE are the only entities with access to the Electronic Hearing Screening Module.
- The Quality Assurance reports which can be generated by each hospital or the State include aggregate reports for either data for each specific hospital or the specific hospital compared to State data. Reports include number of tests conducted, number of newborns who passed/ did not pass/ did not screen, and amount of patient education provided, etc.

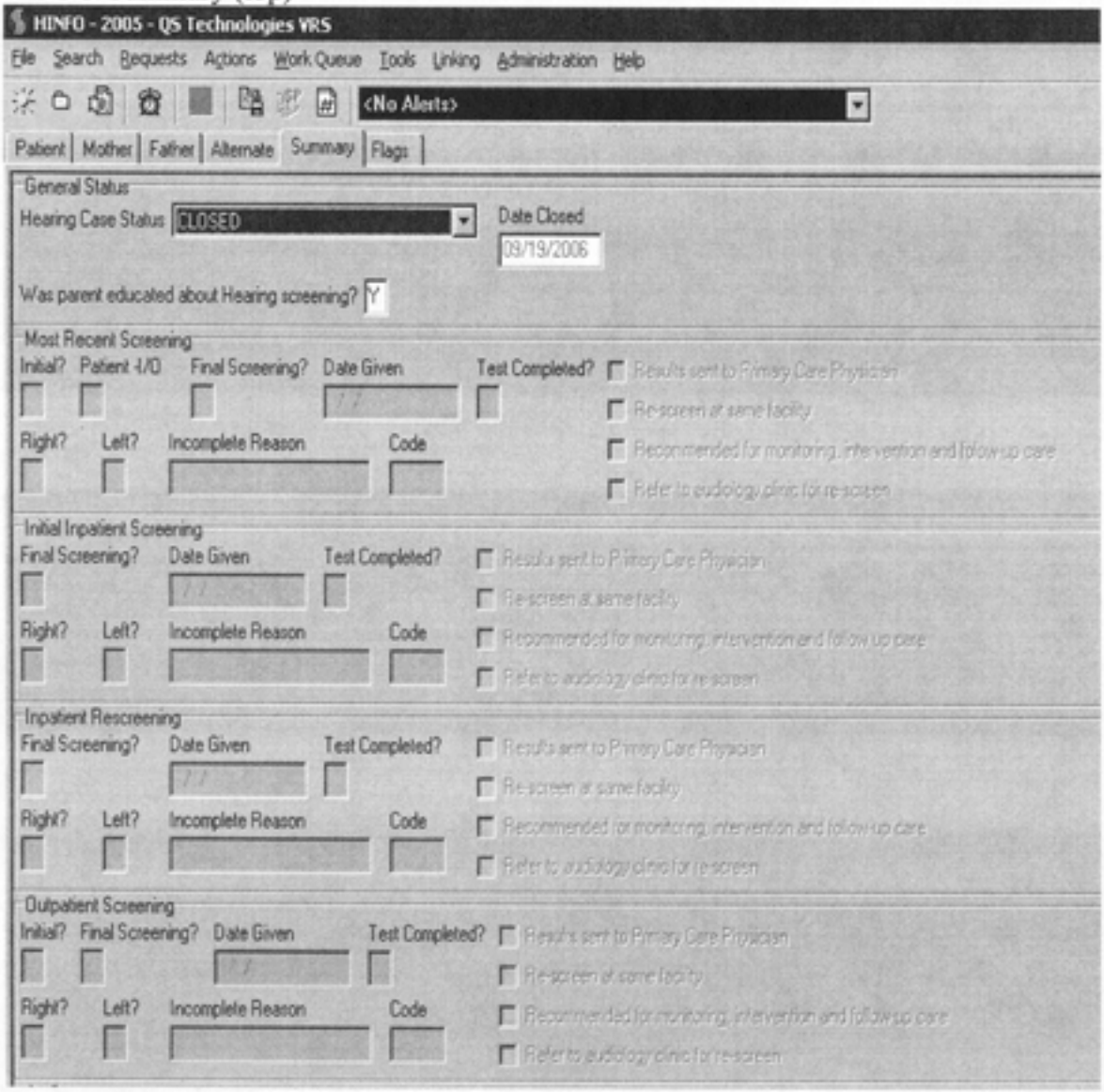
QSTVRS screens for NNHSP

HINFO/Patient



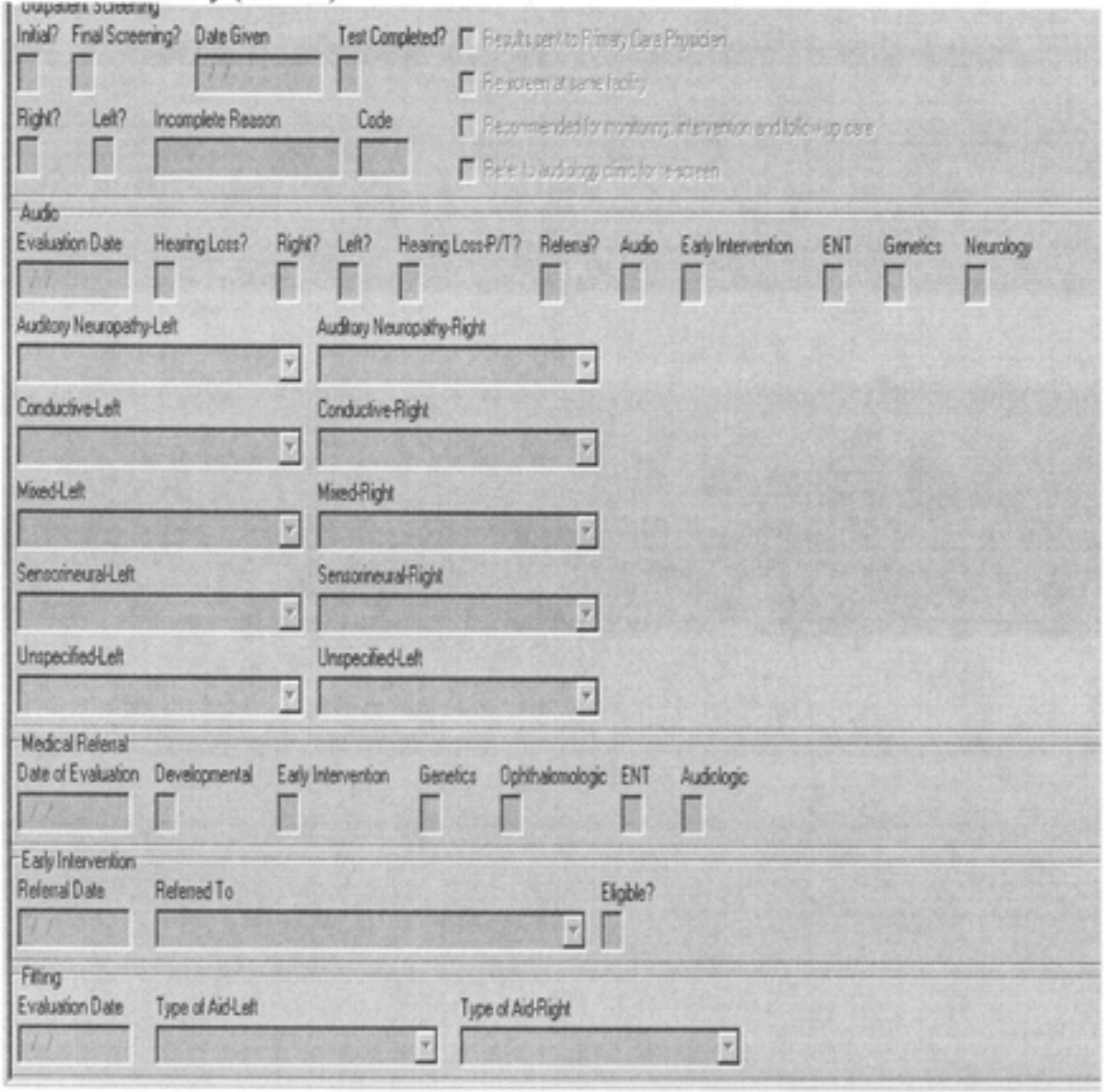
QSTVRS screens for NNHSP

HINFO/Summary (top)



