State Laboratory of Public Health

Epidemiology

Enterics: Essential Info for the Summer

CD Webinar: July 18, 2019

We will cover the essentials

NCEDSS Management (Tammra Morrison)

- Acknowledge labs
- Interview case & document completely
- What warrants an investigation?

Norovirus Outbreaks in Summer Camps (Nicole Lee)

NHGQs / Supplemental Questionnaires (David Senesi)

Laboratory Essentials for Enterics (Shadia Rath - SLPH)

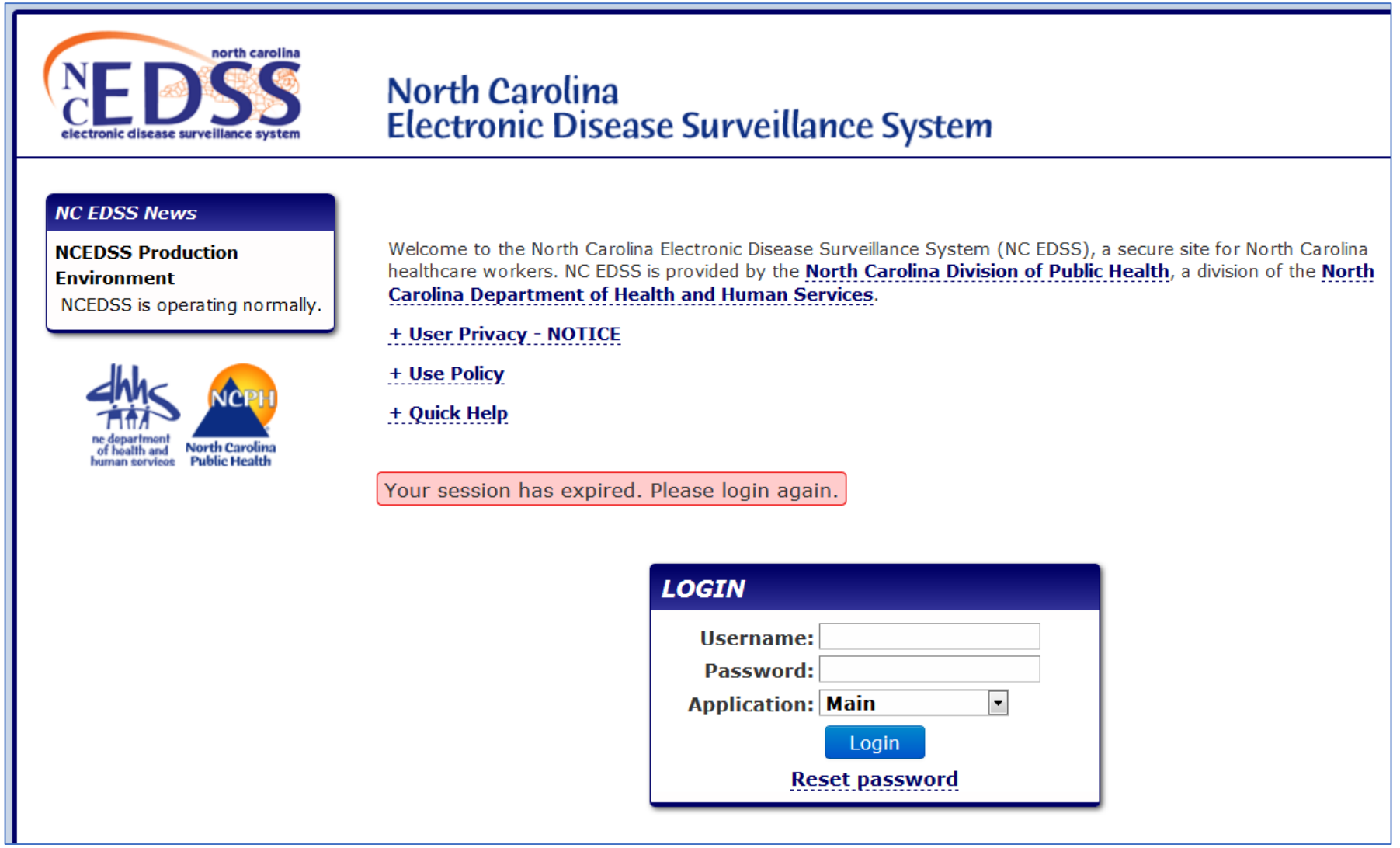
- Approval from state
- Requisitions & Specimen Submissions

Q & A

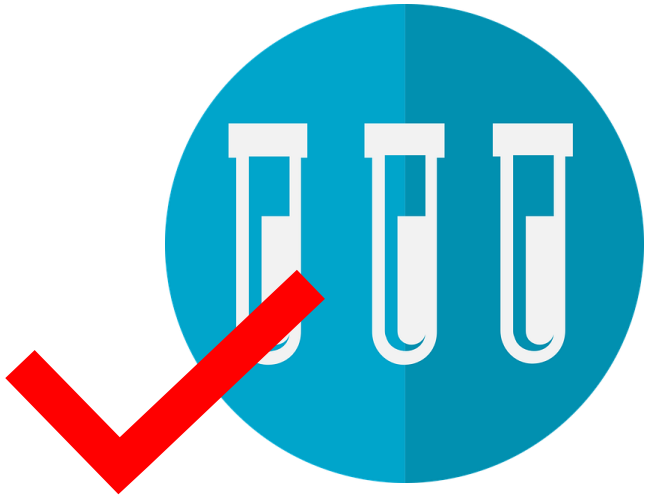
NCEDSS Management

Tammra Morrison

NCEDSS Management



Acknowledge Your Labs



C.1 CD Lab Review Workflows

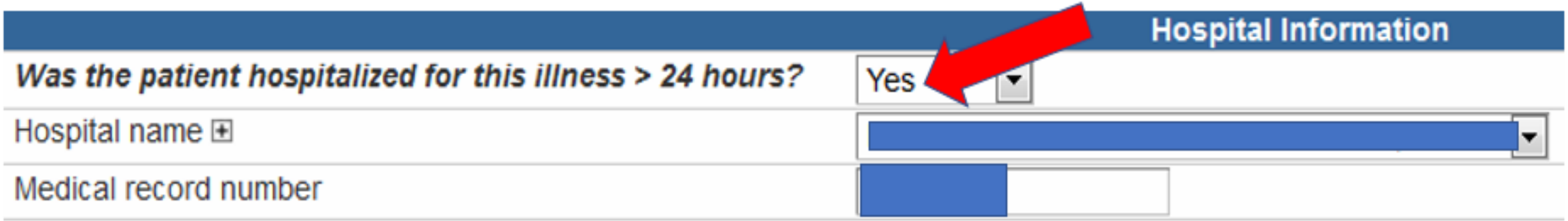
Lab Results - Foodborne and Diarrheal Diseases - Lab result review required

NCEDSS Event Completeness

Clinical Package

Period of Interest Timeframe		
FROM (7 DAYS PRIOR TO SYMPTOM ONSET):	05/09/2019	UNTIL (2 DAYS AFTER START OF ANTIBIOTICS):
General Diagnosti[illegible]formation		
Is / was patient symptomatic for this disease?	Yes	
Date that best reflects the earliest date of illness identification	05/16/2019	
Illness identification date represents:	Date of laboratory testing	

Clinical Package



Risk Package

Child Care / School / College

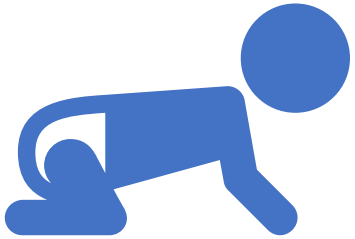
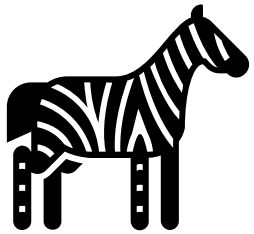
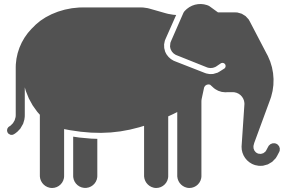
For a brief description of types of child care arrangements, see Summary of NC Child Care Law and Rules at http://ncchildcare.dhhs.state.nc.us/pdf_Forms/Law_Summary_05_05.pdf or call 1-800-859-0829 and speak with regulatory staff at the NC Division of Child Development.

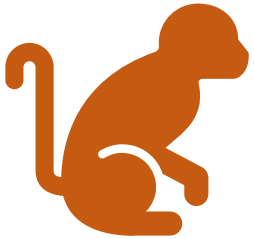
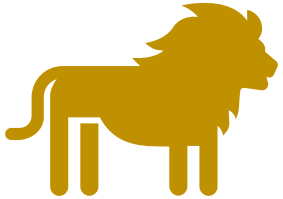
Is the patient involved in child care or the parent/primary caregiver of a child in child care?	No	
Is patient a student? (Use Add New for each school) ⊞	No	Add New
Is patient a school WORKER / VOLUNTEER in NC school setting? (Use Add New for each school) ⊞	No	Add New

Behavioral Risk and Congregate Living

During the period of interest did the patient stay in any congregate living facilities or other locations that were not their primary residence? ⊞ ℹ	zz_No	Add New
In what setting was the patient most likely exposed?	27. Unknown	

When to Investigate

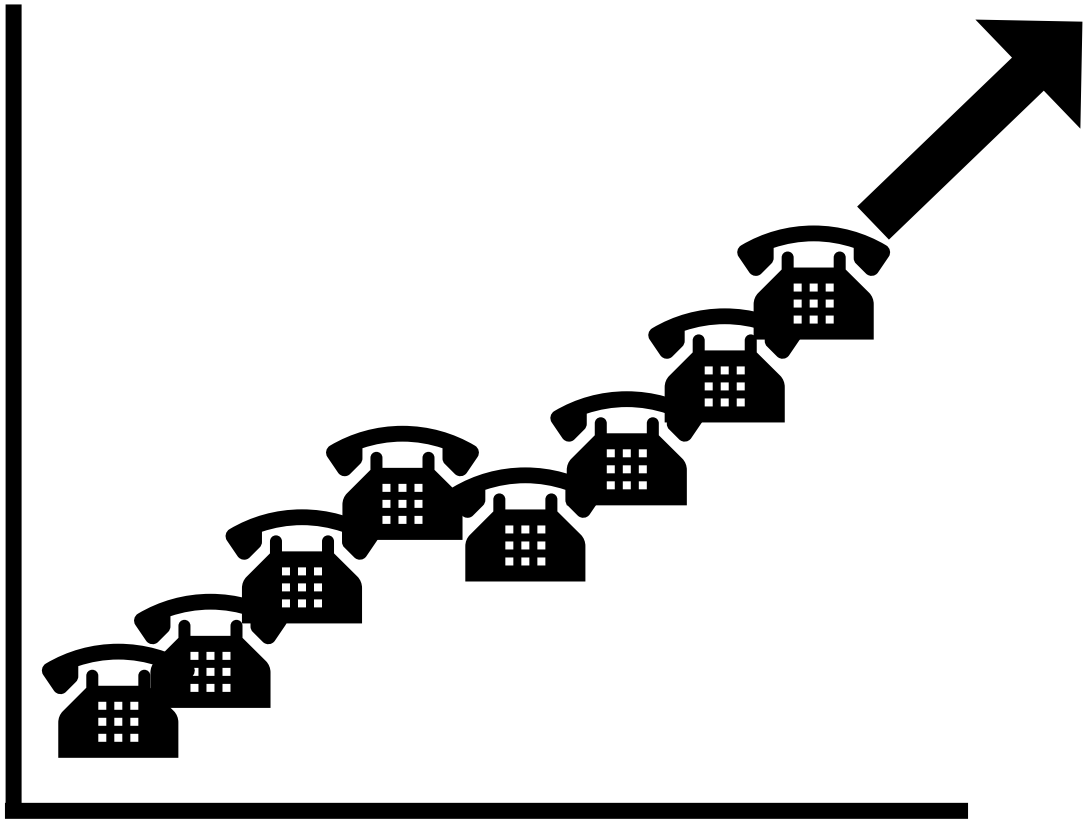

Any questions?

