NEW YORK STATE DEPARTMENT OF HEALTH

Communicable Disease Reporting Requirements

Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10,2.14). The primary responsibility for reporting rests with the physician; moreover, laboratories (PHL 2102), school nurses (10NYCRR 2.12), day care center directors, nursing homes/hospitals (10NYCRR 405.3d) and state institutions (10NYCRR 2.10a) or other locations providing health services (10NYCRR 2.12) are also required to report the diseases listed below.

Anaplasmosis
Amebiasis
Animal bites for which rabies prophylaxis is given[1]
Anthrax[2]
Arboviral infection[3]
Babesiosis
Botulism[2]
Brucellosis[2]
Campylobacteriosis
Chancroid
Chlamydia trachomatis infection
Cholera
Coronavirus
- COVID-19 (SARS CoV-2)
- **Severe Acute Respiratory Syndrome (SARS)**
- **Middle East Respiratory Syndrome (MERS)**

Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli 0157:H7 infection[4]
Ehrlichiosis
Encephalitis
Foodborne Illness
Giardiasis
Glanders[2]
Gonococcal infection
Haemophilus influenzae[5] (invasive disease)
Hantavirus disease
Hemolytic uremic syndrome
Hepatitis A
Hepatitis A in a food handler
Hepatitis B (specify acute or chronic)
Hepatitis C (specify acute or chronic)
Pregnant hepatitis B carrier
Herpes infection, infants aged 60 days or younger
Hospital associated infections (as defined in section 2.2 10NYCRR)
Influenza, laboratory-confirmed
Legionellosis
Listeriosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Melioidosis[2]
Meningitis
- Aseptic or viral
- **Haemophilus**
- **Meningococcal**
- Other (specify type)

Meningococcemia
Monkeypox
Mumps
Pertussis
Plague[2]
Poliomyelitis
Psittacosis
Q Fever[2]
Rabies[1]
Respiratory syncytial virus (RSV) laboratory-confirmed
Respiratory syncytial virus (RSV) pediatric fatalities
Rocky Mountain spotted fever
Rubella (including congenital rubella syndrome)
Salmonellosis
Shigatoxin-producing E.coli[4] (STEC)
Shigellosis[4]
Smallpox[2]
Staphylococcus aureus[6] (due to strains showing reduced susceptibility or resistance to vancomycin)
Staphylococcal enterotoxin B poisoning[2]
Streptococcal infection (invasive disease)[5]
- Group A beta-hemolytic strep
- Group B strep
- Streptococcus pneumoniae

Syphilis, specify stage[7]
Tetanus
Toxic shock syndrome
Transmissable spongiform encephalopathies[8] (TSE)
Trichinosis
Tuberculosis current disease (specify site)
Tularemia[2]
Typhoid
Vaccinia disease[9]
Varicella (not shingles)
Vibriosis[6]
Viral hemorrhagic fever[2]
Yersiniosis

WHO SHOULD REPORT?

Physicians, nurses, laboratory directors, infection control practitioners, health care facilities, state institutions, schools.

WHERE SHOULD REPORT BE MADE?

Report to local health department where patient resides. Contact Person

Name Ulster County Department of Health Communicable Disease

Address 239 Golden Hill Lane
Kingston, NY 12401

Phone 845-340-3090 Fax 845-340-3162

WHEN SHOULD REPORT BE MADE?

Within 24 hours of diagnosis:

- Phone diseases in bold type,
- Report all other diseases promptly to county health department where individual resides.
- In New York City use form PD-16.

SPECIAL NOTES

- Diseases listed in **bold type** warrant prompt action and should be reported **immediately** to local health departments by phone followed by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16.
- In addition to the diseases listed above, any unusual disease (defined as a newly apparent or emerging disease or syndrome that could possibly be caused by a transmissible infectious agent or microbial toxin) is reportable.
- Outbreaks: while individual cases of some diseases (e.g., streptococcal sore throat, head lice, impetigo, scabies and pneumonia) are not reportable, a cluster or outbreak of cases of any communicable disease is a reportable event.
- **Cases of HIV infection, HIV-related illness and AIDS (Stage 3) are reportable on the Medical Provider HIV/AIDS and Partner/Contact Report Form DOH-4189. The form may be obtained by contacting:**

  Division of Epidemiology, Evaluation and Partner Services
  P.O. Box 2073, ESP Station
  Albany, NY 12220-2073
  (518) 474-4284

  In NYC: New York City Department of Health and Mental Hygiene
  For HIV/AIDS reporting, call: (212) 442-3388