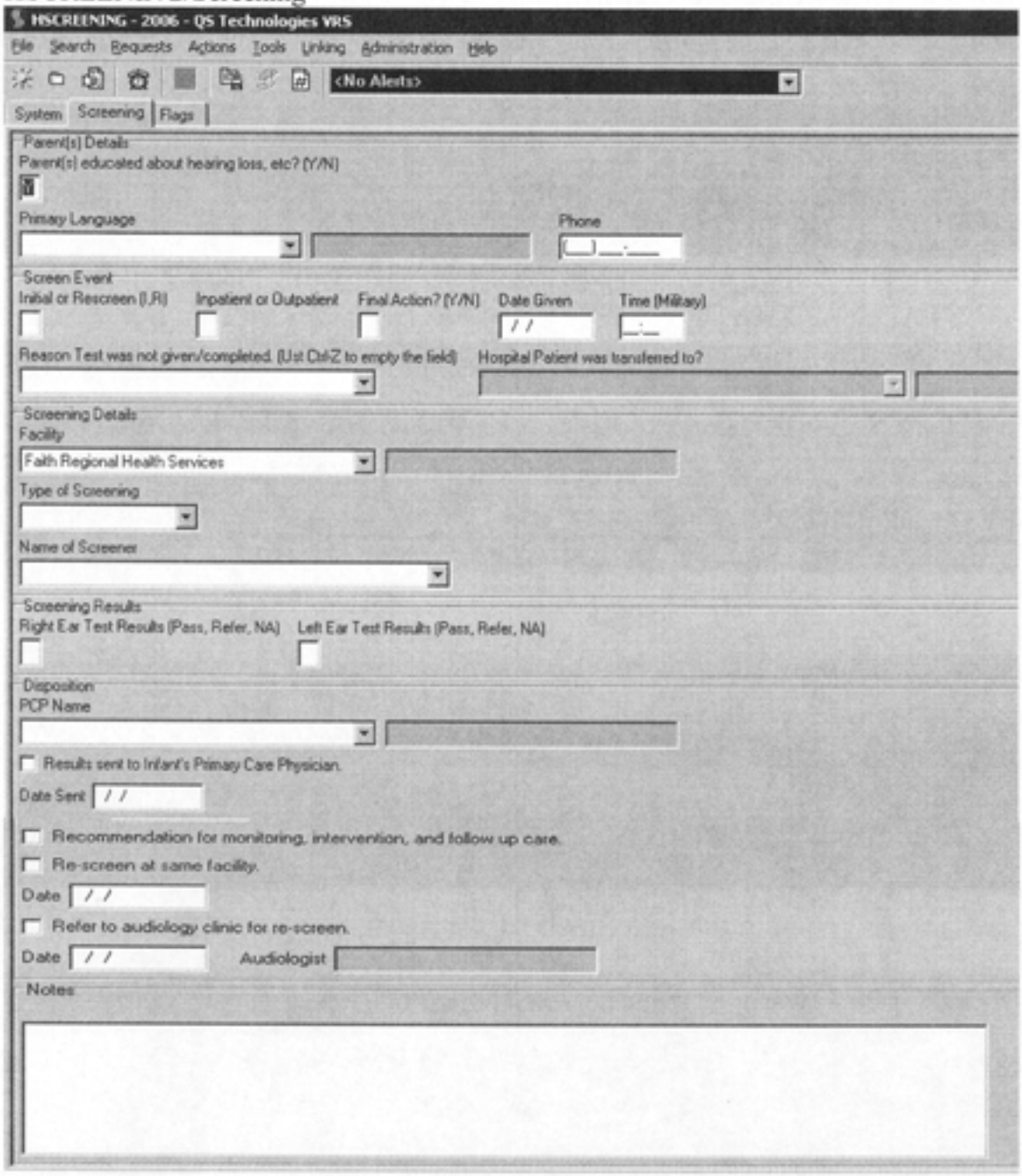
QSTVRS screens for NNHSP

HINFO/Summary (bottom)



QSTVRS screens for NNHSP

HSCREENING/Screening



VI. Chronic Disease Reporting
A. Schematic

- Status:
  - Mandatory

- Reporters:
  - Doctors
  - Labs
  - Hospitals

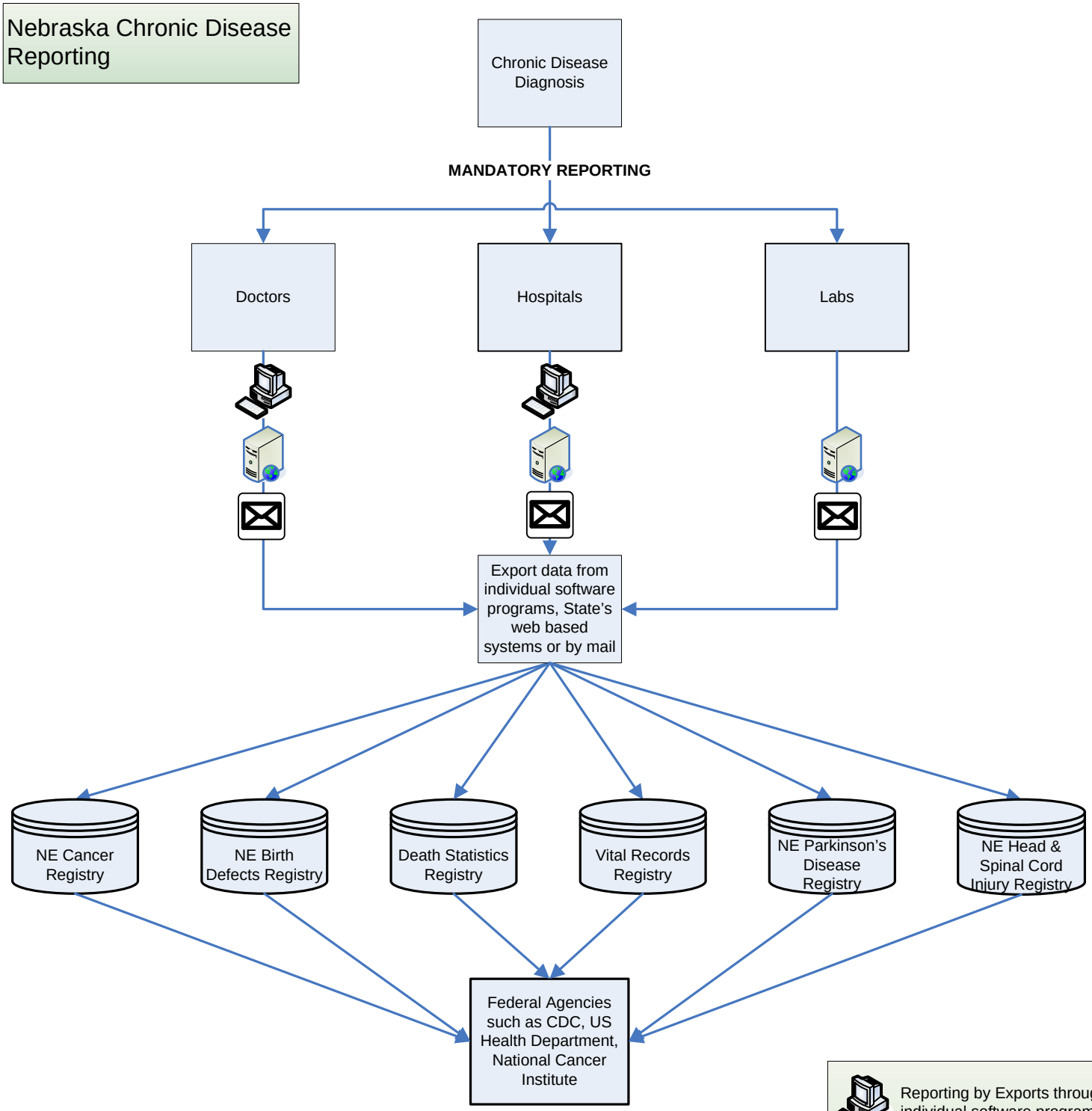
- Methods of Reporting:
  - Mail Reporting- Paper form or Disk
  - Direct reporting to web based registries
  - Software Exports to accommodate different programs used by the reporters (e.g., HHSS Secure Information eXchange (SIX) server)

- Report To/Into:
  - Chronic Disease registries- Cancer; Birth Defects; Vital Records- Death Statistics (web based), Birth, Marriage, & Divorce; Parkinson's Disease; and Head & Spinal Cord Injury
  - Federal Agencies, Centers for Disease Control and Prevention, US Health Department, National Cancer Institute, etc.

- Re-entry of Data:

- Reporting Back:
  - Aggregate reports are available by special request
  - Research requests

Nebraska Chronic Disease Reporting



- The State is not required to send any reports back to counties or districts. However, aggregate data reports are available by special request.
- Each Registry's staff also collects data on site- at the doctors' offices, hospitals, and labs. Then the staff will enter the data into the appropriate Registry.
- For clarification, the Death Statistics web-based module is part of the Vital Records Registry. Coroners, funeral home directors, and county sheriff's officers also enter deaths in this module via the web.

