SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

CORTEX TELEVISION LLC dba The Healthcare Channel,

Petitioner,

-against-

NEW YORK STATE DEPARTMENT OF HEALTH,

Respondent,

For a Judgment Under Article 78 of the Civil Practice Law and Rules.

Index No. 155606/2021
(Justice John J. Kelley)

REPLY AFFIRMATION IN FURTHER SUPPORT OF ARTICLE 78 PETITION

JOHN DELLAPORTAS, an attorney duly admitted to practice law before the Courts of the State of New York, who is not a party to this action, hereby affirms under penalties of perjury and pursuant to CPLR 2106, as follows:

1. I am a member of the law firm of Emmet, Marvin & Martin, LLP, counsel to CORTEX TELEVISION, LLC dba The Healthcare Channel ("Petitioner") in the above-captioned Article 78 proceeding. I respectfully submit this reply affirmation: (a) in further support of the Verified Petition, brought against Respondent New York State Department of Health ("DoH") pursuant to Freedom of Information Law ("FOIL"), New York Public Officers Law § 84 *et seq.*, for a Judgment: (i) declaring that DoH acted unlawfully and with no reasonable basis in failing to produce the requested records, and that DoH must therefore release such records within five days of the date of judgment, (ii) awarding Petitioner its attorneys' fees and costs incurred in this litigation as allowed under FOIL, and (iii) granting such other and further relief as this Court may deem just and proper; and (b) in opposition to DoH's cross-motion pursuant to CPLR 511 for an Order changing the venue to Albany County.

2. In support of its Verified Petition, and in opposition to DoH's cross-motion, Petitioner respectfully states as follows:

Background

3. Petitioner brings this Article 78 proceeding in order to vindicate its and the public's right to critically important hospital data that will enable future researchers to understand the relative efficacy of treatments and approaches across hospitals in addressing COVID-19, thereby hopefully leaving the nation better prepared for the next pandemic. New York State has experienced nearly 54,000 confirmed COVID-19 deaths. Most occurred in hospitals. However, such hospital deaths have not been spread even across the hospitals of this State. Rather, certain hospitals, particularly those in the state-run New York City Health and Hospitals Corporation ("HHC"), have performed measurably worse than others, with deadly consequences for the historically disadvantaged communities those hospitals serve.

4. As discussed in the Verified Petition, Petitioner is a multimedia global portal that disseminates medical education about the latest clinical developments and controversies. Its Founder, Executive Producer and Editor-in-Chief is Steven E. Greer, MD, a New York medical doctor licensed to practice surgery after receiving residency training at New York University. Dr. Greer has published white paper and textbooks while at NYU Medical Center. Dr. Greer also received several large grants from the Veterans Affairs to conduct multi-center wound healing trials using sub-atmospheric pressure dressing. Dr. Greer pioneered new ways to treat chronic wounds in the elderly populations. In addition to his clinical and research work, Dr. Greer is a groundbreaking medical journalist. In 2012, he published an OpEd with the *Wall Street Journal* entitled "Inside ObamaCare's Grant-Making" exposing problems with an Affordable Care Act bureaucracy called the Center for Medicare and Medicaid Innovation.

5. On January 27, 2021 Petitioner filed the following FOIL Request with DoH:

1. Please provide documents that list all of the acute care hospitals controlled by the New York City Health and Hospitals Corporation (HHC), which is a New York State public benefit corporation.

2. Please documents the total number of deaths recorded at each of these HHC hospitals annually since 2016.

3. Please provide documents that detail total deaths by individual HHC hospitals from January 1, 2020 to current.

4. Please provide documents that detail total deaths by all hospitals regulated by the New York Health Department from January 1, 2020 to current, and broken down by each individual hospital.

5. Please provide documents that detail the guidelines issued by the State of New York for handling the clinical care of COVID-infected patients. These guidelines should include when and how to administer medications and ventilators.

6. Please provide documents that detail the number of COVID patients in HHC hospitals, since January of 2020, who received monoclonal antibodies, and/or remdesivir, and/or plasma from COVID patients. The data should be detailed by each individual hospital.

7. Please provide documents that detail the number of COVID patients who were treated with ventilators while admitted to an HHC hospital and their outcome (i.e. discharged alive or died while on the ventilator).

8. Please provide documents that plans to create hospice-like wards within ICUs of HHC hospitals where COVID patients were left to receive minimal care from doctors and nurses.

9. Please provide documents that detail the administration of COVID vaccines in HHC hospitals to date, detailed by each hospital.

(Collectively, the "Requests.")

6. Five months later, on May 25, 2021, DoH produced certain data responsive to Requests Nos. 1-4 and 9. However, the data was incomplete; DoH blamed a "reporting lag." DoH further stated: "After conducting a diligent search, no records responsive to parts 5, 6, and 8 of your request have been located." Petitioner appealed, but its appeal was denied.