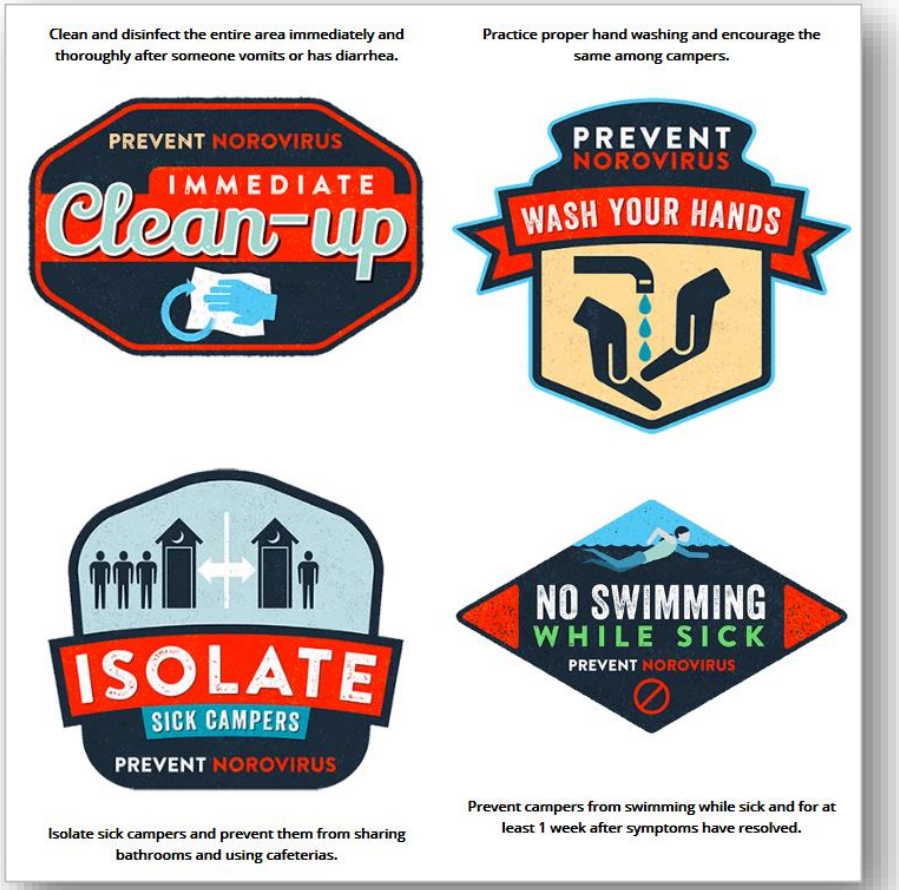
NCEDSS Management

Norovirus Outbreaks in Summer Camps

Nicole Lee

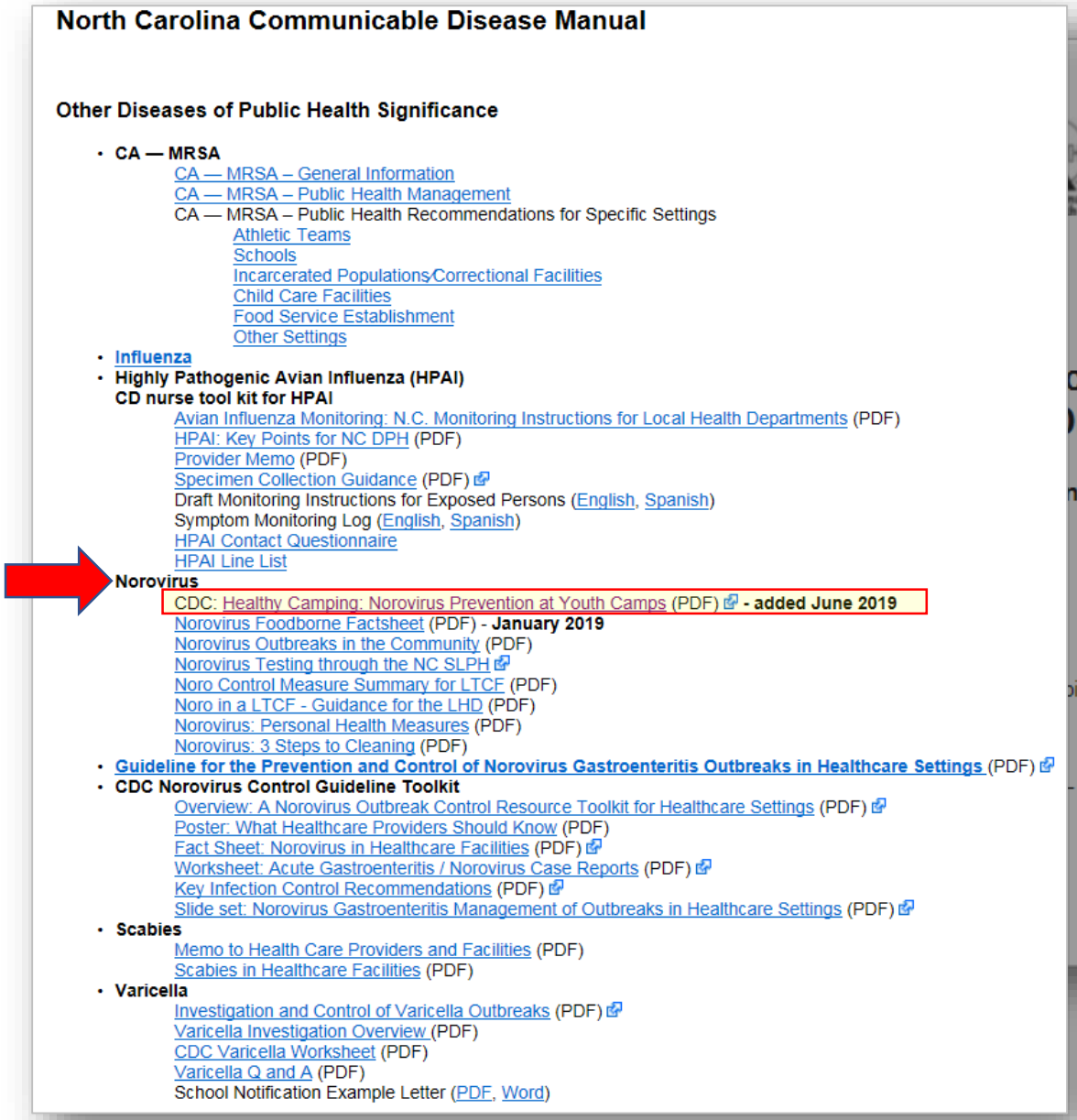
Norovirus in Summer Camps – increasingly common





www.cdc.gov/norovirus

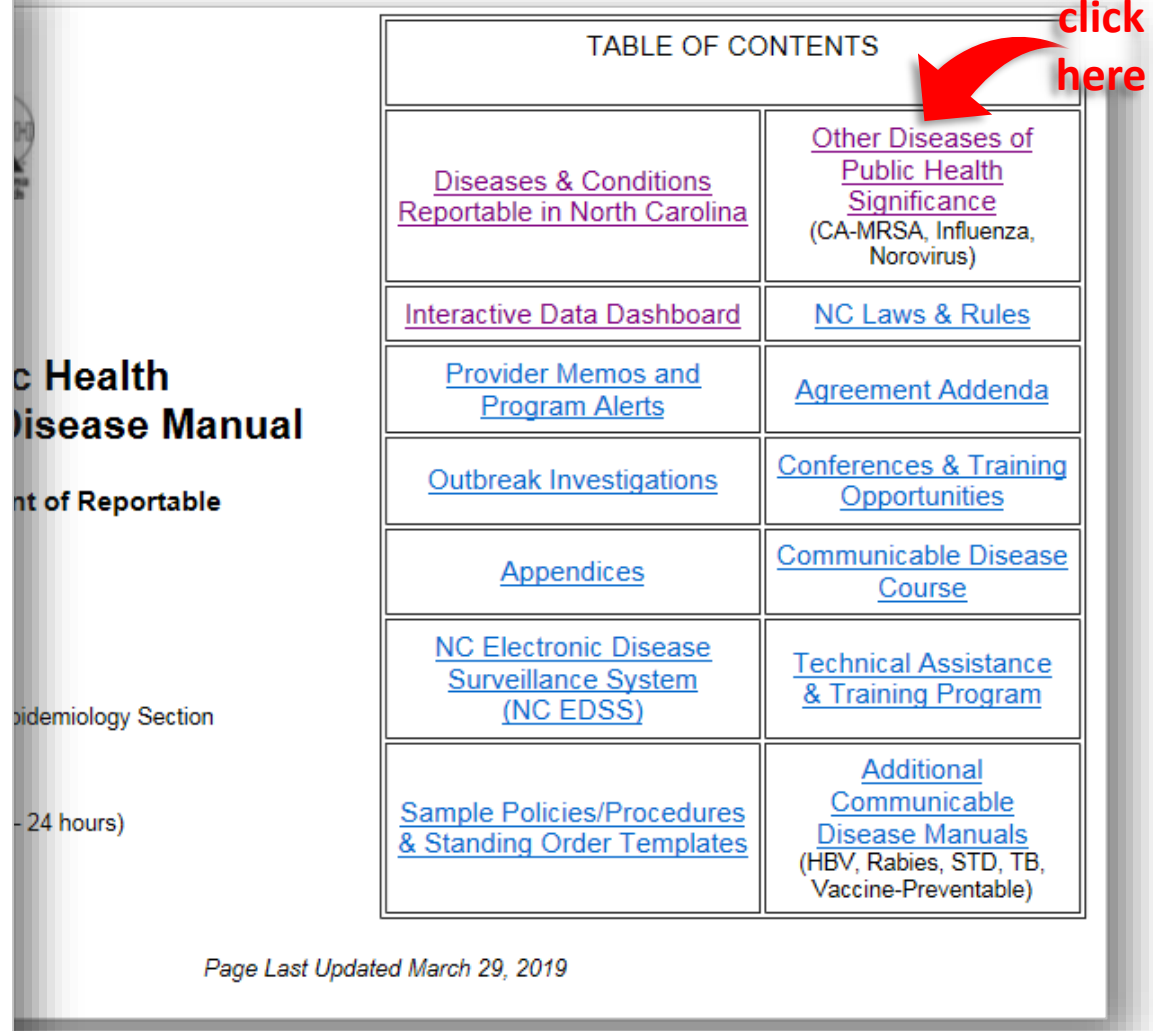
Camp resources are on CD Manual



North Carolina Communicable Disease Manual

Other Diseases of Public Health Significance

- **CA — MRSA**
  - CA — MRSA – General Information
  - CA — MRSA – Public Health Management
  - CA — MRSA – Public Health Recommendations for Specific Settings
    - Athletic Teams
    - Schools
    - Incarcerated Populations/Correctional Facilities
    - Child Care Facilities
    - Food Service Establishment
    - Other Settings
- **Influenza**
- **Highly Pathogenic Avian Influenza (HPAI)**
  CD nurse tool kit for HPAI
  - Avian Influenza Monitoring: N.C. Monitoring Instructions for Local Health Departments (PDF)
  - HPAI: Key Points for NC DPH (PDF)
  - Provider Memo (PDF)
  - Specimen Collection Guidance (PDF)
  - Draft Monitoring Instructions for Exposed Persons (English, Spanish)
  - Symptom Monitoring Log (English, Spanish)
  - HPAI Contact Questionnaire
  - HPAI Line List
- **Norovirus**
  - CDC: Healthy Camping: Norovirus Prevention at Youth Camps (PDF) **- added June 2019**
  - Norovirus Foodborne Factsheet (PDF) - **January 2019**
  - Norovirus Outbreaks in the Community (PDF)
  - Norovirus Testing through the NC SLPH
  - Noro Control Measure Summary for LTCF (PDF)
  - Noro in a LTCF - Guidance for the LHD (PDF)
  - Norovirus: Personal Health Measures (PDF)
  - Norovirus: 3 Steps to Cleaning (PDF)
- **Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings** (PDF)
- **CDC Norovirus Control Guideline Toolkit**
  - Overview: A Norovirus Outbreak Control Resource Toolkit for Healthcare Settings (PDF)
  - Poster: What Healthcare Providers Should Know (PDF)
  - Fact Sheet: Norovirus in Healthcare Facilities (PDF)
  - Worksheet: Acute Gastroenteritis / Norovirus Case Reports (PDF)
  - Key Infection Control Recommendations (PDF)
  - Slide set: Norovirus Gastroenteritis Management of Outbreaks in Healthcare Settings (PDF)
- **Scabies**
  - Memo to Health Care Providers and Facilities (PDF)
  - Scabies in Healthcare Facilities (PDF)
- **Varicella**
  - Investigation and Control of Varicella Outbreaks (PDF)
  - Varicella Investigation Overview (PDF)
  - CDC Varicella Worksheet (PDF)
  - Varicella Q and A (PDF)
  - School Notification Example Letter (PDF, Word)



c Health
Disease Manual
nt of Reportable
idemiology Section
- 24 hours)

TABLE OF CONTENTS

click here

Diseases & Conditions Reportable in North Carolina	Other Diseases of Public Health Significance (CA-MRSA, Influenza, Norovirus)
Interactive Data Dashboard	NC Laws & Rules
Provider Memos and Program Alerts	Agreement Addenda
Outbreak Investigations	Conferences & Training Opportunities
Appendices	Communicable Disease Course
NC Electronic Disease Surveillance System (NC EDSS)	Technical Assistance & Training Program
Sample Policies/Procedures & Standing Order Templates	Additional Communicable Disease Manuals (HBV, Rabies, STD, TB, Vaccine-Preventable)

Page Last Updated March 29, 2019

HEALTHY CAMPING: NOROVIRUS PREVENTION AT YOUTH CAMPS

BASICS ABOUT NOROVIRUS

Norovirus is very contagious and causes vomiting and diarrhea. People of all ages can get infected and sick with norovirus. You can get norovirus from:

- Having direct contact with an infected person, such as shaking hands
- Sharing food or eating utensils with an infected person
- Consuming contaminated food or water
- Touching contaminated surfaces then putting your unwashed hands in your mouth

GUIDANCE FOR PREVENTING NOROVIRUS AT YOUTH CAMPS

- Establish a pre-camp arrival agreement requiring campers to be free of norovirus symptoms upon arrival; let parents know that they may need to pick up ill campers
- Instruct campers and staff on how to properly wash their hands; make sure that handwashing facilities have soap, running water, and disposable towels

Practice Food Safety

- Make sure that campers, staff, and food workers are trained in food safety practices, such as using gloves and utensils when handling or preparing ready-to-eat foods, beverages, or ice
- Do not allow ill campers, staff, or food workers in food service areas until at least 48 hours after their symptoms have resolved
- Campers, staff, and food workers should not cook with or consume untreated water