VII. Nebraska Cancer Registry Reporting
A. Schematic
B. Physician Reporting form

- Status:
  - Mandatory

- Reporters:
  - Doctors
  - Labs (Pathology reports)
  - Hospitals (Registrars)

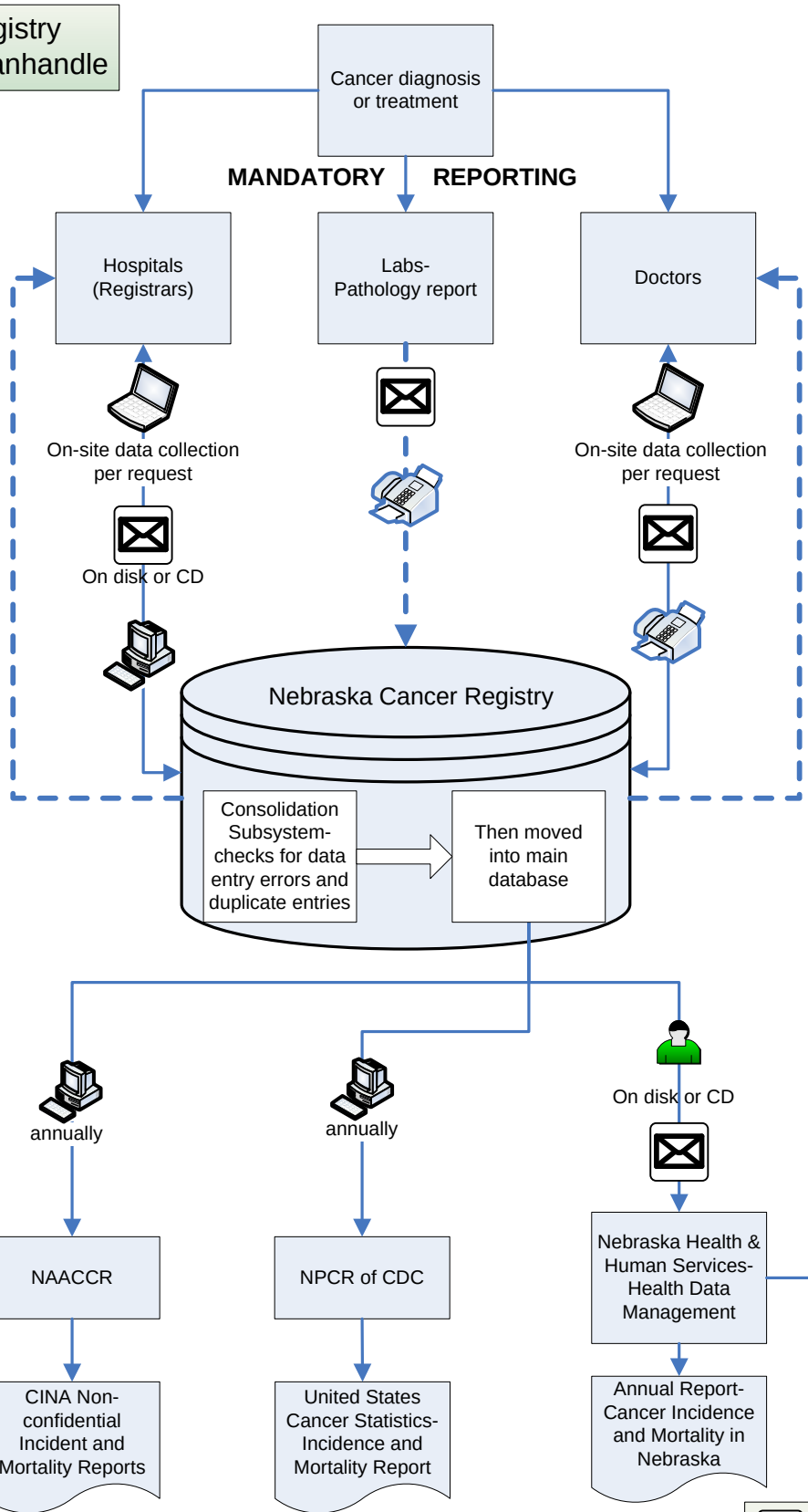
- Methods of Reporting:
  - Paper forms from the physicians
  - Mail- disks or CDs with patient data
  - Fax
  - Secure electronic connection (hospitals)
  - On-site data collection (hospitals and doctors)
  - Periodic personal delivery of disks or CDs with complete data files to the State's Health Data Manager

- Report To/Into:
  - Nebraska Cancer Registry
  - Nebraska Health and Human Services- Health Data Management
  - North American Association of Central Cancer Registries
  - National Program of Cancer Registries (CDC)

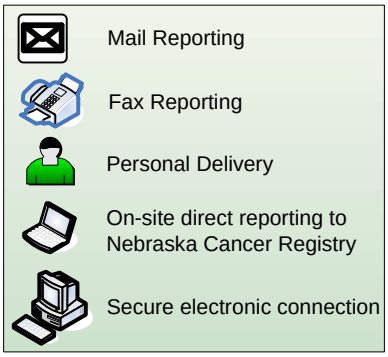
- Re-entry of Data:

- Reporting Back:
  - Aggregate reports are available by special request
  - National reports of cancer incidence and mortality statistics
  - State Annual Report of cancer incidence and mortality statistics

Nebraska Cancer Registry Reporting from the Panhandle



- Nebraska Cancer Registry (NCR) has developed a specialized form to obtain specific patient information from doctors. After the doctors complete the form, they will mail or fax it back to the NCR.
- Doctors who have more than 5 cases of cancer diagnosis or treatment and hospitals that have less than 50 cases of cancer diagnosis or treatment have the option to request onsite data collection by the NCR staff.
- CINA- Cancer Incidence in North America



Patient Name _____ DOB _____ Age ____

Patient Address at Diagnosis _____

SSN _____ Race _____ Gender _____

Primary Cancer Site _____ Date of diagnosis _____

Histology _____

_____

Was patient hospitalized for this cancer? ☐ Yes ☐ No

If yes, name of hospital _____ _____
Has this patient had any of the following treatments? Date
Surgery. If yes, specify date, procedure and place of surgery:

_____

_____

Chemotherapy/Hormone Therapy ☐ Yes ☐ No _____
Date

Radiation Therapy ☐ Yes ☐ No _____
Date

Other Therapy _____

Name of Physician responsible for on-going cancer therapy/care: _____

_____

Date you last saw the patient _____

Patient Status:
- Alive, free of cancer _____
- Alive, evidence of cancer _____
- Alive, cancer status unknown _____
- Deceased, free of cancer _____
- Deceased, evidence of cancer _____
- Deceased, cancer status unknown _____

Followup contact/Next of Kin _____
Name and address

_____

Return this form to: Judy Paradies, CTR
Nebraska Cancer Registry
8601 West Dodge Road #114A
Omaha, NE 68114 FAX: 402-354-3388

VIII. Nebraska Trauma Registry Reporting

A. Schematic

B. NARSIS Reporting form

C. Screen print of e-NARSIS

D. NTRACS Required Data Template

- Status:
  - Mandatory

- Reporters:
  - Ambulance Personnel
  - Hospital (Registrars)

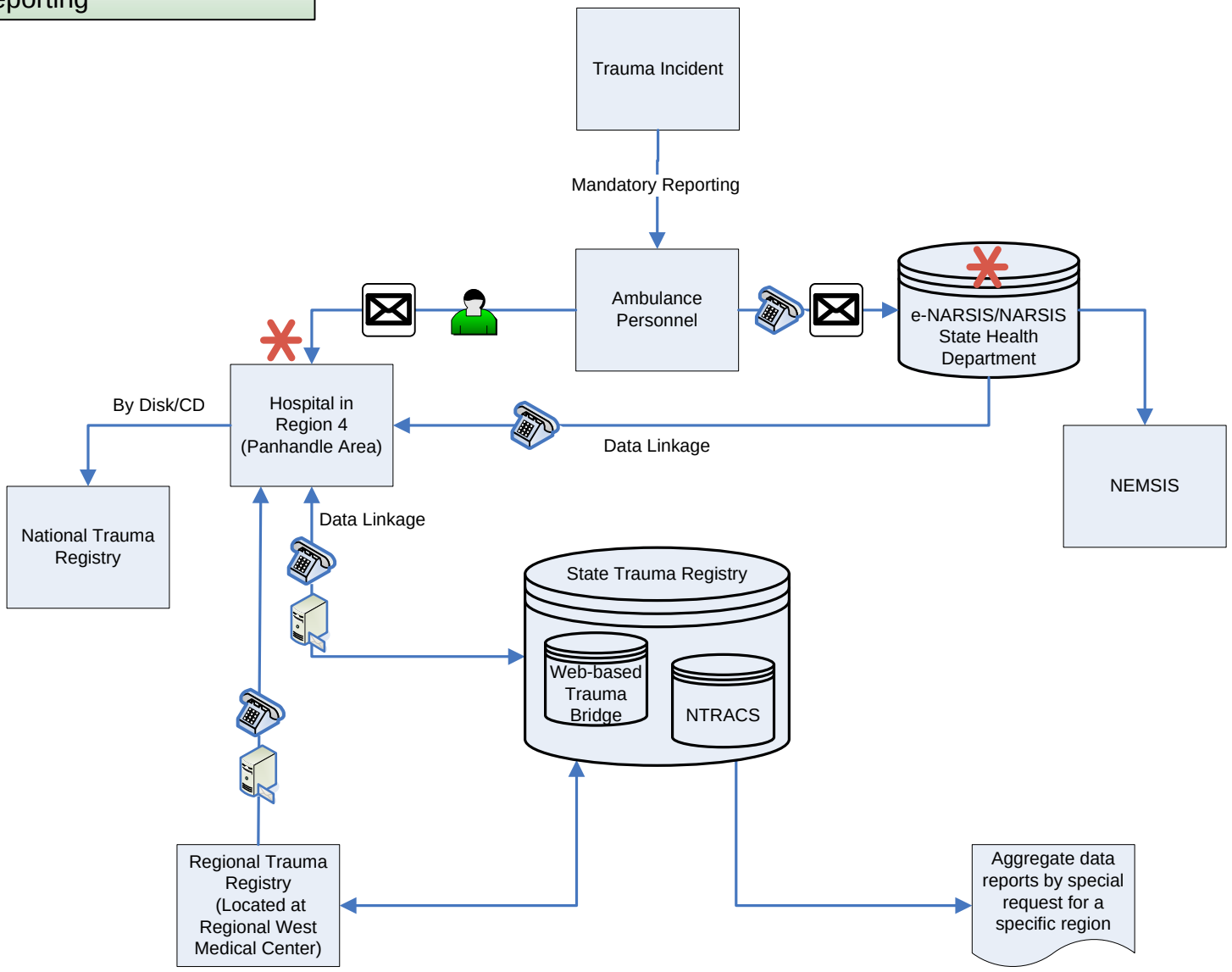
- Methods of Reporting:
  - Paper forms
  - Mail- disks or CDs with trauma patient data
  - Phone
  - E-mail
  - Data Linkage through web-based Trauma Bridge System