DoH's Opposition and Cross-Motion

7. On June 10, 2021, Petitioner commenced this proceeding. *See* Doc. 1. DoH has now filed its opposition, along with a cross-motion to change venue. Although rather voluminous, most of DoH's submission appears to be boilerplate recycled from other cases.

8. The relevant parts of the opposition can be found in a Certification (Doc. 27) and an accompanying Affidavit (Doc. 19) of Rosemarie Hewig, who describes herself as "an employee of the Records Access of the New York State Department of Health." In her Certification, Ms. Hewig states that DoH "conducted a diligent search for records responsive to" Petitioner's FOIL request. In her Affidavit, she acknowledges that DoH "would have records in its possession in its role as regulator such as information that is required to be reported to the Department by hospitals," but she claims that "the relevant Programs" (a term she does not define) have somehow "confirmed" that DoH has no documents responsive to Request Nos. 5-8. She further states that a "reporting lag" of up to 180 days is acceptable for certain data.

9. In a second Affidavit (Doc. 32), Ms. Hewig argues that venue should be in Albany, because all of DoH's decision-making took place in Albany.

10. In an accompanying Memorandum of Law (Doc. 18), DoH argues that: "With respect to requests 5 through 8, after a diligent search, the Department determined that such records are not in the Department's possession. … There is ample authority that where an agency provides a certification that it is unable to find records after a diligent search, that is the end of the inquiry." *Id.* at 3, 14 (citing cases). DoH claims the case should be transferred under CPLR 506(b) because "the 'material events' … took place in Albany." DoH does not address the significance of where the missing records are located, because it claims such records do not exist.

11. For the reasons set forth below, DoH's arguments are without merit.

Argument

I. DoH's Opposition Is Without Merit Since The Requested Records Exist

12. DoH claims its self-serving Certification is "the end of the inquiry." The case law holds otherwise. In *Rattley v. New York City Police Dep't*, 96 N.Y.2d 873, 875 (2001), for example, the Court of Appeals held that, "even where an entity properly certifies that it was unable to locate requested documents after performing a diligent search, the person requesting the documents may nevertheless be entitled to a hearing on the issue where he or she can articulate a demonstrable factual basis to support the contention that the requested documents existed and were within the entity's control." (Citations omitted).

13. Petitioner has such a demonstrable factual basis here.

14. According to DoH's web site: "Reporting of suspected or confirmed communicable diseases is mandated under the New York State Sanitary Code (10NYCRR 2.10). Although physicians have primary responsibility for reporting, … health care facilities … and any other individuals/locations providing health care services are also required to report communicable diseases." https://www.health.ny.gov/professionals/diseases/reporting/communicable/. The cited Section 2.10, in turn, further provides that: "When a case which is required to be reported under section 2.1 of this Part occurs in a State institution or a facility licensed under Article 28 of the Public Health Law, the person in charge of the institution or facility shall report the case to the State Department of Health …." (Emphasis added.)

15. Upon information and belief, all eleven hospitals operated by HHC are Article 28 institutions subject to this law. *See* https://www.health.ny.gov/facilities/hospital/. As such, such hospitals must comply with the foregoing reporting requirements.

16. Significant to this case, unsurprisingly, "2019 Novel Coronavirus (COVID-19)" is

one of the "communicable diseases" for which reporting is mandatory. *See* https://health.ny.gov/forms/instructions/doh-389_instructions.pdf. As DoH further explains: "Diseases listed in bold type [COVID is among those so listed] warrant prompt action and should be reported immediately … by submission of the confidential case report form (DOH-389). In NYC use case report form PD-16." (Emphasis added.)

17. Both Form DOH-389 and PD-16 -- true and correct copies of which are annexed hereto as Exhibit A -- require the hospital to report "treatment." In other words, by law, DoH possesses the very records of COVID treatment which it claimed it could not find. Further, the "immediacy" of this reporting requirement means there should be no time "lag." Such records may not be found on the "SPARCS" program that DoH searched, but nothing in FOIL permits DoH to limit its search to just that one particular program.

18. As DoH admits in its Memorandum of Law, it "does not rely on the exemptions under the Freedom of Information Law, Section 84, *et seq.*" Doc. 18 at 3. Rather it only claims, incorrectly, that such records do not exist. They do. They should be produced without further delay. And because DoH had no reasonable basis for denying access to such records in the first place, Petitioner should be awarded attorney's fees under POL § 89(4)(c).

19. Lastly, this should be without prejudice to other responsive records DoH likely has. COVID is the most studied and recorded epidemic of our lifetimes; there are surely more records than DoH has previously identified, from a cursory search of a single database. Indeed, its denials have already proven themselves untrustworthy. Petitioner should be afforded the opportunity to take proper discovery from DoH, and conduct an evidentiary hearing as to the true scope of DoH's records, and not merely have to take DoH's word for it. New Yorkers deserve health equity. In order to get there, we must first learn what previously went wrong.