Clean Up Vomit and Diarrhea Immediately

- After someone vomits or has diarrhea, always thoroughly clean then disinfect the entire area immediately
- Put on rubber or disposable gloves, and wipe the entire area with paper towels, soap, and hot water
- Then disinfect the area using a bleach-based household cleaner as directed on the product label
  - If no such disinfectant is available, you can use a solution made with 5 tablespoons to 1.5 cups of household bleach per 1 gallon of water
- Leave the bleach disinfectant on the affected area for at least 5 minutes
- Then clean the entire area again with soap and hot water

Isolate ill campers and staff

- Isolate ill campers and staff from healthy campers and staff
- Provide separate restrooms and eating areas until at least 48 hours after ill campers and staff symptoms have resolved
- Campers and staff who are vomiting or have diarrhea should not swim or participate in recreational water activities until at least 1 week after these symptoms have resolved

WHAT TO TELL STAFF, INCLUDING FOOD WORKERS, ABOUT NOROVIRUS PREVENTION

- Practice food safety
- Practice and instruct campers on proper handwashing
- Make sure ill campers and staff are appropriately isolated, and ensure they use separate restrooms and eating areas until 48 hours after their symptoms resolve
- Immediately clean then disinfect the entire area after someone vomits or has diarrhea

WHAT TO TELL PARENTS AND KIDS ABOUT NOROVIRUS PREVENTION

- Ill campers may need to be picked up
- Do not drop off ill campers or campers who have been ill in the last 48 hours
- Make sure campers
  - wash their hands often with soap and water
  - do not share food and drinks with others
  - practice healthy hygiene
  - report any illness to camp staff

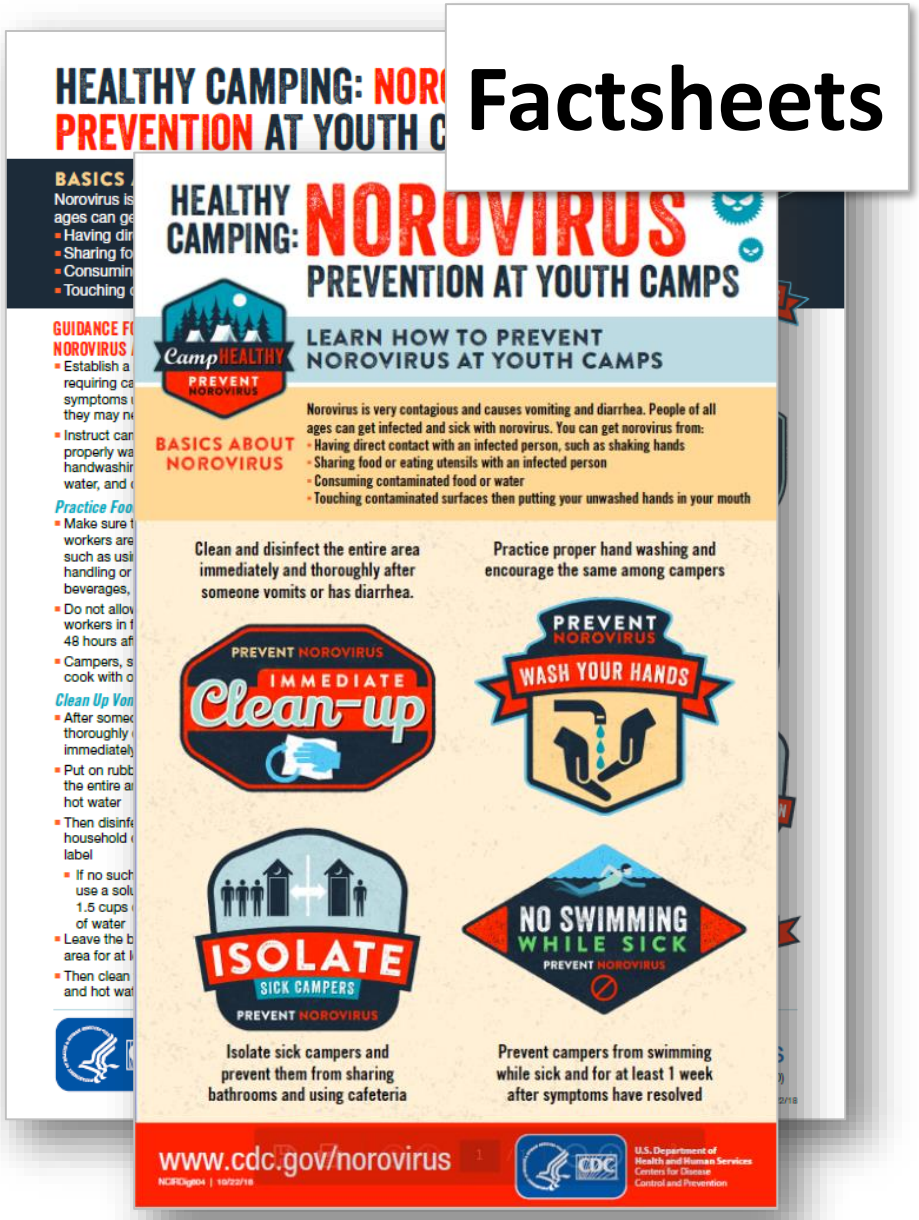
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

For more information, visit:
www.cdc.gov/norovirus

National Center for Immunization and Respiratory Diseases (NCIRD)

10/22/18

Here are more camp resources…



Factsheets

YouTube

https://www.youtube.com/watch?v=TAkH4jakLYA (2 min)

https://www.youtube.com/watch?v=LJ6B0IT-vsc (12 sec)

https://www.youtube.com/watch?v=AOxZuV5gin0 (15 sec)

Be proactive about norovirus outbreak control in camps

1. Share resources early

2. Communicate control measures clearly

1. Handwashing
2. Environmental cleaning
3. Keep ill away from well

3. Maintain line list of ill

Any questions?

Norovirus in Summer Camps

NHGQs & Supplemental Questionnaires

David J Senesi

What Are NHGQ and Supplemental Questionnaires

- **These are the "Not Again" forms**
- Supplemental forms are annoying
- The forms always come after the case has been investigated
- In some cases the forms are "sweet and short"
- Some are exceptionally long
- Some are confusing
- The forms are used for national cluster (outbreak) investigations
- CDC requests them

Why Are NHGQ and Supplemental Questionnaires Required

- They help probe more into the investigation
- The forms help to clarify details
- Most importantly, these questionnaires are developed to probe specific entities or things
- The forms are used for uniformity in national cluster (outbreak) investigations
- The forms help focus on a specific hypothesis/theory that CDC may want to prove so as to make scientific conclusion.

Currently 6 Pathogens Require Supplemental or NHGQ Forms

- Vibrio (COVIS)
- Listeria (Listeria Initiative)
- Typhoid/paratyphoid
- Cyclospora
- Trichinella
- Multistate clusters

https://www.cdc.gov/nationalsurveillance/pdfs/cdc5279-covis-vibriosis-508c.pdf

State:____ Year: _____ Age: ____ Sex: ____ Last Name:__ __ __

CHOLERA AND OTHER VIBRIO ILLNESS SURVEILLANCE REPORT

OMB 0920-0728 Exp. Date 01/31/2019

REPORTING HEALTH DEPARTMENT		
State	City	County/Parish
☐☐		

SEND COMPLETED REPORT TO STATE INFECTION CONTROL
State will forward to:
covfiaresponse@cdc.gov
E-fax: 404-235-1735
Centers for Disease Control and Prevention
Enteric Diseases Epidemiology Branch
1600 Clifton Road, MS C09
Atlanta, GA 30333

1. PATIENT CASE INFORMATION

1. First 3 letters of patient's last name: ___ ___ ___
2. Sex: ☐ M ☐ F ☐ Unk
3. Date of birth (MM/DD/YYYY): ___/___/____ 4. Age: __ __ YEARS __ __ MONTHS
5. NNDSS Case ID:
6. Race:
☐ American Indian/Alaska Native
☐ Black or African American
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Other
☐ Not provided/Unknown
☐ Asian
7. Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unk/Not Provided
8. Occupation: _____

2. LABORATORY INFORMATION

Use the *Vibrio* Species key to indicate which species were positively identified by culture or CIDT result as applicable.

Vibrio Species Key

V. alginolyticus—ALG
V. cholerae O1—CH1
V. cholerae O139—CH3
V. cholerae non-O1, non-O139—CHN
V. cincinnatiensis—CIN
Photobacterium damselae subsp. *Damselae*—DAM
V. fluvialis—FLU
V. furnissii—FUR
Grimontia hollisae—HOL
V. metschnikovii—MET
V. mimicus—MIM
V. parahaemolyticus—PAR
V. vulnificus—VUL
Vibrio—species not identified—NID
Other—OTH (Specify below)
Multiple species—MUL (Specify below)

Laboratory results (If more than one specimen is tested, complete one row per specimen. If more than two specimens were tested, please check here _____ and attach additional sheet. CIDT indicates a culture-independent diagnostic test.)

1. Specimen one: Date collected: __ __/__ __/__ __ (mm/dd/yy) Received at public health laboratory? ☐ Y ☐ N ☐ U If yes, State lab ID:_____

Specimen source:
☐ Stool ☐ Blood ☐ Wound
☐ Other (If wound or other, specify site): _____

Culture, result:
☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If positive, species identified: _____
If species identified as multiple or other, specify:
_____

CIDT, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If applicable, species identified:
_____
Name/type of diagnostic test used:_____

2. Specimen two: Date collected: __ __/__ __/__ __ (mm/dd/yy) Received at public health laboratory? ☐ Y ☐ N ☐ U If yes, State lab ID:_____

Specimen source:
☐ Stool ☐ Blood ☐ Wound
☐ Other (If wound or other, specify site): _____

Culture, result:
☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If positive, species identified: _____
If species identified as multiple or other, specify:
_____

CIDT, result: ☐ Pos ☐ Neg ☐ Unk ☐ Not Done
If applicable, species identified:
_____
Name/type of diagnostic test used:_____

3. If other non-*Vibrio* organism(s) isolated from same specimen, list:_____

Complete only if isolate is *Vibrio cholerae* O1 or O139:

4. Serotype: ☐ Inaba ☐ Ogawa
5. BioType: ☐ El Tor ☐ Classical ☐ Not done ☐ Unk

https://www.cdc.gov/listeria/pdf/listeria-case-report-form-omb-0920-0004.pdf

U.S. DEPARTMENT OF HEALTH and HUMAN SERVICES — CENTERS FOR DISEASE CONTROL AND PREVENTION

CDC *Listeria* Initiative
Case Report Form

Version 2.0

Please complete this questionnaire for all laboratory-confirmed listeriosis cases.

Instructions are available in a separate two-page document.

Please remove this page before submitting form to CDC

State public health laboratory isolate ID: _____	
Patient's name: _____	**Date of Birth:** ____/____/_____
Address: _____ **City:** _____ **State:** ____ ____ **Zip:** ____ ____ ____ ____ ____	
Phone numbers: (h) _____ (w) _____ (m) _____	
Hospital: _____ **Hospital contact:** _____ **Phone:** _____	**Hospital:** _____ *(if >1 hospital)* **Hospital contact:** _____ **Phone:** _____
If surrogate interview: **Interviewee name:** _____ **Interviewee phone number(s):** _____ _____	

Form Approved - OMB No. 0920-0728

https://epi.dph.ncdhhs.gov/cd/lhds/manuals/cd/reportforms/CNHGQ_2019.pdf

v 3.1 (March 2019)

Cyclosporiasis National Hypothesis Generating Questionnaire

State/NNDSS ID#: _____

Reset Form

Form Approved
OMB No. 0920-1198
Exp. Date 09/30/2020

General information (Questions to be completed by interviewer before the questionnaire is administered)

1. Classify case based on CDC case definition: ☐ Confirmed ☐ Probable

Laboratory information:

2. Date(s) stool collected for *Cyclospora* testing: _____

3. Test results: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending

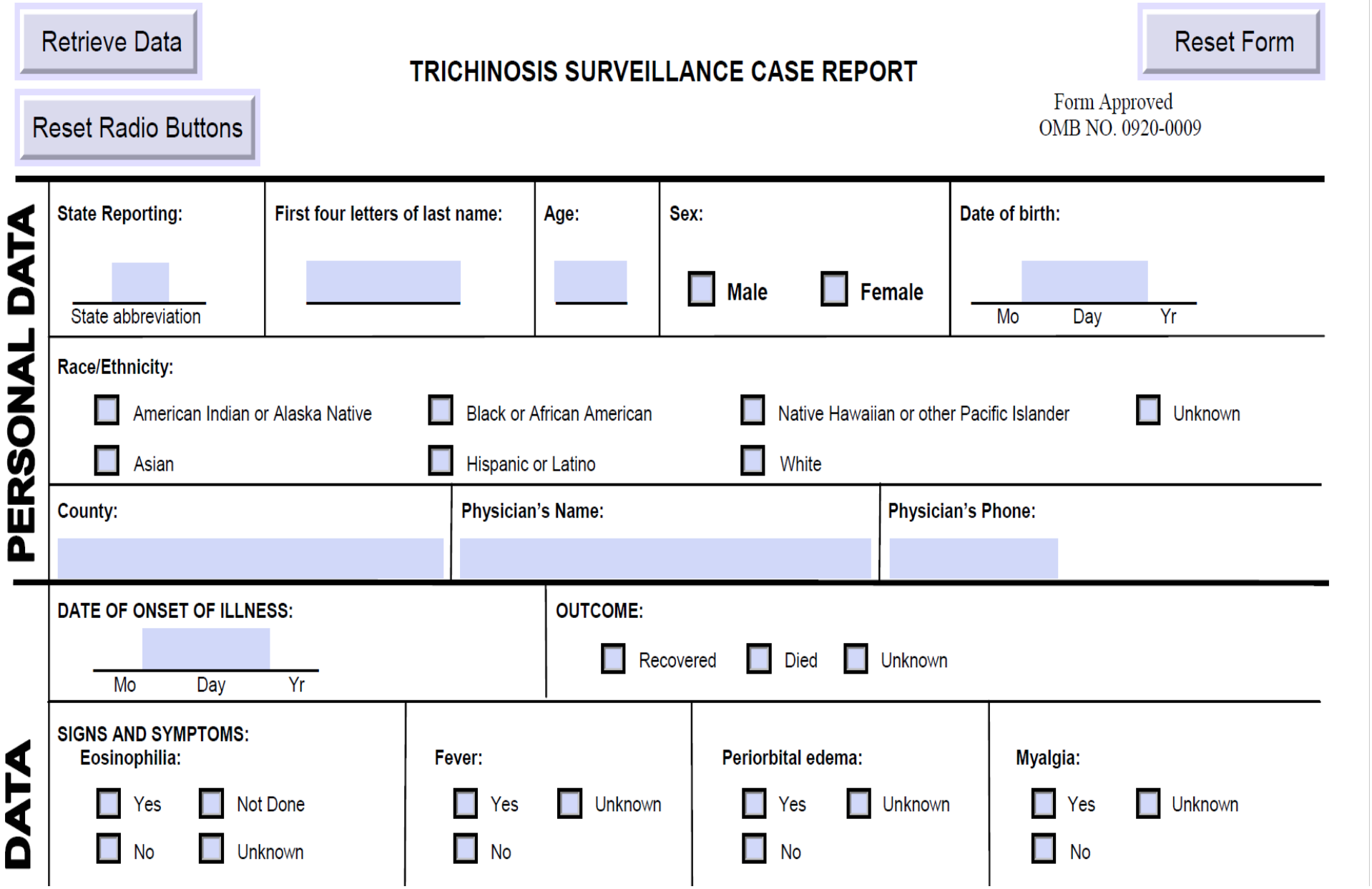
4. Specify type of testing laboratories and testing method(s) (Check all that apply including confirmatory lab/test):

	O&P (e.g., microscopy, stained smears)	GI PCR Panel (e.g., BioFire FilmArray®)	PCR (Not part of panel)	Lab-developed test	Other
Clinical lab	☐	☐	☐	☐	☐
Commercial lab	☐	☐	☐	☐	☐
State lab	☐	☐	☐	☐	☐
CDC lab	☐	☐	☐	☐	☐

5. Specify name(s) of lab-confirmed coinfection: _____ ☐ Not applicable

6. State Lab Accession Number: _____

https://www.cdc.gov/parasites/trichinellosis/resources/pdf/trichinellosis_case_report_form.pdf



Retrieve Data

Reset Form

Reset Radio Buttons

TRICHINOSIS SURVEILLANCE CASE REPORT

Form Approved
OMB NO. 0920-0009

PERSONAL DATA

State Reporting: _____ State abbreviation

First four letters of last name: _____

Age: _____

Sex: ☐ Male ☐ Female

Date of birth: _____ Mo Day Yr

Race/Ethnicity:

☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or other Pacific Islander ☐ Unknown

☐ Asian ☐ Hispanic or Latino ☐ White

County: _____

Physician's Name: _____

Physician's Phone: _____

DATE OF ONSET OF ILLNESS: _____ Mo Day Yr

OUTCOME:

☐ Recovered ☐ Died ☐ Unknown

DATA

SIGNS AND SYMPTOMS:

Eosinophilia:

☐ Yes ☐ Not Done

☐ No ☐ Unknown

Fever:

☐ Yes ☐ Unknown

☐ No

Periorbital edema:

☐ Yes ☐ Unknown

☐ No

Myalgia:

☐ Yes ☐ Unknown

☐ No

https://www.cdc.gov/nationalsurveillance/pdfs/typhi-surveillance-form.pdf

Reset Form

DEPARTMENT OF
HEALTH & HUMAN SERVICES
CENTERS FOR DISEASE CONTROL
AND PREVENTION
ATLANTA, GA 30333

TYPHOID AND PARATYPHOID FEVER SURVEILLANCE REPORT

CDC NO.:

STATE LAB ISOLATE ID NO.

CENTERS FOR DISEASE CONTROL AND PREVENTION

Form Approved:
OMB No. 0920-0728

Instructions:

– Please complete this form only for new, symptomatic, culture-proven cases of typhoid or paratyphoid fever. –

DEMOGRAPHIC DATA

1. Reporting State:

2. First three letters of patient's last name:

3. Date of birth: Mo. Day Yr. *or* Age: (in years)

4. Sex: ☐ Male ☐ Female

5. Does the patient work as a foodhandler? ☐ Yes ☐ No ☐ Unk.

6. Citizenship: ☐ U.S. ☐ Other: _____ ☐ Unk.

CLINICAL DATA

7. Was the patient ill with typhoid or paratyphoid fever? (fever, abdominal pain, headache, etc) ☐ Yes ☐ No ☐ Unk.

If Yes, give date of onset of symptoms: Mo. Day Yr.

8. Was the patient hospitalized? ☐ Yes ☐ No ☐ Unk.

If Yes, how many days was the patient hospitalized? Days

9. Outcome of case: ☐ Recovered ☐ Died ☐ Unk.

LABORATORY DATA

10. Date *Salmonella* first isolated: Mo. Day Yr.

Site(s) of isolation: *(check all that apply)*

☐ Blood ☐ Stool ☐ Gall Bladder ☐ Other (specify): _____

Serotype:

☐ Typhi ☐ Paratyphi A ☐ Paratyphi B ☐ Paratyphi C

11. Was **antibiotic sensitivity testing** performed

Multistate Outbreak Supplemental Form

LIVE POULTRY EXPOSURE QUESTIONNAIRE FOR *SALMONELLA*

LAST UPDATED: APRIL 2018

Notes to Interviewer:

- *Instructions in italics are for interviewer only. Please do not read italicized words to person being interviewed.*
- *Please administer this questionnaire to the patient (or patient's caregiver).*
- *Please review the final optional questions at the end, if your health department is able to investigate further.*
- *Please fill out one form for every patient and complete as much of the information as possible. Thank you!*

Epi Info ID _____

Section 1: INTERVIEW INFORMATION *(To be completed by interviewer prior to questionnaire administration)*

1. *PulseNet ID #:* _____ 2. *State/Local/Other ID #:* _____
3. *PulseNet cluster code:* _____ 3a. *PFGE Pattern:* _____ 3b. *Serotype* _____
4. *Date of Interview:* __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) *(If unknown, enter 99/99/9999)*

Interviewer information

5. *Name:* 7. *Contact phone number:* (____) _____-_____
6. *Agency:*

8. *Did the patient die?* ☐Yes ☐No ☐Don't know
   8a: If the patient died, was it attributable to Salmonella? ☐Yes ☐No ☐Don't know
9. *Respondent was:* ☐Patient ☐Parent ☐Other

Hello. My name is _____and I'm calling from the _____Department of Health. We are investigating an outbreak of *Salmonella* infections. We are calling everyone who became sick to ask more detailed questions about contact with live poultry. This should not take more than 10 minutes.
You do not have to respond to any question that you do not want to, but your answers will be useful for understanding the cause of people's illness and preventing other people from getting sick. Any information you provide will remain confidential, to the extent allowed by law.
Are you willing to participate?
If Yes: Is now a good time?
(If yes, skip to Section 2) If no, is there a better time to call back? __ __ / __ __ / __ __ __ __ (___:____ am/pm)
If No: Thank you for your time. *(End Interview)*

Part I: Patient Interview

Section 2: DEMOGRAPHIC DATA
I'd like to begin by asking a few questions about you/the patient and your household.

1. What are your state, county, and zip code? State abbr. _____ County _____ Zip Code _____
2. Age _____ ☐ Years ☐ Months ☐ Days | 3. Sex: ☐ Male ☐ Female ☐ Unknown
4. How do you describe your ethnicity? ☐ Hispanic ☐ Non-Hispanic ☐ Unknown ☐ Declined to answer
   4a. If Hispanic: What origin? ☐ Mexican, Mexican American ☐ Puerto Rican ☐ Cuban ☐ Other:_____
5. How do you describe your race?
   - ☐ Black/African American
   - ☐ Native American Indian/Alaska Native
   - ☐ Native Hawaiian/Pacific Islander (specify)
     - ☐ Native Hawaiian
     - ☐ Guamanian/Chamorro
     - ☐ Samoan
     - ☐ Other Pacific Islander
   - ☐ Asian (specify)
     - ☐ Asian Indian
     - ☐ Chinese
     - ☐ Filipino
     - ☐ Japanese
     - ☐ Korean
     - ☐ Vietnamese
     - ☐ Other Asian
   - ☐ White (specify)
     - ☐ Middle Eastern/North African
     - ☐ Not Middle Eastern/North African
   - ☐ Unknown race
   - ☐ Other race: _____
   - ☐ Declined to answer
6. What is your/the patient's occupation or job? _____

Section 3: CLINICAL INFORMATION
Now I have a few questions about your/the patient's illness.

1. What date did [you/the patient] first feel sick? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) ☐ Don't know

Yes	Maybe	No	Don't Know	Did/were [you/the patient]…
☐	☐	☐	☐	2. Have any diarrhea (defined as at least 3 loose stools in 24 hours)?
				2a: What day did the diarrhea start? __ __ / __ __ / __ __ __ __ (M M / D D / Y Y Y Y) ☐ Don't know
☐	☐	☐	☐	3. Hospitalized overnight?

Any questions?

NHGQs / Supplemental Questionnaires

Laboratory Essentials for Enterics

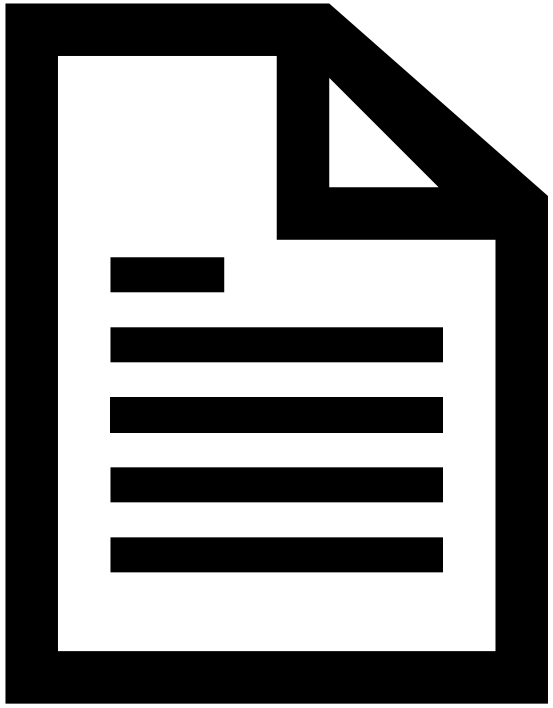
Shadia Rath

“There’s so much time and energy devoted to an outbreak. It’s painful to hear that the lab couldn’t test a specimen due to collection error or mislabeling. That is usually the last missing piece that we will never know.”

~ Nicole Lee

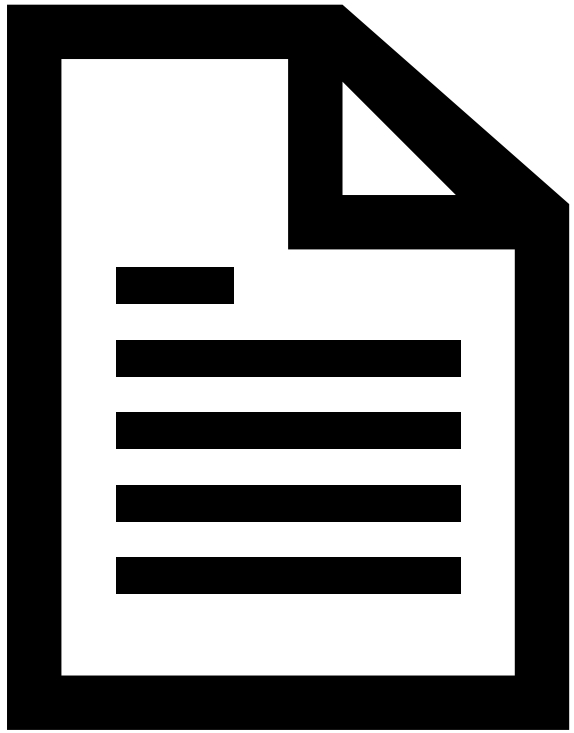
Laboratory Essentials for Enterics

Requisitions and Stool Collection



What's important and why

Enteric Requisitions



Enteric Requisition Screenshots

ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name				
First Name	MI			
Maiden Name/Surname				
Address/Attention:				
Street Address:			Address 2:	City:
State:	Zip Code:	County Code:	County Name:	Phone Number:
SSN: __ __ __/__ __/__ __ __ __			Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __	
Medical Record Number:			Date of Birth: __ __/__ __/__ __ __ __	
Sex: ❑ Male ❑ Transgender M2F ❑ Female ❑ Transgender F2M ❑ Unknown ❑ Transgender Unknown ❑ Ambiguous			Race (mark all that apply): ❑ White ❑ American Indian/ Alaska Native ❑ Black ❑ Native Hawaiian/ Pacific Isles ❑ Asian ❑ Unknown	Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Submitter