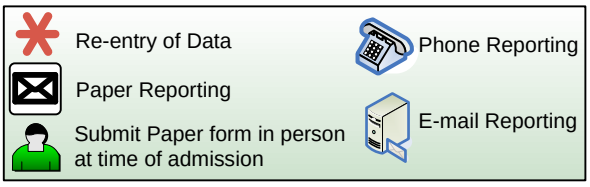
- Report To/Into:
  - e-NARSIS/NARSIS
  - Regional Trauma Registry (Regional West Medical Center)
  - NTRACS (State Trauma Registry)
  - National Trauma Registry
  - National Emergency Medical Services Information System

- Re-entry of Data:
  - Hospitals
  - e-NARSIS/NARSIS

- Reporting Back:
  - Aggregate reports are available by special request
  - Monthly Quality Assurance Reports for Hospitals and Regional Trauma Registries
  - Semi-annual Result Report from State Trauma Registry to State Trauma Board

Nebraska Trauma Registry Reporting





- Electronic Nebraska Ambulance and Rescue Service Information System (e-NARSIS) is a voluntary web-based registry of information collected by ambulance personnel. The data collected include date/time of run, interventions administered, the patient's age, sex, race, and injury/illness.
- NEMSIS- National Emergency Medical Service Information System
- NTRACS- National Trauma Registry of the American College of Surgeons
- Feedback loop occurs for two purposes: Data Quality Assessment or Revision for incorrect/missing patient information. Check points occur at regional and state level. Site hospital is contacted via phone or e-mail (with no patient identifiers included) to make the correction.
- Aggregate data is provided by special request only.
- Training began in March for the web-based Trauma Bridge System in which hospitals statewide will be connected by one system and each facility will be able to access their patients' trauma information . Currently, RWMC and 6 hospitals in Region 4 use this system. Also, e-NARSIS data will be able to be exported into the bridge system, so there will be less duplicate entry.

NARSIS Patient Care Report - Confidential Record - Keep Secure

B100813

Service	Unit #	EMS Run #	Patient Care #	Response #	Trauma Band #

First Name | M.I. | Last Name | Gender Male Female | SS #

Home Address | City | State/Country | Zip | DOB M____ D____ Y____ | Age ❑ Min. ❑ Months ❑ Hours ❑ Years

Incident Address or Location | City | County | Zip | BSI Devices ❑ Eye Protection ❑ Gloves ❑ Gown ❑ Mask

Dispatched As | Chief Complaint and/or Signs & Symptoms | Temperature | Weight

Date & Time of Symptom Onset ____/____/____ ____:____ am/pm	Position	Time	Pulse	B.P.	Respiration Own/Assist	O2 Sat.	L.O.C.
Date & Time Dispatch Notified ____/____/____ ____:____ am/pm	Stand Sit Recline Flat			/	/	%	A V P U
Date & Time of Call/Dispatch ____/____/____ ____:____ am/pm	Stand Sit Recline Flat			/	/	%	A V P U
Time Ambulance En Route ____:____ am/pm	Stand Sit Recline Flat			/	/	%	A V P U
Response Code to Scene 1 or 3	Stand Sit Recline Flat			/	/	%	A V P U
Time First Responder at Scene ____:____ am/pm	Stand Sit Recline Flat			/	/	%	A V P U

Time Arrived at Scene ____:____ am/pm

Time Arrived at Patient ____:____ am/pm

Time Unit Left Scene ____:____ am/pm

Transport Code to Destination 1 or 3

Time Unit at Destination/Facil. ____:____ am/pm

Time Unit Back in Service ____:____ am/pm

Time Unit Back at Station ____:____ am/pm

Time CPR Discontinued ____:____ am/pm

Respirations: ❑ Regular ❑ Shallow ❑ Labored

Skin: ❑ Normal ❑ Pale ❑ Cool ❑ Flushed ❑ Dry ❑ Warm ❑ Cyanotic ❑ Wet ❑ Hot ❑ Jaundiced

L Breath Sounds R		L Pupils R	
❑ Normal ❑		❑ Normal ❑	
❑ Abnormal ❑		❑ Dilated ❑	
❑ Decreased ❑		❑ Constricted ❑	
❑ Absent ❑		❑ Sluggish ❑	
❑ Rales ❑		❑ No Reaction ❑	
❑ Ronchi ❑		❑ N/A ❑	
❑ Stridor ❑			
❑ Wheezes ❑			
❑ N/A ❑			

Splints and Immobilization ❑ N/A
❑ Air ❑ Cardboard ❑ Rigid ❑ Vacuum ❑ SAM ❑ Wire Ladder ❑ Traction ❑ Sling/Swathe ❑ C Collar ❑ Blanket Roll ❑ Short Board ❑ Long Board ❑ KED ❑ Pillow ❑ Other

Airway Management ❑ N/A
❑ BVM ❑ Nasal Airway ❑ Combitube ❑ Nasal Cannula ❑ Cricothyrotomy ❑ Non Rebreather ❑ Endotracheal ❑ Oral Airway ❑ Heimlich Maneuver ❑ Suction ❑ Lighted Stylette ❑ None ❑ Mask ❑ Other, use narr. ❑ 0²@_____ LPM

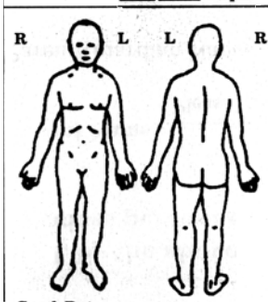
Abdomen	UL	LL	UR	LR
Normal	❑	❑	❑	❑
Tender	❑	❑	❑	❑
Rigid	❑	❑	❑	❑
Distended	❑	❑	❑	❑

Wound Care
❑ Direct Pressure ❑ Pressure Dressing ❑ Dry Sterile ❑ Pressure Point ❑ Elevation ❑ Tourniquet ____:____ ❑ Ice ❑ Wet Dressing ❑ Occlusive Dressing ❑ N/A

Patient History/Pre-existing Conditions
❑ Asthma ❑ CVA ❑ Hypotension ❑ Renal ❑ Skin ❑ Cancer ❑ Diabetes ❑ Musco./Skel. ❑ Respiratory ❑ None ❑ Cardiac ❑ Hypertension ❑ Psych./Behav. ❑ Seizures ❑ Other, use narr.