II. Venue Should Remain In New York County

20. Lastly, the case should remain in New York County. DoH's request to move the proceeding to Albany is just intended to burden Petitioner, which is not a valid basis for transfer. The statute at issue, CPLR 506(b), permits an action to be brought "where the material events otherwise took place." Had DoH conducted a proper search, the material events would have taken place in significant part in New York County, where the online records are likely located. *See* https://www.health.ny.gov/professionals/diseases/reporting/communicable/ (hospitals "belonging to NYC MED can complete and submit the form online").

21. DoH should not be rewarded for ignoring its FOIL obligations. This case is about healthcare in New York City. It should remain in New York City.

Conclusion

22. For the foregoing reasons, (a) the relief sought in the Verified Petition should be granted in full, or else the matter set down for an evidentiary hearing; and (b) the cross-motion to transfer venue to Albany County should be denied.

Dated: New York, New York
August 30, 2021

JOHN DELLAPORTAS

Exhibit A

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)
- ☐ Food Service
- ☐ Day Care
- ☐ Health Care
- ☐ Student/School
- ☐ Inmate
- ☐ Correction Worker
- ☐ Unemployed
- ☐ Retired
- ☐ Other ______________
- ☐ Unknown

Setting (resides/attends)
- ☐ Day Care Facility
- ☐ Health Care Facility
- ☐ School
- ☐ Jail/Prison
- ☐ Camp
- ☐ Homeless
- ☐ Other ______________
- ☐ Unknown

Sex
- ☐ Male
- ☐ Female
- ☐ Unknown

Pregnant
- ☐ Yes
- ☐ No
- ☐ Unknown

If Pregnant Due Date: ____/____/____

Race (Check all that apply)
- ☐ White
- ☐ Black
- ☐ Amer. Indian /Alaskan
- ☐ Asian ______________
- ☐ Native Hawaiian/ Pacific Islander ______________
- ☐ Other
- ☐ Unknown

Ethnicity
- ☐ Hispanic
- ☐ Non-Hispanic
- ☐ 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
- ☐ Sporadic
- ☐ Cluster
- ☐ Outbreak
- ☐ Unknown

Case Status
- ☐ Confirmed
- ☐ Probable
- ☐ Suspect
- ☐ Unknown

Local Health Department Signature

____

Date Form Received ____/____/______

Investigation Start Date ____/____/______

Was Patient Notified?
- ☐ Yes
- ☐ No
- ☐ Unknown

NYC Health

New York City Department of Health and Mental Hygiene

Universal Reporting Form

To report an **immediately notifiable** disease or condition, an outbreak among three or more persons or an unusual manifestation of any disease or condition, or any newly apparent or emerging disease or syndrome, call the Provider Access Line at **866-692-3641**.

Diseases and conditions in green and marked with * are **immediately notifable**; those marked with † are immediately notifiable if case meets the risk group criteria on page 2. Report by calling **866-692-3641**.

For all other diseases and conditions, report using Reporting Central online via NYCMED at **www.nyc.gov/health/nycmed**, mail this form to the NYC Department of Health and Mental Hygiene, 42-09 28th Street, CN-22, Long Island City, NY 11101, or call **866-692-3641** for the appropriate fax number.

Go to **www.nyc.gov/health/diseasereporting** for more information.

Patient Information

Patient Last Name	First Name	Middle Name	**DATE OF REPORT** ______ /______ /______
Patient AKA: Last Name	AKA: First Name	AKA: Middle Name	
Age / Date of Birth ______ /______ /______	Country of Birth	Social Security Number	**DATE OF DIAGNOSIS** ______ /______ /______
If patient is a child, Guardian Last Name	Guardian First Name	Guardian Middle Name	
Medical Record Number	Medicaid Number		**DATE OF ILLNESS ONSET** ______ /______ /______
Patient Home Address	City	State / Zip Code	

Country

Borough: ☐ Manhattan ☐ Bronx ☐ Brooklyn ☐ Queens ☐ Staten Island ☐ Unknown ☐ Not NYC

Email Address	Mobile Phone	Home Phone	☐ Homeless

Sex ☐ Male ☐ Transgender MTF ☐ Unknown ☐ Female ☐ Transgender FTM

Race ☐ Black ☐ American Indian/Alaska Native ☐ Asian ☐ Unknown ☐ White ☐ Native Hawaiian/Pacific Islander ☐ Other: ______________

Ethnicity ☐ Hispanic ☐ Unknown ☐ Non-Hispanic

Is patient alive? ☐ Yes ☐ No ☐ Unknown

If no, date of death: ______ /______ /______

Is patient pregnant? ☐ Yes ☐ No ☐ Unknown

If yes, due date: ______ /______ /______

Is case suspected to be due to healthcare associated transmission? ☐ Yes ☐ No ☐ Unknown