EIN: __ __ __ __ __ __ __ __ __ - __ __	Submitter Name:	
Address:	Address 2:	City:
State:	Zip Code:	County Name:
Phone Number:	Email Address:	Fax Number:
Ordering Provider NPI:	Ordering Provider First and Last Name:	

Specimen

Collection Date: __ __/__ __/__ __ __ __	Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __
Specimen Type: ❑ Clinical ❑ Isolated Organism (describe):_____	**Specimen Source:** ❑ Stool ❑ Rectal Swab ❑ Blood ❑ Urine ❑ Wound Site: _____ ❑ Other: _____
Test Ordered: ❑ **Enteric Pathogens** ❑ **E. coli 0157/STEC** ❑ **Salmonella** ❑ **Campylobacter** ❑ **Shigella** ❑ **Yersinia** ❑ **Other** _____	Laboratory Number: *Do Not Write in this Space*

Other

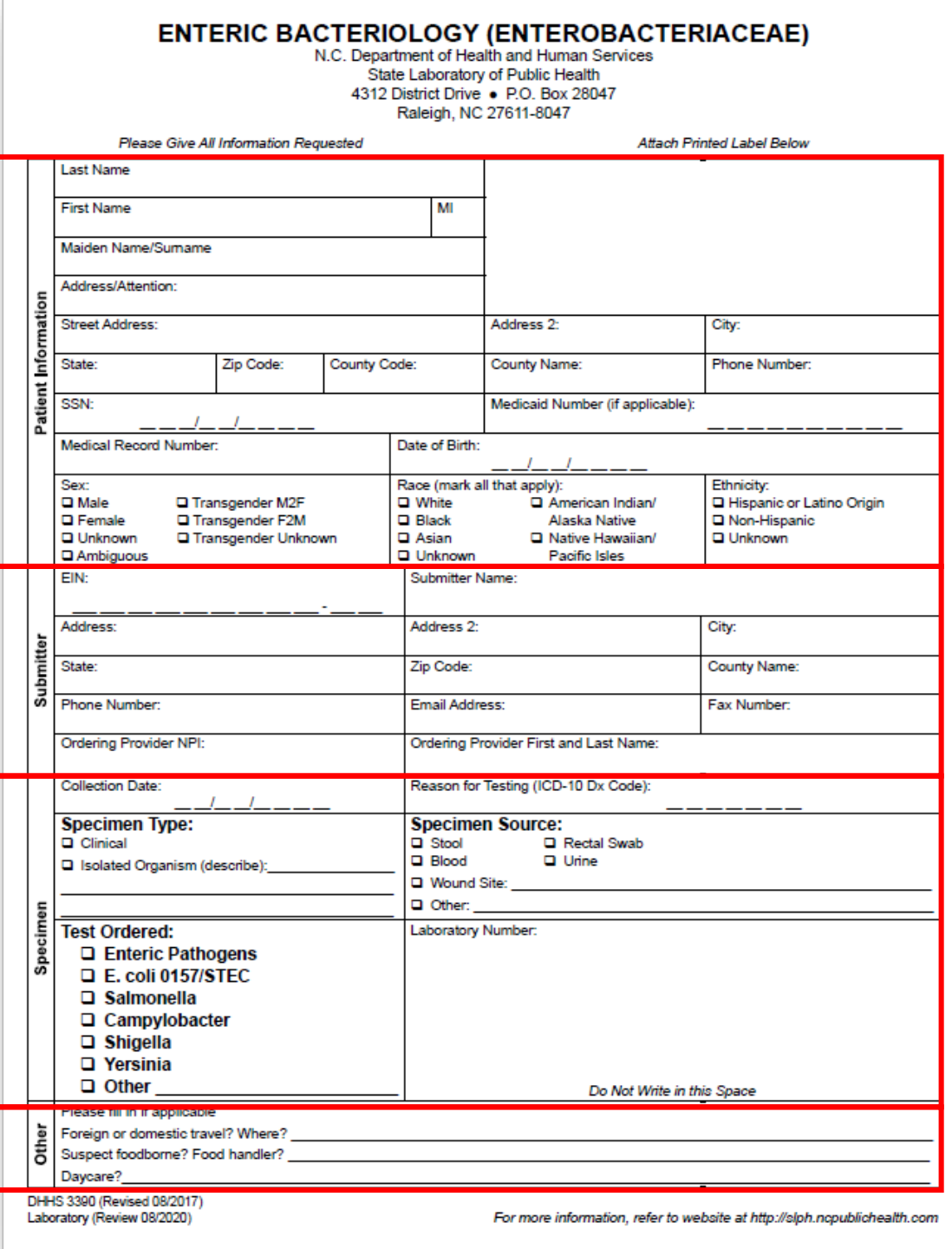
Please fill in if applicable
Foreign or domestic travel? Where? _____
Suspect foodborne? Food handler? _____
Daycare? _____

DHHS 3390 (Revised 08/2017)
Laboratory (Review 08/2020)

For more information, refer to website at http://slph.ncpublichealth.com

Enteric Requisition Screenshots

- Patient
- Submitter
- Specimen
- Other



ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

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State Laboratory of Public Health
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Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name
First Name | MI
Maiden Name/Surname
Address/Attention:
Street Address: | Address 2: | City:
State: | Zip Code: | County Code: | County Name: | Phone Number:
SSN: __ __/__ __/__ __ __ __ | Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __
Medical Record Number: | Date of Birth: __ __/__ __/__ __ __ __
Sex: ❑ Male ❑ Female ❑ Unknown ❑ Ambiguous ❑ Transgender M2F ❑ Transgender F2M ❑ Transgender Unknown
Race (mark all that apply): ❑ White ❑ Black ❑ Asian ❑ Unknown ❑ American Indian/ Alaska Native ❑ Native Hawaiian/ Pacific Isles
Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Submitter

EIN: __ __ __ __ __ __ __ __ __ - __ __
Submitter Name:
Address: | Address 2: | City:
State: | Zip Code: | County Name:
Phone Number: | Email Address: | Fax Number:
Ordering Provider NPI: | Ordering Provider First and Last Name:

Specimen

Collection Date: __ __/__ __/__ __ __ __
Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Specimen Type:
❑ Clinical
❑ Isolated Organism (describe):_____

Specimen Source:
❑ Stool ❑ Rectal Swab
❑ Blood ❑ Urine
❑ Wound Site: _____
❑ Other: _____

Test Ordered:
- ❑ **Enteric Pathogens**
- ❑ **E. coli 0157/STEC**
- ❑ **Salmonella**
- ❑ **Campylobacter**
- ❑ **Shigella**
- ❑ **Yersinia**
- ❑ **Other** _____

Laboratory Number:

Do Not Write in this Space

Other

Please fill in if applicable
Foreign or domestic travel? Where? _____
Suspect foodborne? Food handler? _____
Daycare? _____

DHHS 3390 (Revised 08/2017)
Laboratory (Review 08/2020)

For more information, refer to website at http://slph.ncpublichealth.com

Enteric Requisition Screenshots: Patient

ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name			
First Name	MI		
Maiden Name/Surname			
Address/Attention:			
Street Address:		Address 2:	City:
State:	Zip Code: / County Code:	County Name:	Phone Number:
SSN: __ __ __/__ __/__ __ __ __		Medicaid Number (if applicable):	
Medical Record Number:		Date of Birth: __ __/__ __/__ __ __ __	

Mandatory

Sex:
- ❑ Male
- ❑ Female
- ❑ Unknown
- ❑ Ambiguous
- ❑ Transgender M2F
- ❑ Transgender F2M
- ❑ Transgender Unknown

Race (mark all that apply):
- ❑ White
- ❑ Black
- ❑ Asian
- ❑ Unknown
- ❑ American Indian/ Alaska Native
- ❑ Native Hawaiian/ Pacific Isles

Ethnicity:
- ❑ Hispanic or Latino Origin
- ❑ Non-Hispanic
- ❑ Unknown

City:
Phone Number:
Ethnicity:
❑ Hispanic or Latino Origin
❑ Non-Hispanic
❑ Unknown
City:
County Name:
Fax Number:
in this Space
Foreign or domestic travel? Where?
Suspect foodborne? Food handler?
Daycare?

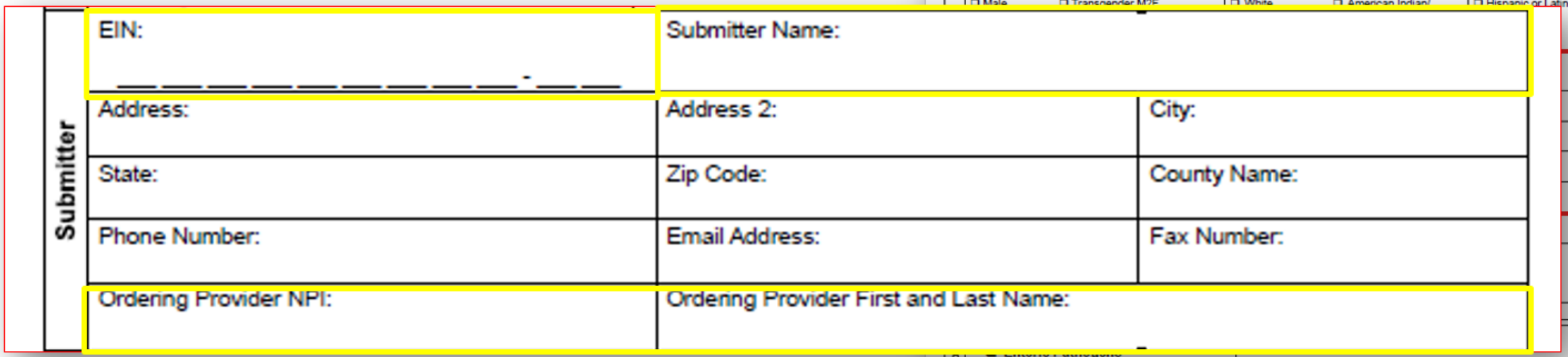
DHHS 3390 (Revised 08/2017)
Laboratory (Review 08/2020)

For more information, refer to website at http://elph.ncpublichealth.com

Enteric Requisition Screenshots: Submitter

Facility Federal Tax ID #

Facility Name



Submitter			
	EIN:	Submitter Name:	
	Address:	Address 2:	City:
	State:	Zip Code:	County Name:
	Phone Number:	Email Address:	Fax Number:
	Ordering Provider NPI:	Ordering Provider First and Last Name:	

National Provider Identifier # and Name

ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

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Patient Information

Last Name				
First Name		MI		
Maiden Name/Surname				
Address/Attention:				
Street Address:			Address 2:	City:
State:	Zip Code:	County Code:	County Name:	Phone Number:
SSN: ___/___/____			Medicaid Number (if applicable):	
Medical Record Number:			Date of Birth: ___/___/____	
Sex: ☐ Male ☐ Transgender M2F			Race (mark all that apply): ☐ White ☐ American Indian/	Ethnicity: ☐ Hispanic or Latino Origin

Sp

- ☐ E. coli 0157/STEC
- ☐ Salmonella
- ☐ Campylobacter
- ☐ Shigella
- ☐ Yersinia
- ☐ Other _____

Do Not Write in this Space

Other

Please fill in if applicable
Foreign or domestic travel? Where? _____
Suspect foodborne? Food handler? _____
Daycare? _____

DHHS 3390 (Revised 08/2017)
Laboratory (Review 08/2020)

For more information, refer to website at http://slph.ncpublichealth.com

Enteric Requisition Screenshots: Specimen

Stool samples ≤ 7 days old

Mandatory information

ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name
First Name | MI
Maiden Name/Surname
Address/Attention:
Street Address: | Address 2: | City:
State: | Zip Code: | County Code: | County Name: | Phone Number:
SSN: ___/___/____ | Medicaid Number (if applicable): _____
Medical Record Number: | Date of Birth: ___/___/____
Sex: | Race (mark all that apply): | Ethnicity:

Specimen

Collection Date: ___/___/____

Reason for Testing (ICD-10 Dx Code): _____

Specimen Type:
- ❑ Clinical
- ❑ Isolated Organism (describe): _____

Specimen Source:
- ❑ Stool
- ❑ Rectal Swab
- ❑ Blood
- ❑ Urine
- ❑ Wound Site: _____
- ❑ Other: _____

Test Ordered:
- ❑ Enteric Pathogens
- ❑ E. coli 0157/STEC
- ❑ Salmonella
- ❑ Campylobacter
- ❑ Shigella
- ❑ Yersinia
- ❑ Other _____

STEC only, cannot order EIEC.

Laboratory Number:

Note: Stool samples for Vibrio use Enteric form.
Isolates of Vibrio use Atypical/Special Bacteriology form.

Do Not Write in this Space

Daycare?