Signs and Symptoms and/or Chief Complaint

❑ Abdominal Pain	❑ Breathing Diff.	❑ Eye Pain	❑ Hyperthermia	❑ Paralysis	❑ Unconscious
❑ Abrasion/s	❑ Cardiac Arrest	❑ Fever	❑ Hypoglycemia	❑ Rectal Bleed	❑ Vomiting
❑ Airway Obstruction	❑ Chest Pain	❑ Fracture/s	❑ Hypotension	❑ Respiratory Arrest	❑ Weak/Malaise
❑ Allergic Reaction	❑ Confused	❑ Gynecologic	❑ Hypothermia	❑ Respiratory Distres.	❑ Wound/s
❑ Amputation/s	❑ Dehydration	❑ Headache	❑ Nausea	❑ Seizures/Convuls.	❑ None
❑ Avulsion/s	❑ Diarrhea	❑ Hematoma/s	❑ Obstetric	❑ Sprain/Strain	❑ Other, use narr.
❑ Behavioral	❑ Dizziness	❑ Hyperglycemia	❑ Pain, use narr.	❑ Syncope	
❑ Back Pain	❑ Ear Pain	❑ Hypertension	❑ Palpitations		



Crash Data
❑ Driver ❑ Passenger ❑ Pedestrian
❑ Restrained ❑ Unrestrained ❑ Airbag & Belt ❑ Airbag Only ❑ Airbag - Side ❑ Lap Belt Only ❑ Other, use narr. ❑ Lap & Shder. ❑ Ejected - Y / N ❑ Helmet - Y / N ❑ Inf./Child Seat ❑ Sleeper Net ❑ Unknown if safety devices used

❑ ATV ❑ Motorcycle ❑ Bi./Tricycle ❑ Truck ❑ Car ❑ Van ❑ Bus ❑ Other vehicle

7	4	1
8	5	2
9	6	3

Patient Medications ❑ None ❑ Unknown ❑ Transported with Patient

Allergies ❑ None ❑ Unknown

Glasgow Coma Score

Trauma Score

Medications and IV Therapy ❑ N/A

Number of IV Attempts Unsuccessful_____

Time	Type	Dosage	Route	Rate	Gauge	Location	Am't Infused	Medic

Pt. Care Provided Prior to EMS Arrival:

Time of each electrotherapy attempt and the results of each administered:

Narrative:

Insurance Information

Receiving Facility or Location

Name or Code # of EMS Primary Care Giver and Team Members

Received By

Ending Mileage

Attend ED MD

EMS Medical Control MD

Beginning Mileage

Family MD

Total Mileage

SERVICE COPY

Medical Release

Refusal of Evaluation, Treatment and / or Transportation

Emergency Medical Services Personnel Instructions

CRITERIA

1. Make sure the patient is a mentally competent adult (19 or older) and has the legal capability of refusing evaluation, treatment and transportation. The patient is mentally competent, if he/she is aware of his/her surroundings, oriented to time, place, person and events. The person cannot be significantly mentally impaired in any way, either congenitally, physiologically, (e.g. - head injury) or chemically (e.g. – alcohol or drug abuse)
2. If the patient is under the age of 19, only a legal guardian can refuse medical care on behalf of the patient. If a parent or legal guardian is not present, a police officer should make the evaluation, treatment and transportation decision.
3. The witness to the refusal should in most cases be law enforcement personnel. If law enforcement is not available, the family/responsible party, should be the witness. AS A LAST RESORT the EMS provider may sign as the witness if none of the above named persons are present.

PROCEDURE

1. Fill out the Refusal or Evaluation, Treatment and/or Transportation form in INK.
2. Ascertain the Patient Name, Age, Date of Birth, Home Address including City, State, Zip Code and Phone Number.
3. In the presence of the witness read the "Refusal of Evaluation, Treatment and/or Transportation" to the Patient or Legal Guardian.
4. Ask the Patient and/or the Legal Guardian if he/she understands what was read to them. If the Patient and/or the Legal Guardian does not understand what was read, read the "Refusal of Evaluation, Treatment and/or Transportation" to them again asking them periodically, if they understand what you are reading.
5. Have the Patient and/or the Legal Guardian sign the "Refusal of Evaluation, Treatment and/or Transportation" form.
6. If the Patient and/or the Legal Guardian refuses to sign the form have the law enforcement personnel sign the form for the Patient and/or the Legal Guardian in the Witness section.
7. After the Patient and/or the Legal Guardian or Law Enforcement person has signed the form, the out of hospital provider/s signs the form.

RELEASE OF LIABILITY

"I hereby acknowledge that I have been advised that evaluation, treatment and/or transportation is necessary for my condition.

I have also been informed of the potential risk involved if I do not comply with this advice.

I hereby state my refusal to follow the advice given me by emergency medical personnel and refuse further evaluation, treatment and/or transportation to a medical facility.

I, by the above statements, absolve and hold harmless of any responsibility all emergency services personnel, and their agents, from any ill effects which may result from my actions."

Patient Name_____Age_____Date of Birth_____
(Please Print)

Parent/Guardian Name_____ Date_____ Time_____

Patient Street Address, City, State, Zip Code and Phone Number_

_____

_____

Type of Incident_____

Patient Signature _____ Date_____ Time_____

WITNESS

The patient, and/or their guardian, named above has refused the medical services as indicated and refused to sign this form acknowledging his/her act. Signing this form I hereby attest to these facts and the accuracy of the information herein.

Witness Signature_____ Title_____

Date_____ Time_____

EMS Provider Signature_____ Date_____ Time_____

NARSIS Patient Care Report - Confidential Record - Keep Secure

B100813

1. Level of Licensure/Service
1 – BLS Transport
2 – BLS Nontransport
3 – ALS Transport
4 – ALS Nontransport
5 – Air

2. Street Type
1 – City Highway
2 – City Interstate
3 – City Street
4 – Rural Highway
5 – Rural Interstate
6 – Rural Road
7 – Other, use narrative

3. Response Area
1 – City/Town
2 – Rural/Country

4. Location of Call/Type
1 – Assisted Living
2 – Clinic/MD Office
3 – Correctional Facility
4 – Extended Care Facility
5 – Farm/Ranch
6 – Hospital
7 – Industrial Site
8 – Office/Business
9 – Public Area
10 – Public Building
11 – Rec/Sports Facility
12 – Residence
13 – Str/Rd/H.way/I.st
14 – Urgent Care Center
15 – Walk-ins
16 – Water
17 – Other, use narrative
18 – N/A

5. Mechanism of Injury or Illness - "The Cause"
1 – Adverse Drug Reaction
2 – Animal
3 – Blunt Object
4 – Burn/Chemical
5 – Burn/Thermal
6 – Child Abuse - Suspected
7 – Choking/Aspiration
8 – Domestic Violence
9 – Drowning
10 – Electric Shock
11 – Explosion
12 – Fall
13 – Gunshot - Acci.
14 – Gunshot - Intent.
15 – Inhalation
16 – Impaled Object
17 – Machine/Equipment
18 – Motor Vehicle Crash
19 – Overdose Accidental
20 – Overdose Intentional
21 – Penetrating Object
22 – Poisoning - Acci.
23 – Poisoning - Intent.
24 – Sexual Assault
25 – Sports/Play Injury
26 – Strangulation/Suff.
27 – Suicide
28 – Other, use narrative
29 – N/A

6. What is wrong with the Medical Patient or Trauma Patient?
(See page 8 for coding)

7. Severity of Medical or Trauma Codes
1 – Green/Non Urgent
2 – Yellow/Urgent
3 – Red/Life Threatening
4 – Black/DOA
5 – Code 99 CPR in Progress

8. Race
1 – Asian
2 – Black
3 – Hispanic
4 – Hispanic Non-white
5 – Native American
6 – White
7 – Other, use narrative
8 – Unknown

9. Care Refused
1 – DNR
2 – Guardian Signature
3 – Patient Signature
4 – Power of Attorney for Health Care
5 – Other
6 – N/A

10. Factors Affecting EMS Delivery
1 – Adverse Weather
2 – Combative Patient
3 – Crowd Control
4 – Delay in Access
5 – Delay in Detection
6 – Extrication >20 Min
7 – EMS Vehicle Problems
8 – Equipment
9 – HAZMAT
10 – Language Barrier
11 – Suspected Alcohol
12 – Suspected Drugs
13 – Terrain
14 – Traffic
15 – Weapon
16 – Other, use narrative
17 – N/A

11. Time for Extrication
1 – 0 to 5 Minutes
2 – 6 to 10 Minutes
3 – 11 to 15 Minutes
4 – 16 to 20 Minutes
5 – >20 Minutes
6 – N/A

12. Outcome of Call
1 – Cancelled
2 – Dead at Scene
3 – False Call
4 – Interfacility Transfer
5 – Refused Transport
6 – Refused Treatment
7 – Standby
8 – To Clinic
9 – To Hospital
10 – To Nursing Home
11 – To Personal Resid.
12 – Transferred to ALS
13 – Transferred to BLS
14 – Treat, No Transport
15 – Transport - other
16 – Other, Use Narrative
17 – Transport to Airport
18 – Transfer. to Air Rescue
19 – Unable to Locate Pt.
20 – Pt. Died Enroute