Was patient admitted to hospital? ☐ Yes ☐ No ☐ Unknown

Admission date: ______ /______ /______

Discharge date: ______ /______ /______

Is patient a newborn infant? ☐ Yes ☐ No ☐ Unknown

If yes, name of hospital where infant was born ______________________

Name of facility where infant's mother obtained prenatal care ______________________

Foreign travel

Countries ______________________ **Date returned to U.S.** ______ /______ /______

Other Information

REPORTER

Name of Person Reporting Disease	Email address	Phone	
Name of Facility of Person Reporting Disease	National Provider Identifier (NPI) Code	Permanent Facility Identifier (PFI) Code	
Facility Street Address	City	State	Zip Code

FACILITY

Name of Hospital/Healthcare Facility Providing Care for Patient	Facility National Provider Identifier (NPI) Code	Permanent Facility Identifier (PFI) Code	
Facility Street Address	City	State	Zip Code

LAB

Name of Testing Laboratory	Phone	CLIA Number	
Laboratory Street Address	City	State	Zip Code

PROVIDER

Name of Provider Caring for Patient	National Provider Identifier (NPI) Code	Fax	
Email address	Phone	Mobile	
Provider Street Address	City	State	Zip Code

Patient Last Name	First Name	Medical Record Number

Diseases and conditions in green and marked with * are immediately notifiable; those marked with † are immediately notifiable if case meets the risk group criteria at the bottom of the page. Report by calling **866-692-3641**.

For all other diseases and conditions, report using Reporting Central online via NYCMED at **www.nyc.gov/health/nycmed**, mail this form to the NYC Department of Health and Mental Hygiene, 42-09 28th Street, CN-22, Long Island City, NY 11101, or call **866-692-3641** for the appropriate fax number.

Go to **www.nyc.gov/health/diseasereporting** for more information.

☐ **Amebiasis**†

☐ **Anaplasmosis** (Human granulocytic anaplasmosis)

Animal bite – see Environmental Conditions section on page 3. See rabies if potential for exposure.

☐ **Anthrax***

☐ **Arboviral infections,** acute*

Specify which virus: ______________
If Chikungunya, Dengue, West Nile, Yellow Fever or Zika report as such.
Attach copies of diagnostic laboratory results if available.

☐ **Babesiosis**

☐ **Botulism***
○ Foodborne ○ Infant ○ Wound

☐ **Brucellosis***

☐ **Campylobacteriosis**†

Carbon Monoxide poisoning* – see Poisonings section on page 3

Chancroid – see STD section on page 4

☐ **Chikungunya**

Chlamydia – see STD section on page 4

☐ **Cholera***

Creutzfeldt-Jakob disease – see Transmissable spongiform encephalopathy

☐ **Cryptosporidiosis**†

☐ **Cyclosporiasis**†

☐ **Dengue**
Attach copies of dengue diagnostic laboratory results if available.

☐ **Diphtheria***

Drownings – see Environmental Conditions section on page 3

☐ **Ehrlichiosis** (Human monocytic ehrlichiosis)
If human granulocytic anaplasmosis report as anaplasmosis.

☐ **Encephalitis**
If Jul.1–Oct. 31 consider and test for West Nile virus. If due to another reportable disease (e.g. Lyme, West Nile, arbovirus), report under the other disease.

☐ ***Escherichia coli*** 0157:H7 infection†

Falls from windows – see Environmental Conditions section on page 3

☐ **Food poisoning** in a group of 2 or more individuals*

☐ **Giardiasis**†

☐ **Glanders***

Gonorrhea – see STD section on page 4

Granuloma inguinale – see STD section on page 4

☐ ***Haemophilus influenzae*** (invasive disease)†

Test type:
○ Culture ○ Antigen
○ PCR ○ Gram stain
○ Other ______________

Specimen Source:
○ Blood ○ CSF ○ Unknown
○ Other ______________

Specify Serotype:
○ Type B ○ Not typeable
○ Not tested ○ Unknown
○ Other ______________

☐ **Hantavirus disease***

☐ **Hemolytic uremic syndrome**

FOR ALL HEPATITIS REPORTS

Jaundice ○ Yes ○ No ○ Unknown

ALT (SGPT) value:________ ○ Unknown

Lab reference range:________ ○ Unknown

☐ **Hepatitis A**†
Total Ab to Hepatitis A is NOT reportable.
IgM anti-HAV: ○ Pos ○ Neg ○ Unknown

☐ **Hepatitis B**†
Report at least one positive hepatitis B test result.
Total Ab to Hepatitis B is not reportable.

IgM anti-HBc:	○ Pos	○ Neg	○ Unknown
HBsAg:	○ Pos	○ Neg	○ Unknown
HBeAg:	○ Pos	○ Neg	○ Unknown
HBV Nucleic Acid:	○ Pos	○ Neg	○ Unknown

If IgM is positive, describe symptoms and risk in comments box on last page.