DHHS 3390 (Revised 08/2017)
Laboratory (Review 08/2020)

For more information, refer to website at http://slph.ncpublichealth.com

Enteric Requisition Screenshots

ENTERIC BACTERIOLOGY (ENTEROBACTERIACEAE)

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name
First Name | MI
Maiden Name/Surname
Address/Attention:
Street Address: | Address 2: | City:
State: | Zip Code: | County Code: | County Name: | Phone Number:
SSN: __ __/__ __/__ __ __ __ | Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __
Medical Record Number: | Date of Birth: __ __/__ __/__ __ __ __
Sex: ❑ Male ❑ Female ❑ Unknown ❑ Ambiguous ❑ Transgender M2F ❑ Transgender F2M ❑ Transgender Unknown
Race (mark all that apply): ❑ White ❑ Black ❑ Asian ❑ Unknown ❑ American Indian/ Alaska Native ❑ Native Hawaiian/ Pacific Isles
Ethnicity: ❑ Hispanic or Latino Origin ❑ Non-Hispanic ❑ Unknown

Submitter

EIN: __ __ __ __ __ __ __ __ __ - __ __
Submitter Name:
Address: | Address 2: | City:
State: | Zip Code: | County Name:
Phone Number: | Email Address: | Fax Number:
Ordering Provider NPI: | Ordering Provider First and Last Name:

Specimen

Collection Date: __ __/__ __/__ __ __ __
Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __
Specimen Type: ❑ Clinical ❑ Isolated Organism (describe):_____
Specimen Source: ❑ Stool ❑ Rectal Swab ❑ Blood ❑ Urine ❑ Wound Site: _____ ❑ Other: _____
Test Ordered: | Laboratory Number:

Other

Please fill in if applicable
Foreign or domestic travel? Where? _____
Suspect foodborne? Food handler? _____
Daycare? _____

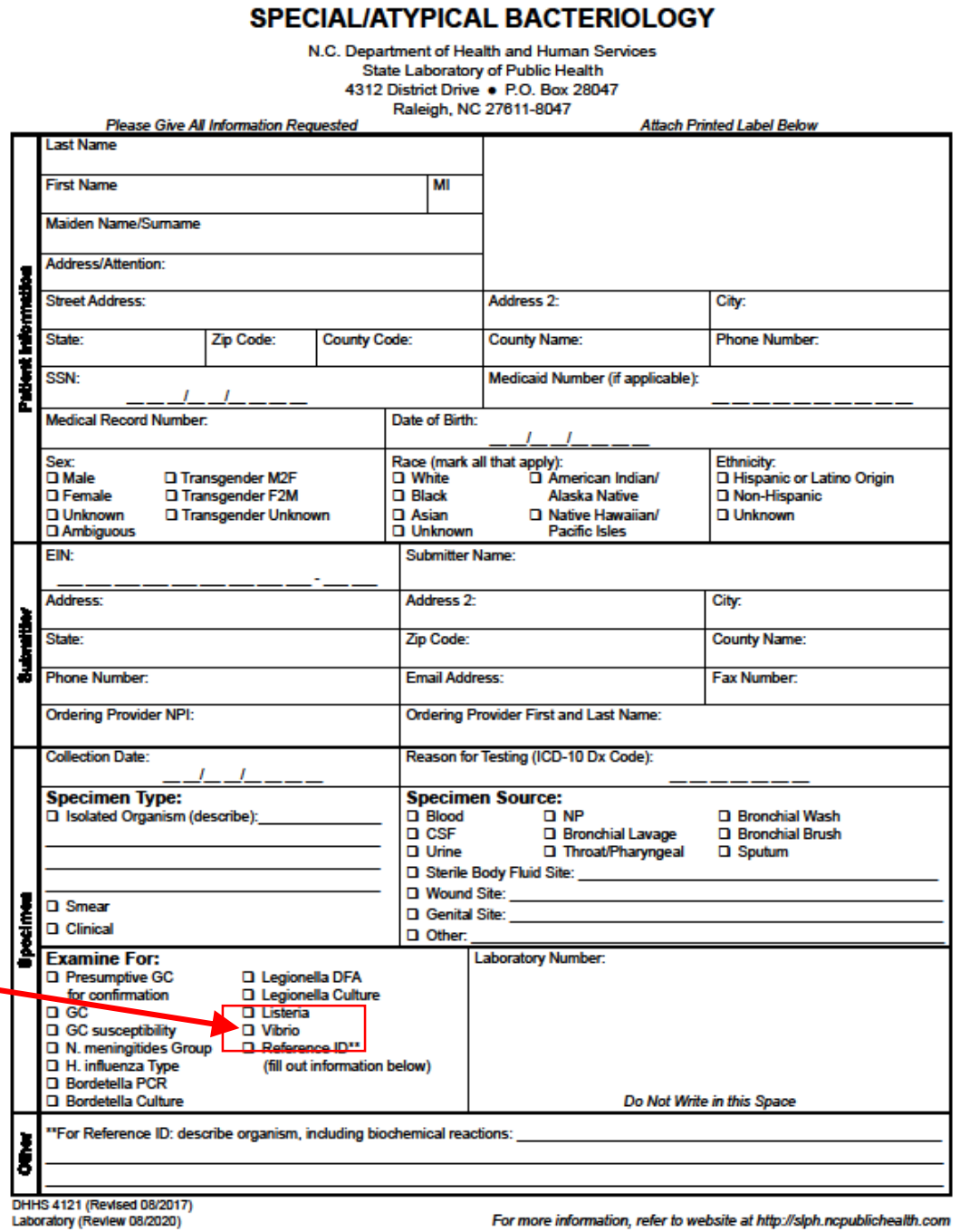
Other
Suspect foodborne? Food handler? _____
Daycare? _____

Atypical Bacteriology Requisition Screenshots

Use when sending isolates of Vibrio

Fill out same mandatory fields as on Enteric Bacteriology form.

Under ‘Examine For’ check the **‘Vibrio’** box



SPECIAL/ATYPICAL BACTERIOLOGY

N.C. Department of Health and Human Services
State Laboratory of Public Health
4312 District Drive • P.O. Box 28047
Raleigh, NC 27611-8047

Please Give All Information Requested — *Attach Printed Label Below*

Patient Information

Last Name
First Name | MI
Maiden Name/Surname
Address/Attention:
Street Address: | Address 2: | City:
State: | Zip Code: | County Code: | County Name: | Phone Number:
SSN: __ __ /__ __ /__ __ __ __ | Medicaid Number (if applicable): __ __ __ __ __ __ __ __ __ __
Medical Record Number: | Date of Birth: __ __ /__ __ /__ __ __ __

Sex:
☐ Male ☐ Transgender M2F
☐ Female ☐ Transgender F2M
☐ Unknown ☐ Transgender Unknown
☐ Ambiguous

Race (mark all that apply):
☐ White ☐ American Indian/ Alaska Native
☐ Black ☐ Native Hawaiian/ Pacific Isles
☐ Asian
☐ Unknown

Ethnicity:
☐ Hispanic or Latino Origin
☐ Non-Hispanic
☐ Unknown

Submitter

EIN: __ __ __ __ __ __ __ __ __ __ - __ __
Submitter Name:
Address: | Address 2: | City:
State: | Zip Code: | County Name:
Phone Number: | Email Address: | Fax Number:
Ordering Provider NPI: | Ordering Provider First and Last Name:

Specimen

Collection Date: __ __ /__ __ /__ __ __ __
Reason for Testing (ICD-10 Dx Code): __ __ __ __ __ __ __

Specimen Type:
☐ Isolated Organism (describe):_____
☐ Smear
☐ Clinical

Specimen Source:
☐ Blood ☐ NP ☐ Bronchial Wash
☐ CSF ☐ Bronchial Lavage ☐ Bronchial Brush
☐ Urine ☐ Throat/Pharyngeal ☐ Sputum
☐ Sterile Body Fluid Site: _____
☐ Wound Site: _____
☐ Genital Site: _____
☐ Other: _____

Examine For:
☐ Presumptive GC for confirmation
☐ GC
☐ GC susceptibility
☐ N. meningitides Group
☐ H. influenza Type
☐ Bordetella PCR
☐ Bordetella Culture
☐ Legionella DFA
☐ Legionella Culture
☐ Listeria
☐ Vibrio
☐ Reference ID** (fill out information below)

Laboratory Number:

Do Not Write in this Space

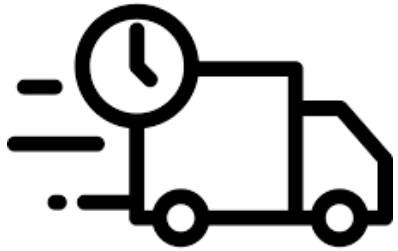
Other

**For Reference ID: describe organism, including biochemical reactions: _____

DHHS 4121 (Revised 08/2017)
Laboratory (Review 08/2020)

For more information, refer to website at http://slph.ncpublichealth.com

Collection



Shipping

Ordering supplies

Stool Specimens

Specimen submission: Stool in Enteric Transport Media (ETM) or Cary-Blair

Norovirus
Salmonella
Shigella
Yersinia
Campylobacter
E. coli 0157
other Shiga-toxin producing *E. coli* (STEC)
Vibrio

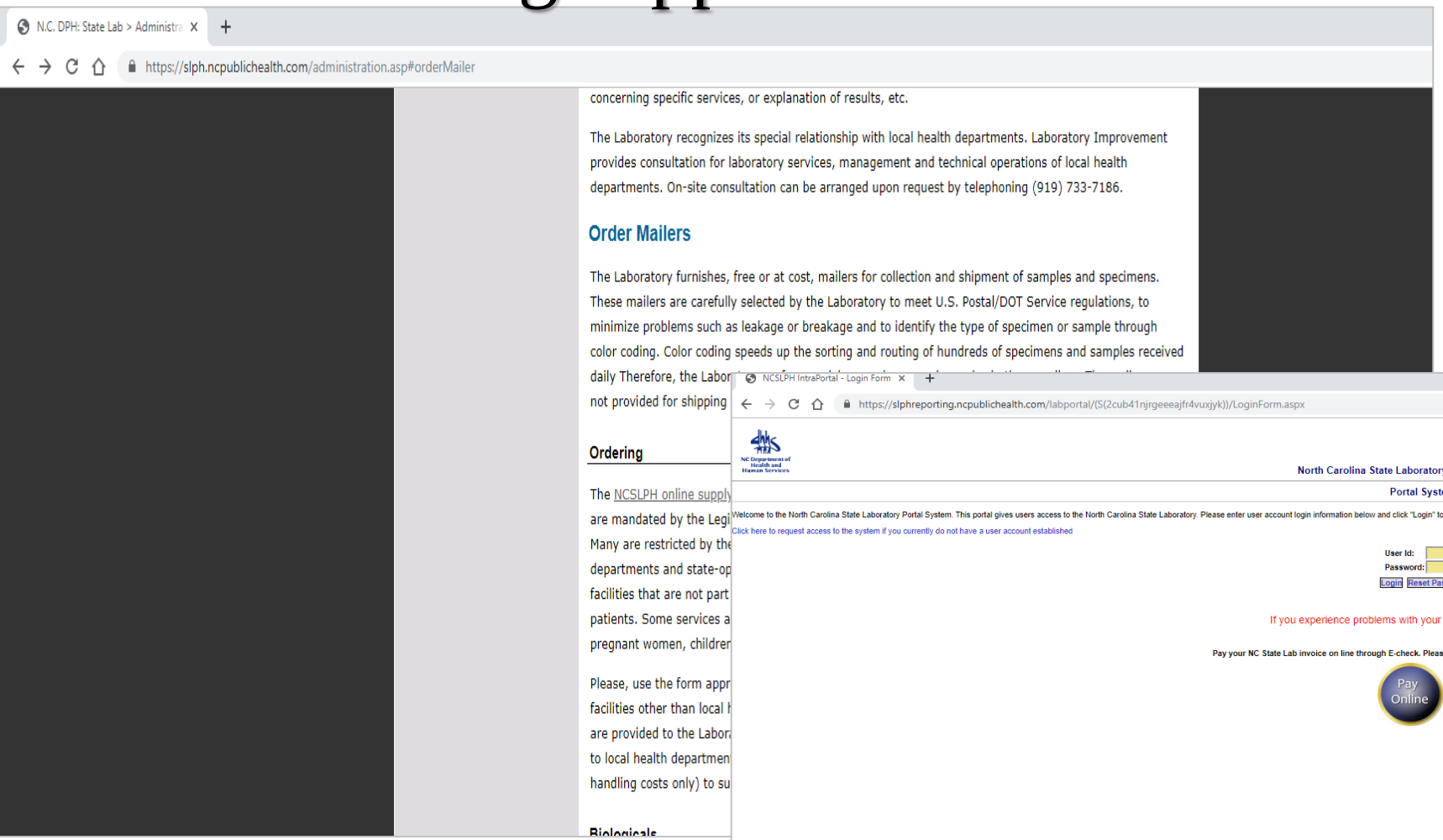
Reference submission: Pure culture slant

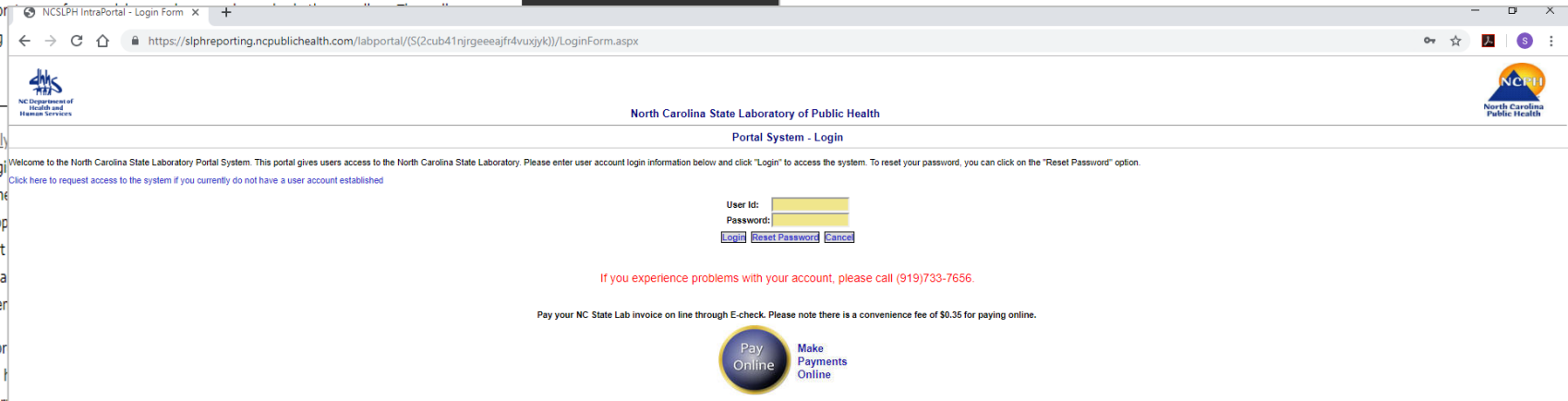
Salmonella
Shigella
Yersinia
Campylobacter
E. coli 0157
other Shiga-toxin producing *E. coli* (STEC)
Listeria
Vibrio