13. Type of Medical Control
1 – New Written Orders
2 – Verbal Orders
3 – Written/Standing Protocol

14. Receiving Hospital Contacted 1 – No 2 – Yes

16. Drug Therapies
1 – Acetaminophen
2 – Activated Charcoal
3 – Adenosine
4 – Albuterol
5 – Aminophylline
6 – Aspirin
7 – Atropine
8 – Bretylium Tosylate
9 – Bumetanide
10 – Calcium Chloride
11 – Calcium Gluconate
12 – Dexamethasone
13 – Dextrose (50%)
14 – Diazepam
15 – Diphenhydramine
16 – Dopamine
17 – Epinephrine
18 – Furosemide
19 – Glucagon
20 – Glucose
21 – Heparin
22 – Ibuprofen
23 – Ipecac
24 – Lidocaine
25 – Magnesium Sulfate
26 – Mannitol
27 – Meperidine
28 – Metaproterenol
29 – Methylprednisolone
30 – Mivacron
31 – Morphine
32 – Narcan
33 – Nitroglycerin
34 – Nitrous Oxide
35 – Oxygen
36 – Pitocin
37 – Procainamide
38 – Sodium Bicarbonate
39 – Succinylcholine
40 – Terbutaline
41 – Thiamine
42 – Toradol
43 – Verapamil
44 – Other - use narrative
45 – N/A
46 – Epinephrine, auto injector

17. IV Therapies/Fluids
1 – D5W
2 – Lactated Ringers
3 – Normal Saline
4 – Other - use narrative
5 – N/A

18. Field Interventions Performed
1 – Allergic Reaction Management
2 – Blood Draw/Successful
3 – Blood Draw/Unsuccessful
4 – Blood Glucose Check
5 – CPR
6 – Defibrillation - Automatic
7 – Defibrillation - Manual
8 – Defibrillation - Semiautomatic
9 – ECG Lead 2
10 – ECG 3 Lead
11 – ECG 12 Lead
12 – Extrication/Rescue
13 – IV, Intraosseous
14 – IV, Monitored
15 – IV, Peripheral
16 – Needle Decompression
17 – Pt. Assisted Medications
18 – Poison Management
19 – Shock Management
20 – Shock Trousers
21 – Other, use narrative
22 – N/A
23 – Cardiac Monitor
24 – IV Attempt Unsuccessful
25 – Mechanical Extrication

Cardiac Data

19. Symptoms prior to arrest? 1 – No 2 – Yes 3 – Unknown

20. Arrest witnessed? 1 – No 2 – Yes 3 – Unknown

21. Witness of Cardiac Arrest
1 – Bystander - use narrative to describe witness 2 – EMS Personnel

22. Arrest to Call
1. 0 – 1 Min. 2. 1 – 2 Min. 3. 2 – 3 Min. 4. 3 – 4 Min. 5. 4 – 5 Min. 6. >5 Min. 7. Unknown

23. Arrest to time of first CPR
1. 0 – 1 Min. 2. 1 – 2 Min. 3. 2 – 3 Min. 4. 3 – 4 Min. 5. 4 – 5 Min. 6. >5 Min. 7. Unknown

24. Pre-EMS Arrival CPR Data
1 – Citizen with dispatcher help
2 – Citizen without dispatcher help
3 – EMS/Fire/Law
4 – MD/DDS/RN/LPN
5 – No CPR initiated
6 – Other use narrative
7 – Defibrillation - NO
8 – Defibrillation - YES

25. Call to Responder CPR
1. <4 Min. 2. 4 – 6 Min. 3. 6 – 8 Min. 4. >8 Min. 5. Unknown

26. Arrest to Defibrillation
1. <4 Min. 2. 4 – 6 Min. 3. 6 – 8 Min. 4. >8 Min. 5. Unknown

27. Number of Pre-EMS Shocks Delivered? (Place # in box 27)

28. Pre-EMS Shocks Successful? 1 – No 2 – Yes (Place # in box 28)

29. Number of EMS Shocks Delivered? (Place # in box 29)

30. EMS Shocks Successful? 1 – No 2 – Yes (Place # in box 30)

31. Arrest to ALS/ACLS
1. <4 Min. 2. 4 – 6 Min. 3. 6 – 8 Min. 4. >8 Min. 5. Unknown

33. Pulse restored prior to hospital? 1 – No 2 – Yes

34. Pulse restored at hospital? 1 – No 2 – Yes 3 – Unknown

TRAUMA SYSTEM ACTIVATION - APPLY TRAUMA BAND

35. Step 1: Vital Signs & Levels of Consciousness
Activate Trauma Protocols and Contact Medical Control

	Adult	Peds
1 – Heart Rate	>130	<60 or >135
2 – Systolic BP	<85	<70 or capillary refill >2 sec
3 – Respiratory Rate	<10 or >29	<10 or >30
4 – Glasgow Coma Score	<13	<13

36. Step 2: Anatomy of Injury
Activate Trauma Protocols and Contact Medical Control
1 – Penetrating injury of head, neck, torso, groin, or
2 – Combination of burns >20%, or involving face or airway, or
3 – Amputation above wrist/ankle, or
4 – Spinal Cord Injury, or
5 – Flail Chest, or
6 – Two or more obvious proximal long bone fractures

37. Step 3: Assess Biomechanics of Injury
Consult Medical Control for System Activation
1 – Ejected from vehicle
2 – Auto-Pedestrian/auto-bicycle injury with significant (>5mph) impact
3 – Motorcycle, ATV, Bicycle Crash
4 – Pedestrian thrown or run over

38. Step 4: Other Risk Factors
Consult Medical Control for System Activation
1 – Provider Impression
2 – Co-morbid Factors
- Extreme of Age (<2 or >60)
- Hostile Environment (e.g. – extremes of heat or cold)
- Medical Illness (e.g. – COPD, CHF, renal failure, etc.)
- Presence of intoxicants/hazardous materials
- Pregnancy

3 – High energy transfer situation
- Rollover
- Falls >10 Feet
- Extrication Time >20 minutes

4 – Burn Injury
- 2nd and 3rd degree burns of face, hands, feet, and perineum.
- Significant Electrical Burns
- Closed space fire (inhalation)

39. Who Activated the Trauma System?
1 – Out-hosp-provider 2 – Receiving Emer. Dept. 3 – Trauma Comm Center

40. Destination Determination
1 – Closest Facility
2 – Diverted
3 – No Preference
4 – Patient/Family
5 – Physician
6 – Protocol
7 – Rotation
8 – Other, use narrative

Incident Info | Call Info | Demographics | History | Physical Assessment | Vital/Treatment | Narrative | Billing | Signatures

Ambulance Patient Care Report

Incident Date 01/18/200 Call # IT0701181001 Patient Care # 1 Trauma Registry ID

Call Level

Life Threat: Not Applicable

Response Times

	Time	Date		Time	Date		Time	D
PSAP Call		01/18/07	Arrive Scene		01/18/07	In Service		01/18
Dispatch Notified		01/18/07	Arrive Patient		01/18/07	Unit Cancelled		01/18
Unit Dispatched		01/18/07	Leave Scene		01/18/07	In Quarters		01/18
Enroute		01/18/07	Arrive Dest.		01/18/07			

First Responder Agencies

First Responder Agencies: Not Applicable, ImageTrend Fire, ImageTrend HAZMAT, ImageTrend Paramedic

Suspected Intentional, or Unintentional Disaster: Not Applicable, Biologic Agent, Building Failure, Chemical Agen

Other Services at Scene: Not Applicable, EMS Mutual Aid, Fire, Hazmat, Law, Other, Other Health Care Provider, Rescue, Utilities, Not Available, Not Known

Mass Casualty Incident: Not Applicable

Date Responder Arrived: 01/18/07 Time Responder Arrived:

Est Date/Time Responder Arrived: Not Applicable

Response Information

(odometer mileage: NI

Incident #: IT0701181001

Responding Unit: Not Applicable

Response Urgency: Not Applicable

EMD Card #:

EMD Performed: Not Applicable

Dispatch Reason: Not Applicable

Starting:

At Scene:

Destination:

Ending:

Personnel

	Crew Member	Level	Role
☒	Not Applicable	Not Applicable	Not Applicable
☒	Not Applicable	Not Applicable	Not Applicable
☒	Not Applicable	Not Applicable	Not Applicable

⊞Add Personnel

Incident Information

Facility Name: Not Applicable

Incident Address | Room/Apartment

Favorite Location

Postal Code 55044 ☐ Check to populate City, County, State from Postal Code. Update Now

City Lakeville County Dakota State MN Lookup

Scene Zone Number Not Applicable

GPS Lat Lon

Location Type

- ○ Not Applicable
- ○ Airport
- ◉ Home/Residence
- ○ Mine or Quarry
- ○ Public Building (schools, gov, offices)
- ○ Trade or Service (Business, bars, restaurants, etc.)
- ○ Not Available
- ○ Farm
- ○ Industrial Place and Premises
- ○ Other Location
- ○ Residential Institution (nursing home, jail/prison)
- ○ Unspecified place
- ○ Not Known
- ○ Health Care Facility (clinic home)
- ○ Lake, River, Ocean
- ○ Place of Recreation or Spc
- ○ Street or Highway