Hepatitis B in pregnancy
Report cases in Reporting Central or fax IMM-5 form to 347-396-2558. For more information, call 347-396-2403.

☐ **Hepatitis C**†
Check all that apply:
○ EIA pos
○ HCV Nucleic Acid (e.g.PCR) pos

Is this an acute infection?
○ Yes
○ No
○ Unknown

Herpes, neonatal – see STD section on page 4

HIV/AIDS
Report using the New York State Provider Report Form (PRF). Call 518-474-4284 for forms or 212-442-3388 for more information.

Influenza
☐ Suspected novel viral strain with pandemic potential (e.g., avian H5N1 or H7N9)*
☐ Death in a child aged 18 or younger

Lead poisoning – see Poisonings section on page 3

☐ **Legionellosis**†
Specify positive test:
○ Culture ○ Urine antigen
○ DFA ○ Serology
○ NAAT or PCR

☐ **Leprosy** (Hansen's disease)

☐ **Leptospirosis**

☐ **Listeriosis**†

☐ **Lyme disease**
Erythema migrans present?
○ Yes ○ No ○ Unknown

☐ **Lymphocytic choriomeningitis virus**

Lymphogranuloma venereum – see STD section on page 4

☐ **Malaria**†
Select at least one of the following:
○ falciparum ○ vivax ○ malariae
○ ovale ○ undetermined
Complete Foreign Travel section on page 1.

☐ **Measles** (rubeola)*

☐ **Melioidosis***

☐ **Meningitis,** bacterial
Specify bacteria identified ______________

☐ **Meningococcal disease,** invasive (including meningitis) *
Test type/Specimen source:
○ Blood culture ○ CSF culture
○ Antigen test from CSF ○ Gram stain
○ PCR ○ Other ______________

☐ **Monkeypox***

☐ **Mumps**†

☐ **Paratyphoid fever**†

☐ **Pertussis** (whooping cough)†

☐ **Pesticide poisoning** - see Poisonings section on page 3

☐ **Plague***

Poisoning – see Poisonings section on page 3

☐ **Poliomyelitis***

☐ **Psittacosis**

☐ **Q Fever***

☐ **Rabies** and **exposure to rabies*** – see animal bites in Environmental Conditions section on page 3

☐ **Ricin poisoning***

☐ **Rickettsialpox**

☐ **Rocky Mountain spotted fever**

☐ **Rubella** (German measles)*

☐ **Rubella syndrome,** congenital

☐ **Salmonellosis**†
Serogroup: ______________
If due to Salmonella typhi or paratyphi, select Typhoid or Paratyphoid Fever.

☐ **Severe or novel coronavirus** (e.g., SARS or MERS-CoV)*

☐ **Shiga-toxin** producing *Escherichia coli* (STEC) infection†

☐ **Shigellosis**†

☐ **Smallpox** (variola)*

☐ **Staphylococcal enterotoxin B poisoning***

☐ ***Staphylococcus aureus,*** vancomycin intermediate (VISA) and resistant (VRSA)*
Source: ________
MIC (µg/ml): ______

☐ ***Streptococcus*** (Group A and B) invasive†
Specify Source: ○ Blood ○ CSF ○ Unknown
○ Other, Specify:__________

Syphilis, including congenital – see STD section on page 4

☐ **Tetanus**

☐ **Toxic shock syndrome**

☐ **Trachoma**

☐ **Transmissible spongiform encephalopathy**
(Creutzfeldt-Jakob disease and variants)
Testing done: ______________
(e.g. 14-3-3 on CSF, brain biopsy, autopsy, EEG/MRI)

☐ **Trichinosis**

Tuberculosis – see Tuberculosis section on page 3

☐ **Tularemia***

☐ **Typhoid fever**†

☐ **Vaccinia disease** (adverse events associated with smallpox vaccination)*

☐ ***Vibrio*** **species,** non-cholera
Specify species:______________

☐ **Viral hemorrhagic fever***

☐ **West Nile** fever and viral neuroinvasive disease (e.g., meningitis and encephalitis)
Attach copies of diagnostic laboratory results if available.

☐ **Yellow fever***
Attach copies of diagnostic laboratory results if available.

☐ **Yersiniosis,** non-plague†

☐ **Zika**

*Report suspected and confirmed cases immediately to 1-866-692-3641 †If case meets any of the risk group criteria below, report immediately to 1-866-692-3641

Risk Groups for Disease Exposure/Transmission

Complete this section for diseases marked with † and if case meets any criteria, report it immediately to 1-866-692-3641.