1. Local health department must be notified prior to initiating rabies prophylaxis.
2. Diseases that are possible indicators of bioterrorism.
3. Including, but not limited to, infections caused by eastern equine encephalitis virus, western equine encephalitis virus, West Nile virus, St. Louis encephalitis virus, La Crosse virus, Powassan virus, Jamestown Canyon virus, dengue and yellow fever.
4. Positive shigatoxin test results should be reported as presumptive evidence of disease.
5. Only report cases with positive cultures from blood, CSF, joint, peritoneal or pleural fluid. Do not report cases with positive cultures from skin, saliva, sputum or throat.
6. Proposed addition to list.
7. Any non-treponemal test ≥1:16 or any positive prenatal or delivery test regardless of titer or any primary or secondary stage disease, should be reported by phone; all others may be reported by mail.
8. Including Creutzfeldt-Jakob disease. Cases should be reported directly to the New York State Department of Health Alzheimer's Disease and Other Dementias Registry at (518) 473-7817 upon suspicion of disease. In NYC, cases should also be reported to the NYCDOHMH.
9. Persons with vaccinia infection due to contact transmission and persons with the following complications from vaccination; eczema vaccinatum, erythema multiforme major or Stevens-Johnson syndrome, fetal vaccinia, generalized vaccinia, inadvertent inoculation, ocular vaccinia, post-vaccinial encephalitis or encephalomyelitis, progressive vaccinia, pyogenic infection of the infection site, and any other serious adverse events.

ADDITIONAL INFORMATION

For more information on disease reporting, call your local health department or the
New York State Department of Health
Bureau of Communicable Disease Control at
(518) 473-4439
or (866) 881-2809 after hours.
In New York City, 1 (866) NYC-DOH1.

PLEASE POST THIS CONSPICUOUSLY

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Epidemiology

Confidential Case Report

County of Residence ____________ Serial # ____________ Date of Report ___/___/___

Patient Information

Patient's Name ____________________
Last First MI Maiden

Patient's Alias ____________________
Last First MI

Guardian's Name ____________________
Last First MI

Patient's Date of Birth ___/___/___ Patient's Age ______ Patient's Country of Birth ____________

Patient's Primary Phone No. (____) ______ - ______ Patient's Secondary Phone No. (____) ______ - ______

Patient's Physical Address ____________________
Number & Street City Zip Code

Patient's Mailing Address (if different) ____________________
City Zip Code

Occupation (works at)	Setting (resides/attends)	Sex	Race (Check all that apply)	Ethnicity
☐ Food Service	☐ Day Care Facility	☐ Male	☐ White	☐ Hispanic
☐ Day Care	☐ Health Care Facility	☐ Female	☐ Black	☐ Non-Hispanic
☐ Health Care	☐ School	☐ Unknown	☐ Amer. Indian /Alaskan	☐ Unknown
☐ Student/School	☐ Jail/Prison		☐ Asian ______	
☐ Inmate	☐ Camp	**Pregnant**	☐ Native Hawaiian/ Pacific Islander ______	
☐ Correction Worker	☐ Homeless	☐ Yes	☐ Other	
☐ Unemployed	☐ Other ______	☐ No	☐ Unknown	
☐ Retired	☐ Unknown	☐ Unknown		
☐ Other ______		If Pregnant Due Date: ___/___/___		
☐ Unknown				

Is Patient Alive? ☐ Yes ☐ No ☐ Unknown If No, Date of Death ___/___/___

Disease ____________________ Site of Infection ____________

Date of First Symptom: ___/___/___ Date of Diagnosis ___/___/___

Hospitalized? ☐ Yes ☐ No ☐ Unknown

Name of Hospital ____________________ Medical Record No. ____________

Admission Date ___/___/___ Discharge Date ___/___/___

Reporter Information

Reporting Individual ____________________ Telephone (____) ______ - ______

Address ____________________

Reporting Source ☐ MD ☐ Lab ☐ Hospital ICN ☐ School Nurse ☐ Public Health Nurse ☐ Other Local Health Department ☐ Other State Health Dept ☐ Other ____________ ☐ Unknown

Provider Name ____________________ Provider Telephone (____) ______ - ______

Testing Laboratory ____________________ Laboratory Telephone (____) ______ - ______

Comments

Include applicable laboratory data, treatment, recent travel, etc. ____________________

For Local Health Department Use

Outbreak Related	Case Status	Local Health Department Signature	Was Patient Notified?
☐ Sporadic	☐ Confirmed	____________________	☐ Yes
☐ Cluster	☐ Probable	Date Form Received ___/___/___	☐ No
☐ Outbreak	☐ Suspect	Investigation Start Date ___/___/___	☐ Unknown
☐ Unknown	☐ Unknown		