Barriers to Patient Care

- ☐ Not Applicable
- ☐ Combative patient
- ☐ Language
- ☐ Physically Restrained
- ☐ Unconscious
- ☐ Not Available
- ☐ Developmentally Impaired
- ☐ None
- ☐ Speech Impaired
- ☐ Weather
- ☐ Not Known
- ☐ Hearing Impaired
- ☐ Physically Impaired
- ☐ Unattended or Unsupervise Minors)

Save/Submit Form

ImageTrend State Bridge v3.6

TRACS **Example 1**

Injury

Date 5/21 Time 1230 City State Zip

GSW left and right chest Driver Passenger SB Airbag Helmet

ED Admission

Arrive: 1317 Arrive from LifeNet from Referring Hospital

Condition: Alert Verbal Respond to Pain Unresponsive

Discharge: 1355 To OR

TTA: Y or N

Who arrived: Trauma MD: PTA Chief: PTA Residents:
NS: Ortho:

ED Assess 1

P 112 RR 30 SBP 100 Temp 95.4

GCS Eye 4 Verbal 5 Motor 6

Airway

ETOH ND Hct 35 Drug Screen ND Base Def. ND Units of RBC 5

ED Assess 2

Head CT	NA	Neg	Pos	Date 5-21	Time 1345
ABD CT	NA	Neg	Pos		
Chest CT	NA	Neg	Pos		
ABD US	NA	Neg	Pos	Date	Time

Consults:

Neurosurgery 5-21

Hospital Diagnosis:

Bilateral hemothorax
Bilateral lung contusions
Bilateral diaphragm
Liver
Spleen
Stomach
Colon
Pancreas
L-1 fracture

ICU Days: 2 **Vent Days.** 1

Operations

- Splenectomy 5-21 1413 Trauma
- Bilateral Chest tubes
  Colon/Stomach Repair
  Liver – axiom drains
  Central Line Catheter

Comorbidity

Hospital Outcomes: Date 5-30 Home Rehab SNF Jail Died Autopsy

TF TPN Uncross Blood PRBCs FFP PLT Steroids NovoSeven Wound VAC

Complications:

Prehospital Walk In

EMS Co _____ Run # _____ Scene Report
Condition: Alert Verbal Stimuli Responds to Pain Unresponsive

Dispatch date_____Time_____Arrive_____Depart_____Arive at Hospital_____

P_____RR_____SBP_____

GCS Eye _____ Verbal _____ Motor_____
Airway Fluids Needle Thoracotomy
Drugs given_____

Referring Hospital Hospital A **Referring MD** Dr._____

Arrival D/T 1241 Discharge D/T 1301

P 112 RR 24 SBP 70 Temp NR

GCS Eye 4 Verbal 5 Motor 6

Head CT	NA	Neg	Pos	Airway_____
ABD CT	NA	Neg	Pos	CPR_____
ABD US	NA	Neg	Pos	ICU_____
Chest CT	NA	Neg	Pos	OR Uncrossmatched Blood

Drugs given_____

Labs: _____

IX. Immunization Reporting

A. Schematic

- Status:
  - Nonmandatory for Public Immunization Clinics & Regional West Medical Center & Affiliates
  - Mandatory for Schools & Early childhood programs

- Reporters:
  - Public Immunization Clinics
  - Regional West Medical Center & Affiliate Doctors' offices
  - Schools & Early childhood programs

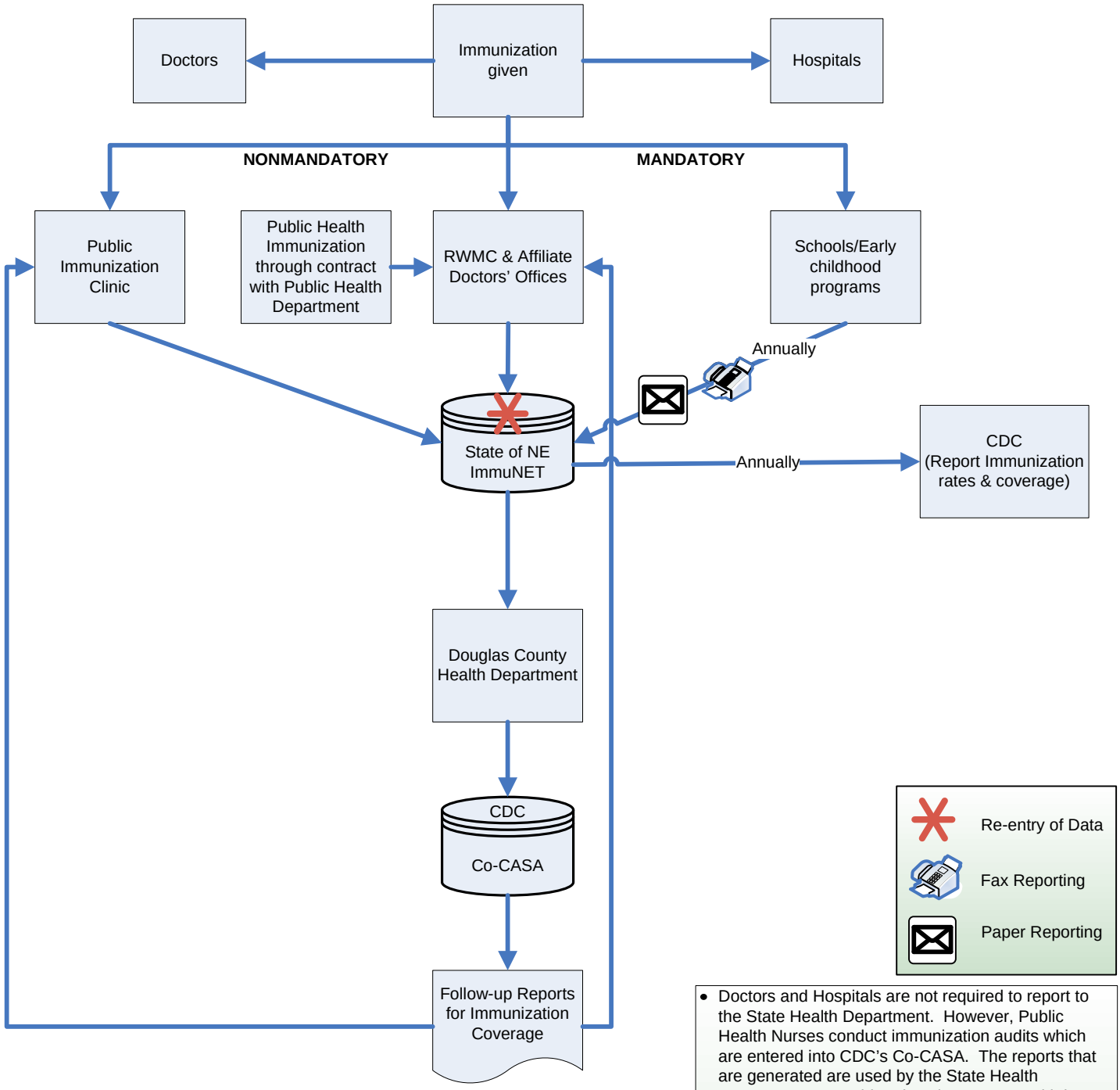
- Methods of Reporting:
  - Secure electronic connection for Public Immunization Clinics & Regional West Medical Center & Affiliates
  - Paper forms & Fax for Schools & Early childhood programs

- Report To/Into:
  - ImmuNET program followed by Douglas County Health Department, then CDC's Comprehensive Clinic Assessment Software Application (Co-CASA) database
  - Centers for Disease Control and Prevention

- Re-entry of Data:
  - ImmuNET program

- Reporting back:
  - Follow-up reports for immunization coverage generated by CDC's Co-CASA program
  - Annual Immunization rates and coverage reports from CDC

Immunization Reporting from the Panhandle



- Doctors and Hospitals are not required to report to the State Health Department. However, Public Health Nurses conduct immunization audits which are entered into CDC's Co-CASA. The reports that are generated are used by the State Health Department to provide education to areas with low immunization coverage.
- Schools are required to report immunizations for children who are in kindergarten and 7th grade and who are out-of-state transfers.
- Public Immunization Clinics include Alliance, Box Butte County, Bridgeport, Chadron, Chappell, Crawford, Gordon, Kimball, Panhandle Community Services, Oshkosh, Scottsbluff, and Sidney.
- Public Health Immunizations which are given under a contract with the Public Health Department are reported the same way as immunizations through RWMC.
- The State is developing a new immunization information system that will be web based, CDC compliant, centralized, and accessible to public and private provider offices and school nurses.