Patient works in:	☐ Childcare	☐ Health care facility	☐ Long-term care facility/Nursing home	☐ Clinical/Research laboratory
☐ Unknown	☐ Food service	☐ Correctional facility	☐ Position with routine animal contact	☐ Other ______________

Patient attends/resides in:	☐ Assisted living facility	☐ School	☐ Dormitory	☐ Long-term care facility/nursing home
☐ Unknown	☐ Correctional facility	☐ Shelter	☐ Day care/group baby-sit	☐ Other congregate living facility (specify: ______________)

Patient Last Name	First Name	Medical Record Number

Environmental Conditions

☐ **Animal bites**

☐ **Exposure to rabies***
Including a bite or other exposure to any animal confirmed to have rabies, or from any rabies vector species (raccoon, bat, skunk, fox or coyote), or any mammal exhibiting signs suggestive of rabies.

Animal Species: ______________________
Breed: ______________ Color(s): ______________
◯ Owned ◯ Stray ◯ Unknown
Owner's Name: ______________________
Address: ______________________
City, State, Zip: ______________________
Phone: ______________________

Date of Bite: ______ / ______ / ______ Area of body bitten:
Activity at time of bite: ______________________
Place of occurrence: ______________________
Treatment given: ______________________
Rabies prophylaxis ◯ Yes ◯ No
HRIG ◯ Yes ◯ No
Rabies Vaccine ◯ Yes ◯ No

☐ **Drownings**
Respiratory impairment from submersion/immersion in liquid.
Drowning Location: ______________________
Outcome: ◯ Death ◯ Morbidity ◯ No Morbidity

☐ **Window Falls**
Falls from windows of buildings with 3 or more dwellings, by children aged 16 years and younger, report by calling 646-632-6204 or on Child Window Fall Notification Report paper form.

Poisonings

ROUTE OF EXPOSURE
◯ Ingestion
◯ Ocular
◯ Dermal
◯ Inhalation
◯ Aural
◯ Bite
◯ Sting
◯ IV

CHEMICAL
☐ **Lead**
For persons aged 16 and older indicate:
Employer ______________________
Employer phone ______________________
☐ **Carbon Monoxide***
Source: ◯ Furnace/Boiler ◯ Generator ◯ Vehicle ◯ Other ______________
☐ **Arsenic** ☐ **Cadmium**
☐ **Mercury** ☐ **Pesticide**
☐ **Other** ______________________

QUANTITY
◯ Milliliter (mL) ______
◯ Mouthful ______
◯ Sip ______
◯ Tablespoon ______
◯ Tab/pill/cap ______
◯ Taste/lick/drop ______
◯ Teaspoon ______
◯ Unknown

DATE AND TIME OF EXPOSURE
______ / ______ / ______
______ : ______
◯ AM ◯ PM

REASON AND SETTING
Unintentional:
◯ General
◯ Environmental
○ Indoor ○ Outdoor
◯ Misuse
◯ Bite/sting
◯ Food poisoning
◯ Occupational
◯ Dietary
◯ Consumer product
◯ Pesticide
◯ Medication (accidental ingestion)
◯ Unknown

Intentional:
◯ Suspected suicide
◯ Misuse
◯ Abuse
◯ Unknown

Other:
◯ Contamination/tampering
◯ Malicious
◯ Withdrawal

Adverse reaction:
◯ Drug
◯ Food
◯ Other
◯ Unknown

SYMPTOM ASSESSMENT (Check all that apply)
◯ None
◯ Nausea/vomiting/diarrhea
◯ Lethargic/stupor/coma
◯ Agitated
◯ Hypertensive
◯ Hypotensive
◯ Tachycardia
◯ Brachycardia
◯ Seizure
◯ Electrolyte abnormalities
◯ Cough/shortness of breath
◯ Occular irritation
◯ Skin irritation
◯ Unknown
◯ Other ______________

PROVIDER TREATMENT
◯ No therapy required
◯ Oral fluids
◯ Emesis
◯ Lavage
◯ Activated charcoal
◯ Cathartic
◯ Chelation
◯ Insect sting mgmt.
◯ Irrigated eye
◯ Oxygen
◯ Naxolone
◯ 50% Dextrose/Thiamine
◯ Alkalinize urine
◯ N-acetylcysteine (Mucromyst)
◯ Other ______________

SPECIMEN SOURCE
◯ Capillary ◯ Venous ◯ Urine
◯ Other ______________
Date Collected
______ / ______ / ______
Date Analyzed
______ / ______ / ______

Laboratory Accession Number
____
Results (units) ______________
Purpose of test:
◯ Initial ◯ Repeat
◯ Follow-up

VITAL SIGNS
Body Weight ______________
◯ Pounds ◯ Kilograms
BP: __ __ __/ __ __ __
Resp: ______
Temp: ______ ○ F ○ C
Pulse: ______
Pupils:
◯ Dilated
◯ Constricted

Tuberculosis

Patient status at time of reporting:
◯ < 5 years old with LTBI
◯ TB suspect or case

Indicate all sites of disease for TB suspect or case:
◯ Pulmonary
◯ Lymphatic
◯ Bone/Joint
◯ Soft tissue/Muscles
◯ Peritoneal
◯ Meningeal
◯ Genitourinary
◯ Gastrointestinal
◯ Other: ______________