Shipped Category B :

USPS
State Courier

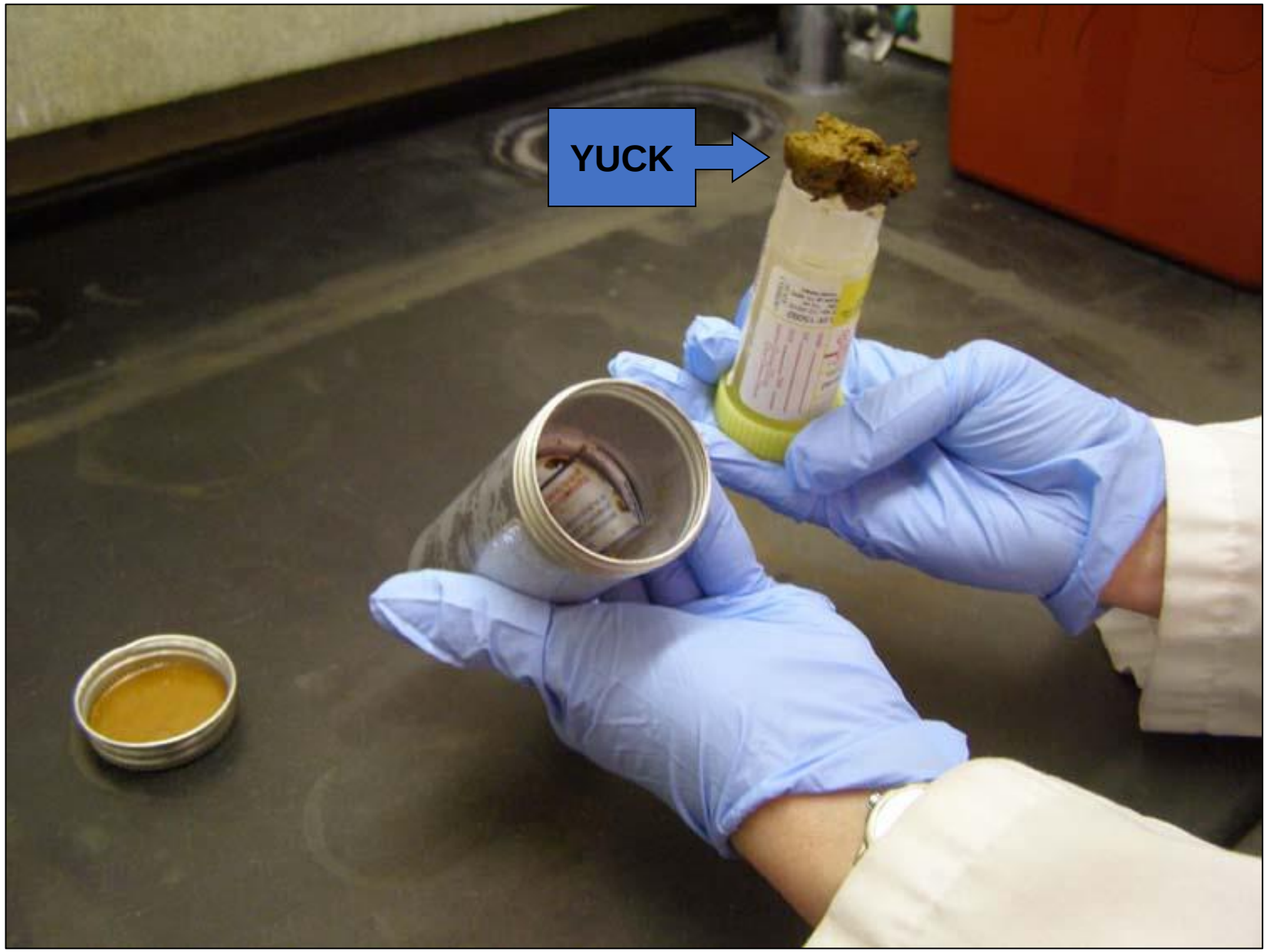
Order mailing supplies:





Pictures

What not to do!


YUCK


Place First Class Postage Here


CHLAMYDIA
JAN-JUNE 2004
Requires First Class
Chlamydia
R


No secondary container


Overpack

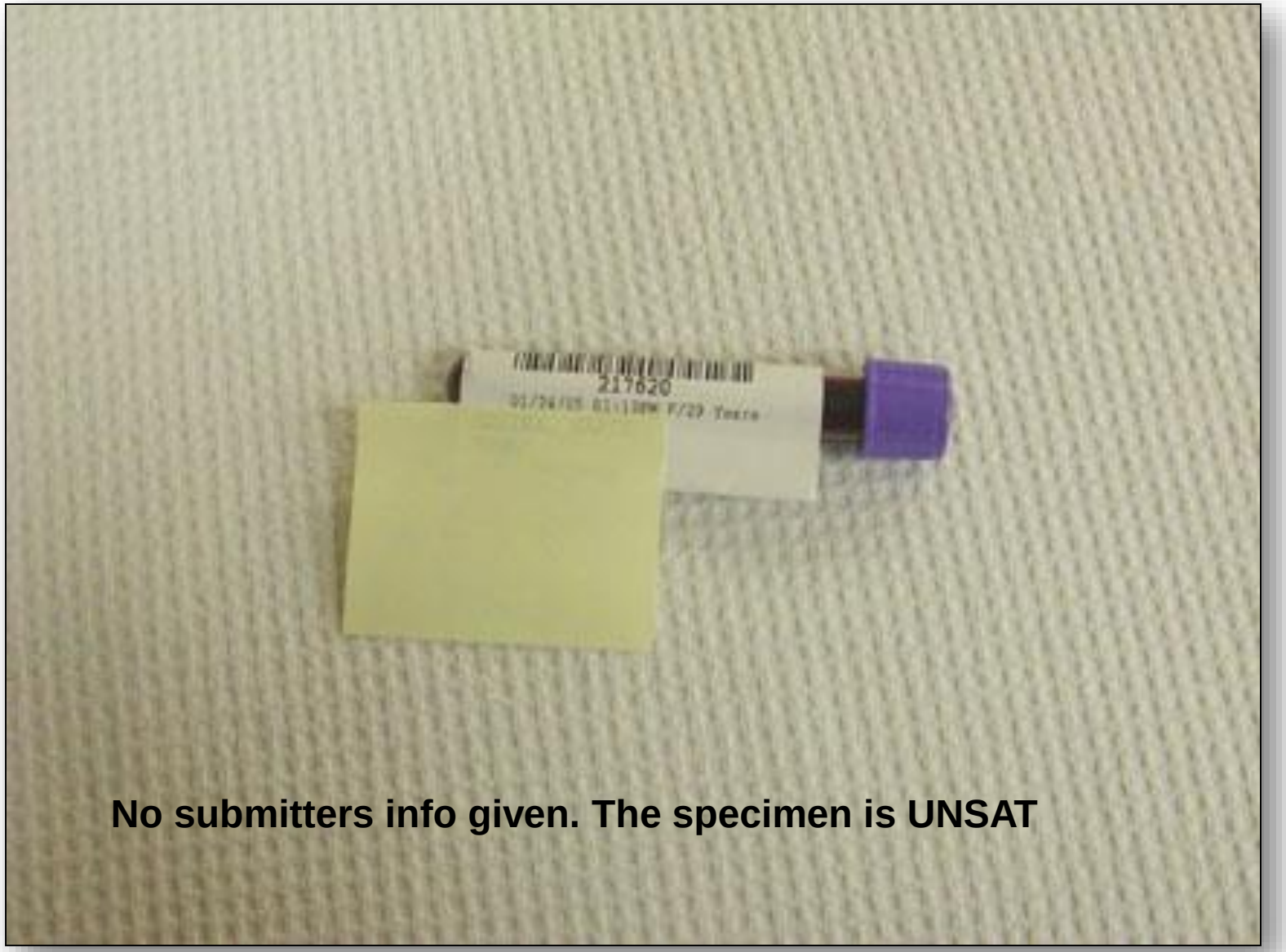

Blood Group &
TEMPERATURE

Which is Packed Correctly for the courier?

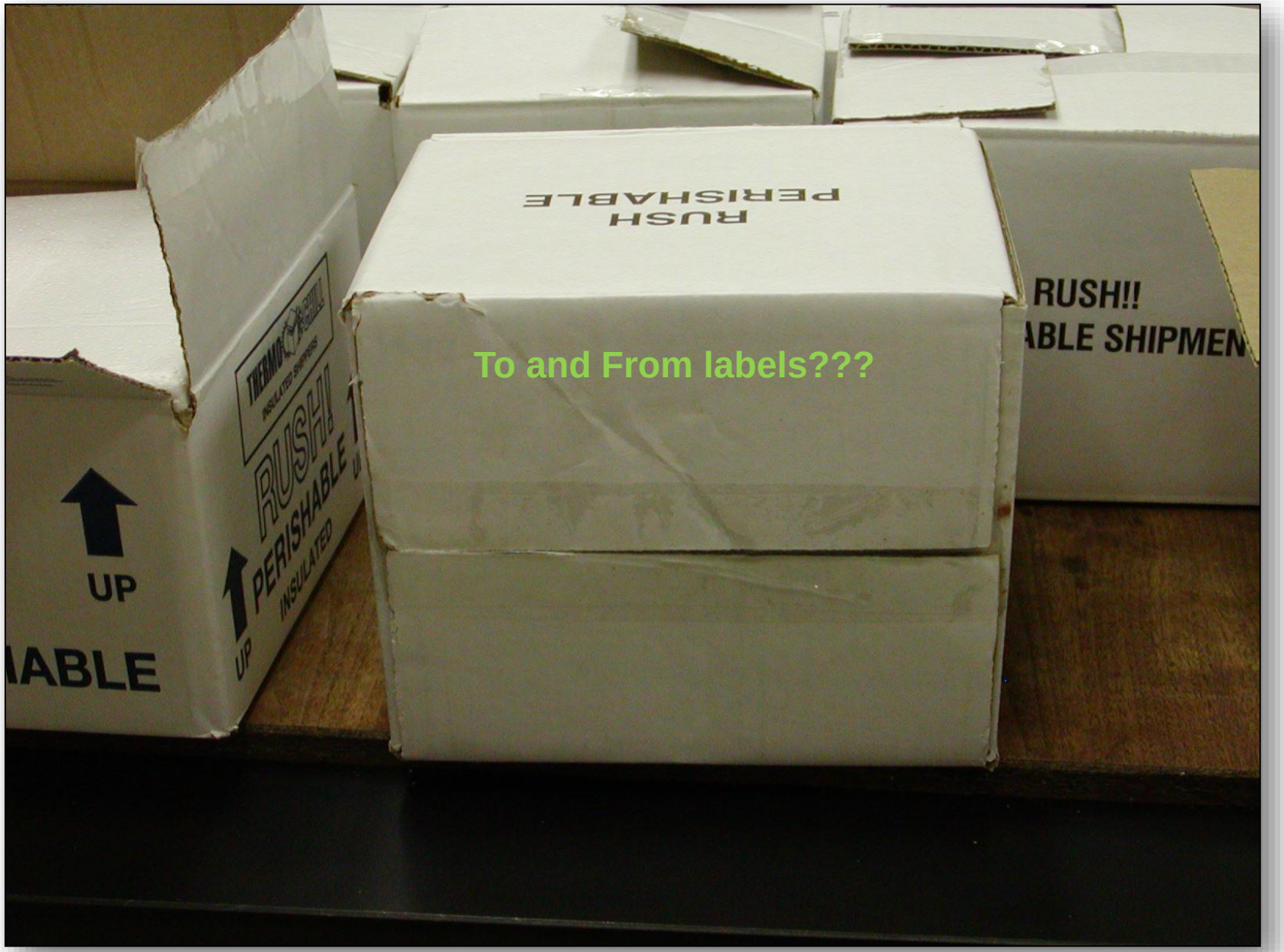
A.

B.