Public Health Reporting Matrix "Draft"

What is being reported?	Who is this being reported for?	Who is reporting?	Who is receiving the report?	How is info reported?	How often is report sent?	Who reports info to Partners?	How is that info reported back to the community?	What are the challenges?
Communicable Disease		Doctors	Local PH Dept if in Lancaster County or Douglas County & then State Health Dept & then CDC	Required: NEDSS, phone, fax, mail Actual: phone	Required to report depending on disease- immediately, within 7 days, or monthly Actual: Rarely do the reporting	PH Dept will call back to patient's doctor's office to get more info on child's medical history & contact information to follow up with patient condition PH Dept & appropriate jurisdiction can review & monitor patient status in NEDSS PH investigators at PH Dept can generate reports and provide info	De-identified Data in NEDSS is sent to CDC who then displays data in MMWR Data analysis summary on HHS website Statistical profiles for each county on HHS website (for HIV, STDs, Immunizations, maternal & child health) By special request- majority receive aggregate data reports (few reports have	Labs not quite integrated w/ disease reporting process- if they were- ↓ entry errors Data registries do not have data analysis or trends (just raw data) In NEDSS, the STD, Lead, HIV/AIDS, & TB lab reports are warehoused and not reviewed
		Labs	Local PH Dept if in Lancaster County or Douglas County & then State Health Dept & then CDC	Paper forms, NEDSS (on-line manual data entry & automated data feed), fax, & secure electronic connection through PHIN-MS	Weekly			
	School-age Children	School Nurses at public & private Schools	Local PH Dept if in Lancaster County or Douglas County &	By phone after irregularity found in monitoring school	Very few per requirements of HHS rules/regs Flu & rashes			

What is being reported?	Who is this being reported for?	Who is reporting?	Who is receiving the report?	How is info reported?	How often is report sent?	Who reports info to Partners?	How is that info reported back to the community?	What are the challenges?
			then State Health Dept & then CDC	absenteeism, Fax, Paper forms (have no access to NEDSS), & then PH Dept enters data into NEDSS, e-mail (with no identifiers)	are most commonly reported Diphtheria: report immediately but occurrence is very rare	within state law Notifications from state are sent to CDC - ~100 notifications per week	specific data)	
	Panhandle Public Health District	Hospitals, doctors, & labs	State Health Dept & then CDC	NEDSS, fax & paper form	Panhandle- ~1/wk	Local PH Dept will call back to patient's doctor's office to get more info on child's medical history, details of present condition & contact information to follow up with patient condition		
			Doctors report directly to Local PH Dept, & then State Health Dept	phone	Rarely			

What is being reported?	Who is this being reported for?	Who is reporting?	Who is receiving the report?	How is info reported?	How often is report sent?	Who reports info to Partners?	How is that info reported back to the community?	What are the challenges?
Lead poisoning and Lead Analysis		Labs, healthcare providers	Local PH Dept if in Lancaster County or Douglas County & then State Health Dept & then CDC	HHS paper forms & NEDSS	Required to be sent within seven days		HHS report for previous years	In NEDSS, the reports are warehoused & not reviewed
Immunization	Infants, Children in kindergarten, 7th grade, & all out-of-state transfers	Providers of the vaccines at the Public Immunization clinics, RWMC, & RWMC's affiliate doctors' offices	State Health Dept & then CDC	ImmuNET	The State has access to ImmuNET so they can view records at anytime. The report given to the CDC is sent annually.	State Health Dept then Douglas County Health Dept	Immunization coverage reports generated from the CDC's Co-CASA.	ImmuNET is not web based, nor centralized, nor HL7 compatible, nor PHIN standard compatible. No statewide centralized database yet.
		Schools & Early childhood programs		Mail or fax reports	Annually			

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Newborn Screening-Metabolic Report	Newborns	Hospital of birth	Pediatrix Database at Pennsylvania Lab then Julie Miller at the Nebraska Newborn Screening program (NNSP), hospital submitter, & then the baby's doctor	The results of the test are downloaded into the Pediatrix database. Then results can be seen by hospital of birth & NNSP. NNSP contacts baby's doctor with results & testing by phone, fax, & mail Pediatric metabolic specialist will also contact the doctor for testing	Daily & Quarterly In 2004-2005, 95% of Birth Parents consented for Newborn Screening (HHS Website)	NNSP & Pediatrix Database at Pennsylvania Lab	Daily Follow up Reports Quarterly Quality Assurance Reports (compare each hospital with state on different variables such as timeliness & accuracy)	

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Newborn Screening-Hearing Report	Newborns	Testing Hospitals	State Health Dept, then newborn's doctor	Vital Records-Birth Certificate Registry-Hearing Screening Module and then by mail or fax to the doctor For newborn's doctor-results reported by fax or mail	Every time a test is conducted on a newborn, a record is entered into the state's Vital Records registry Reports are sent to the newborn's doctor after test is completed and then every two weeks until contact is made Report to the state is required on an annual basis	Nebraska Newborn Hearing Screening Program	Quality Assurance Reports (compare each hospital with state regarding number of tests given, number of newborns who pass the tests, amount of patient education given, etc.	This new electronic system using the Vital Records-Birth Certificate Registry-Hearing Screening Module will not come to Western Nebraska until November or December.

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Lab results	Patients at Nebraska Medical Center (NMC) & Nebraska Public Health Lab (NPHL)	NMC & NPHL	Douglas County- some to the STD section to Liz Berthold & some to Epidemiology Division of Douglas County Health Dept	Paper, fax, secure electronic connection through PHIN-MS to NEDSS	varies from week to week	Public Health nurses have access to results through ELIRT (Electronic Lab Information Reporting Technology) so they can view results	NMC & NPHL do not receive follow up or provide follow up – Douglas County Health Dept or State Health Dept conducts follow up with patient & doctor	May have some technology issues with the connection for PH nurses to ELIRT
	Scottsbluff Public Health Dept	ARUP Laboratories in Salt Lake City for confirmatory tests for reportable diseases RWMC & Labs for other tests such as HVC, RPR, HbSAG, Chlamydia, and GC	Local PH Dept & then State Health Dept & then CDC	NEDSS for positive tests, Through ARUP Connect Internet Services				Using ARUP because more timely. NEDSS difficult to use per Marsha Meyer

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Certain Chronic Diseases & Injuries that are in Health Registries Example: Cancer, Birth Defects, & Spinal cord Injuries		Hospitals, Doctors, Labs	State Health Dept registries, and then the registries report de-identified info to the CDC, US Health Dept., or Federal Agencies such as the National Cancer Institute	Labs report on paper & the State enters the information in the appropriate database. Hospitals & Doctors use their own software system & export the data in a compatible format into the State databases. All reporters enter data directly into the 2 web based systems of the State.		By special request	By special request or through Statistical & aggregate published reports that have no patient identifiers	Statistical & aggregate reports are not always published in the current year because of quality assurance factors.
Mental Health Chronic Diseases	Behavioral Health Patients	Behavioral Health Providers						

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Cancer Diagnosis or Treatment		Hospitals	Nebraska Cancer Registry (NCR), then the State Health Dept., then National Program of Cancer Registries (NPCR) & North American Association of Central Cancer Registries (NAACCR)	Paper, on-site data collection if less than 50 cases to report, or direct reporting through a secure electronic connection	Monthly & within six months from the date of initial diagnosis	Nebraska Cancer Registry	By special request or through Statistical & aggregate published reports that have no patient identifiers	The data from the NCR is first mailed or delivered and then downloaded into the Network at the State Health Dept.
		Doctors		Paper, fax, or on-site data collection if more than 5 cases to report				
		Labs		Paper, fax				
Trauma Incident		Ambulance Personnel, Registrars at hospital, Registrars at regional trauma registry	Regional trauma registry, State trauma registry, National Emergency Medical Service Information System, National	Paper, NTRACS (National Trauma Registry of the American College of Surgeons, e-NARSIS (electronic-Nebraska Ambulance	State trauma registry sends Data Quality Assessment Reports monthly & Assessments to the State trauma board twice a year	State Trauma Registry	By special request through aggregate reports that have no patient identifiers	Each hospital's NTRACS system does not interface with any other hospital's system.

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			Trauma Registry	and Rescue Service Information System)				
HIV/AIDS		Hospitals, Doctors, & Labs	Local PH Dept if in Lancaster County or Douglas County & then State Health Dept & then CDC Counties outside of Lancaster or Douglas counties will report directly to the State H Dept & then CDC	2 Paper forms for diagnosis age: Age <13 Age ≥13 Phone From the State to the CDC- electronically via a very secure connection		No reports back to districts or regions because of confidentiality reasons	HHS reports for previous years State contacts Disease Investigator Specialists who follow up with patient & notifies any identified partners of that patient (Service Partner Notification)	The CDC case report form requires more information than the lab forms that come to the state, so the state must follow up with the doctor or nurse to get the additional data. No centralized database- duplicate reporting from Douglas & Lancaster counties