Collection date: ___ /___ /___ ◯ Unknown

Laboratory Results:
Specimen Number: ______________
◯ Unknown

Specimen Source:
◯ Sputum
◯ Tracheal aspirate
◯ Bronchial fluid/Broncho-alveolar lavage
◯ Lymph node
◯ Lung tissue
◯ Pleural fluid
◯ Pleura
◯ Blood
◯ Urine
◯ Other: ______________________

AFB Smear:
◯ Positive
Smear Grade: ○ suspicious
○ 1+ rare ○ 2+ few
○ 3+ moderate ○ 4+ numerous
◯ Negative ◯ Pending
◯ Not Done ◯ Unknown

Nucleic Acid Amplification (NAA):
Test type: ______________
◯ Positive ◯ Negative
◯ Pending ◯ Not Done
◯ Unknown

Mutation analysis test type: ______________
Mutation detected?
◯ Yes ◯ No ◯ Unknown
If yes, list the genes with mutations: ______________

M. tb Complex Culture:
◯ Positive ◯ Negative
◯ Pending ◯ Contaminated
◯ Not Done ◯ Unknown

Pathology consistent with TB:
◯ Yes ◯ No ◯ Not Done ◯ Unknown
Date: ______ / ______ / ______
Pathology Specimen Number: ______________
Pathology Specimen Source ______________
Pathology Findings: ______________

Chest X-Ray: ______ / ______ / ______
◯ Normal
◯ Abnormal
○ Consistent with TB
○ Evidence of Cavity
○ Evidence of Miliary TB
○ Not consistent with TB

CT Scan ◯ / MRI ◯ ___ /___ /___
Body Site:
◯ Chest ◯ Neck
◯ Abdomen ◯ Pelvis
◯ Head ◯ Spine
◯ Unknown ◯ Other: ______________

◯ Normal
◯ Abnormal
○ Consistent with TB
○ Evidence of Cavity
○ Evidence of Miliary TB
○ Not consistent with TB

Test for TB Infection:
◯ History of positive test result
Year (yyyy): ______
Date of most recent test: ____ /____ /______
Type of Test:
◯ Tuberculin Skin Test (TST/PPD)
◯ QuantiFERON® TB-Gold in tube (QFT-GIT)
◯ T-Spot.TB
◯ Other: ______________
Result:
◯ Positive ◯ Negative ◯ Unknown
◯ Indeterminate ◯ Borderline
Induration ______________ mm

Treatment: On Anti-TB Medications ◯ Yes ◯ No ◯ Unknown

Please complete for each medication: Dose (mg) Frequency/day Start Date

Medication	Dose (mg)	Frequency/day	Start Date
Isoniazid (INH)			/ /
Rifampin (RIF)			/ /
Pyrazinamide (PZA)			/ /
Ethambutol (EMB)			/ /
Other 1 ______			/ /
Other 2 ______			/ /
Other 3 ______			/ /

Airborne Isolation: ◯ Yes ◯ No ◯ Unknown
If yes, date initiated: ____ /____ /____ Date discontinued: ____ /____ /____
Describe other medical problems or other pertinent information in the comments box on the last page.

*Report suspected and confirmed cases immediately to 1-866-692-3641 [†]If case meets any of the risk group criteria on page 2, report immediately to 1-866-692-3641.

Patient Last Name	First Name	Medical Record Number

Sexually Transmitted Diseases

For All STD Reports

As of the date of this report,

Were any of this patient's sex partners notified of possible exposure to an STD? (Check all that apply)
- ◯ Yes, our office notified the partner(s)
- ◯ Yes, the patient was asked to notify partner(s)
- ◯ No
- ◯ Unknown

Did you provide treatment for any of this patient's partners? (Check all that apply)
- ◯ Yes, I saw the sex partner(s) in my office
- ◯ Yes, I gave extra medication for ___(#) partner(s)
- ◯ Yes, I wrote a prescription for ___(#) partner(s)
- ◯ Yes, some other way (specify):_______
- ◯ No
- ◯ Unknown

Is the patient on pre-exposure prophylaxis (PrEP) to prevent HIV infection?
- ◯ Yes, started PrEP at time of current STD diagnosis
- ◯ Yes, already on PrEP at time of current STD diagnosis
- ◯ No
- ◯ Unknown

Please indicate gender of sexual partners in the past year: (Check all that apply)
- ◯ Males
- ◯ Females
- ◯ Transgender Male to Female
- ◯ Transgender Female to Male
- ◯ Unknown

☐ **Chancroid**

Specify type of specimen:
◯ Penile ◯ Vaginal ◯ Endocervical
◯ Anorectal ◯ Oropharyngeal
◯ Other: ______________________