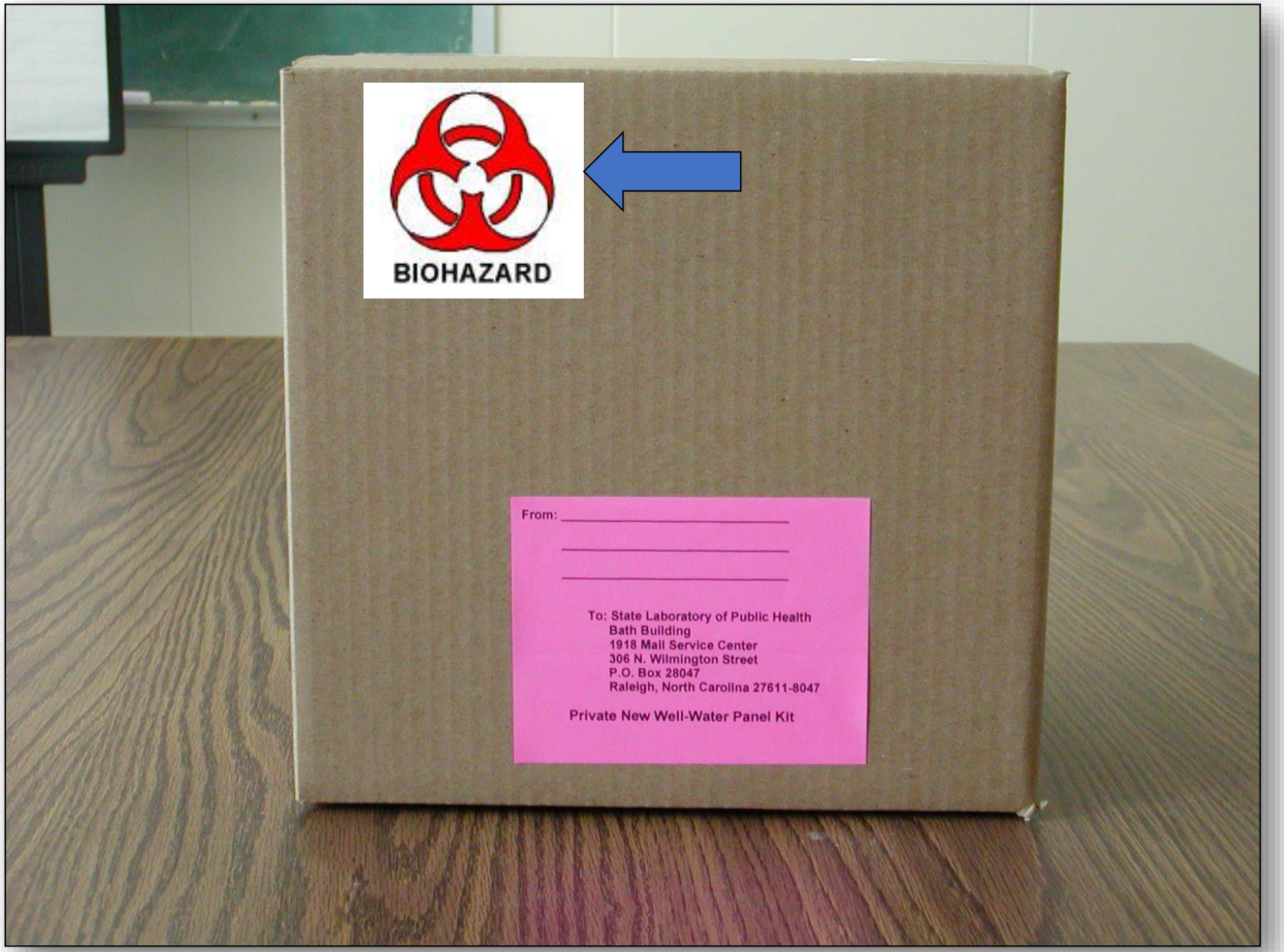
C.

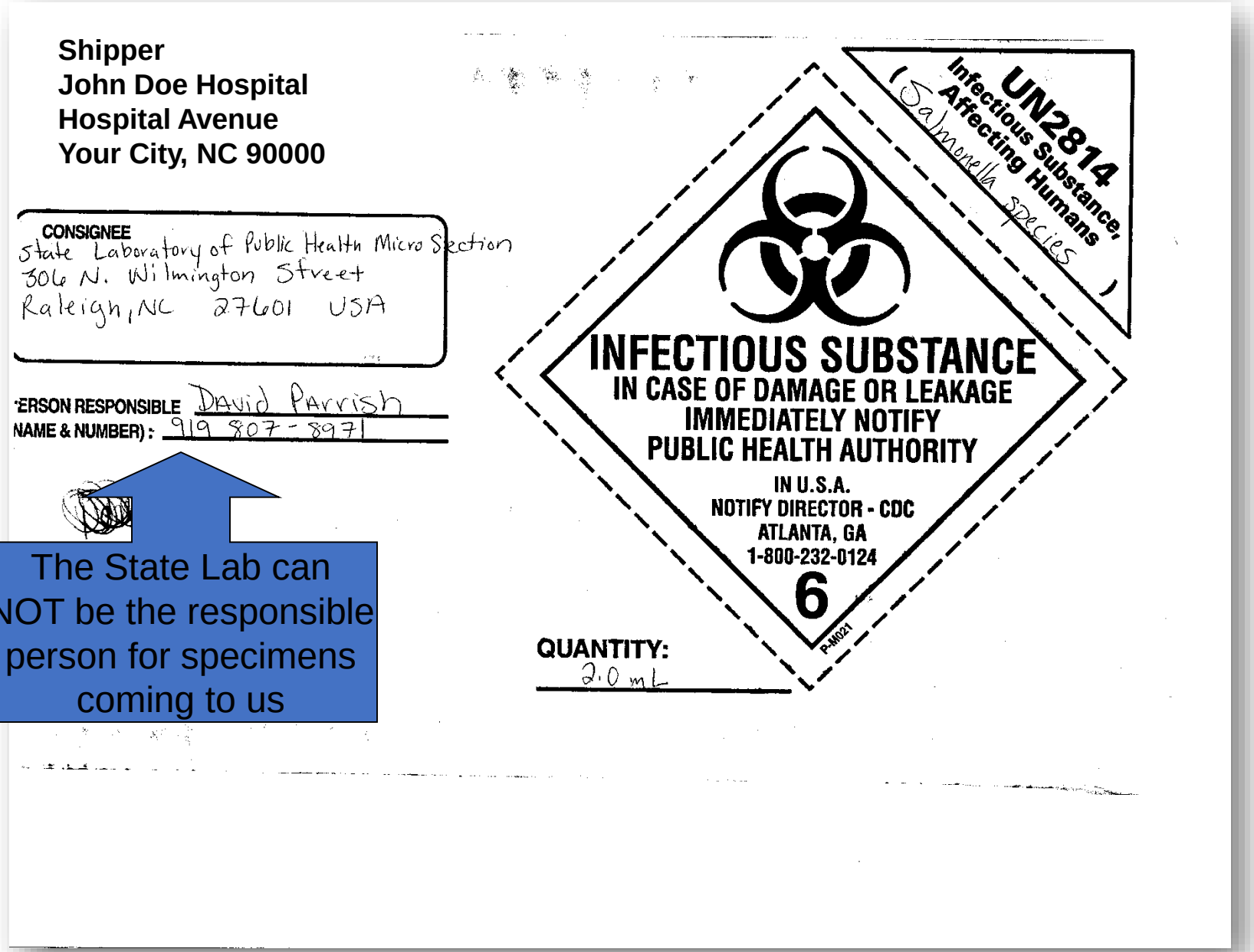


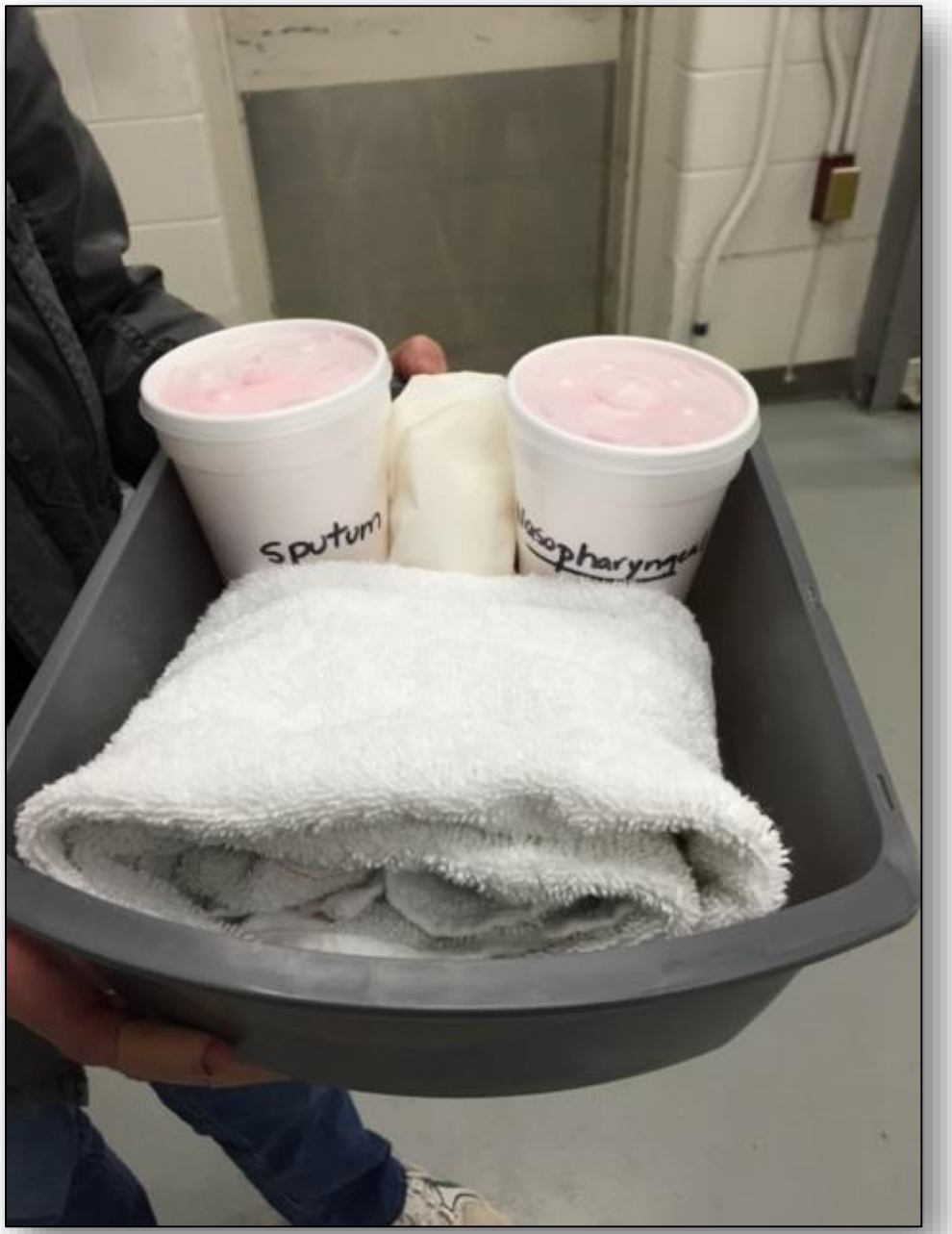
No submitters info given. The specimen is UNSAT


RUSH
PERISHABLE
To and From labels???
RUSH!!
UP
RUSH
PERISHABLE
INSULATED
UP

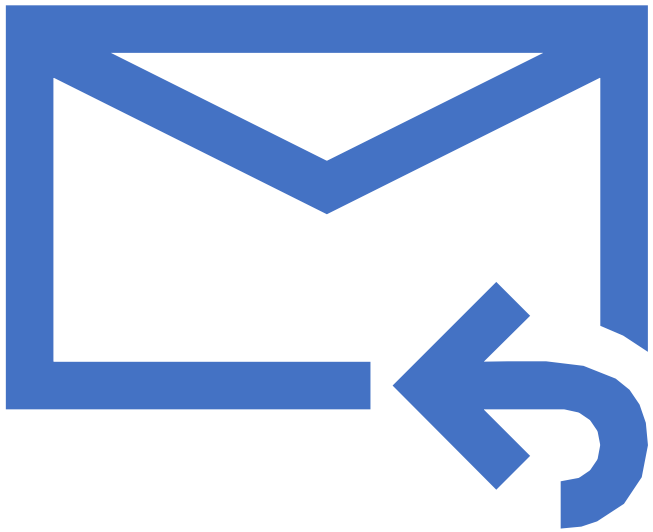

St Joseph's
N.C. Department of Health and Human Services
STATE LABORATORY OF PUBLIC HEALTH
MICROBIOLOGY BRANCH
306 N. WILMINGTON ST. • P.O. BOX 28047
RALEIGH, N.C. 27611-8047


BIOHAZARD
From: _____
_____
_____
To: State Laboratory of Public Health
Bath Building
1918 Mail Service Center
306 N. Wilmington Street
P.O. Box 28047
Raleigh, North Carolina 27611-8047
Private New Well-Water Panel Kit


Shipper
John Doe Hospital
Hospital Avenue
Your City, NC 90000
CONSIGNEE
State Laboratory of Public Health Micro Section
306 N. Wilmington Street
Raleigh, NC 27601 USA
PERSON RESPONSIBLE (NAME & NUMBER): David Parrish 919 807-8971
The State Lab can NOT be the responsible person for specimens coming to us
UN2814
Infectious Substance, Affecting Humans
(Salmonella species)
INFECTIOUS SUBSTANCE
IN CASE OF DAMAGE OR LEAKAGE
IMMEDIATELY NOTIFY
PUBLIC HEALTH AUTHORITY
IN U.S.A.
NOTIFY DIRECTOR - CDC
ATLANTA, GA
1-800-232-0124
6
P-M021
QUANTITY:
2.0 mL


Sputum


Any questions?



Contact Info

NICOLE LEE, MPH
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nicole.lee@dhhs.nc.gov

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Foodborne Nurse Consultant
tammra.morrison@dhhs.nc.gov

DAVID SENESI, MD
Foodborne Epidemiologist
david.senesi@dhhs.nc.gov

SHADIA RATH, MS
Supervisor, Molecular Diagnostic and Epidemiology Laboratory Unit
shadia.rath@dhhs.nc.gov