Specimen collection date: _____ /_____ /______

Treatment: ______________________

Treatment date: ____/____/____ ◯ Unknown

☐ **Chlamydia** (CT)

Specify type of specimen:
◯ Endocervical ◯ Urethral ◯ Anorectal
◯ Oropharyngeal ◯ Urine
◯ Other: ______________________

Specify test type:
◯ Culture ◯ Nucleic acid amplification
◯ Nucleic acid hybridization
◯ EIA ◯ DFA
◯ Other: ______________________

Specimen collection date: ____ /____ /______

Treatment: ______________________

Treatment date:___/____/___ ◯ Unknown

☐ **Gonorrhea*** (GC)

Specify type of specimen:
◯ Endocervical ◯ Urethral ◯ Anorectal
◯ Oropharyngeal ◯ Urine
◯ Other: ______________________

Specify test type:
◯ Culture ◯ Nucleic acid amplification
◯ Nucleic acid hybridization
◯ Other: ______________________

Specimen collection date: _____ /_____ /______

Treatment 1*: ________________mg/gram

Treatment 2*: ________________mg/gram

Treatment date: ____ /____ /____ ◯ Unknown

☐ **Granuloma inguinale**

Specify type of specimen:
◯ Penile ◯ Vaginal ◯ Endocervical
◯ Anorectal ◯ Oropharyngeal
◯ Other ______________________

Specimen collection date: ______ /____ /______

Treatment: ______________________

Treatment date: ____/____/_____ ◯ Unknown

☐ **Herpes, neonatal**

Herpes simplex virus infection in infants aged 60 days and younger.

◯ Clinical diagnosis

◯ Lab confirmed diagnosis
◯ Culture ◯ PCR
◯ Other ______________________

Herpes type: ◯ Type 1 ◯ Type 2 ◯ Not typed

Clinical Syndrome (Check all that apply)
◯ Skin, eye, mucous membrane infection
◯ CNS involvement
◯ Disseminated disease

Herpes lesions present?
◯ Yes, anatomic site________________
◯ No
◯ Unknown

Specimen collection date:____ /____ / ___

Treatment for infant:__________________

Treatment date: ____/____/___ ◯ Unknown

Mother's Name: ____________________

Mother's DOB: ____ /____ /______

Birth Hospital ____________________

Mother's Labor and Delivery Medical Record No:

____

____

☐ **Lymphogranuloma venereum**

Clinical Presentation (Check all that apply)
◯ Proctitis ◯ Lymphadenopathy
◯ Buboe ◯ Skin lesion
◯ Other: ______________

Specimen collection date: ____ /____ /______

Treatment: ______________________

Treatment date: ____/____/____ ◯ Unknown

☐ **Syphilis****

Stage:
◯ Congenital
◯ Primary, chancre present (Check all that apply)
◯ Penile ◯ Vaginal ◯ Endocervical
◯ Anorectal ◯ Oropharyngeal
◯ Other: ______________________
◯ Secondary (Check all that apply)
◯ Alopecia ◯ Condylomata
◯ Mucous patches ◯ Rash
◯ Early Latent
no symptoms, infection ≤ 1 year duration
◯ Late Latent
no symptoms, infection of > 1 year duration
◯ Tertiary, gumma or cardiovascular

Neurologic symptoms present?
◯ Yes ◯ No ◯ Unknown

Ocular symptoms present?
◯ Yes ◯ No ◯ Unknown

Otic symptoms present?
◯ Yes ◯ No ◯ Unknown

Treatment – list medication and dosage below:

____

____

____

Treatment date:___ /____ /___ ◯ Unknown

Continue to next column

Syphilis Test Types: (Check all that apply)

1. Serologic tests for syphilis

A. Non-treponemal Test

◯ RPR ◯ Reactive ◯ Non-reactive

Titer ______________________

◯ VDRL ◯ Reactive ◯ Non-reactive

Titer ______________________

Specimen collection date: _____ /_____ /______

B. Treponemal Test

◯ TP-PA/MHA-TP ◯ Reactive ◯ Non-reactive

◯ FTA ◯ Reactive ◯ Non-reactive

◯ Treponemal IgG ◯ Reactive ◯ Non-reactive

Specimen collection date: _____ /_____ /______

2. Cerebrospinal fluid tests

◯ CSF VDRL ◯ Reactive ◯ Non-reactive

◯ CSF FTA ◯ Reactive ◯ Non-reactive

◯ Other Test: ____________ Result ___________

Specimen collection date: _____ /_____ /______

◯ Elevated CSF protein ◯ Yes ◯ No

◯ Elevated CSF leukocytes ◯ Yes ◯ No

Specimen collection date: _____ /_____ /___

3. Organism visualization

◯ Darkfield ◯ Positive ◯ Negative

◯ Other Test: ____________ Result ___________

Specimen collection date: _____ /_____ /______

* For uncomplicated gonococcal infections of the cervix, urethra, anorectum or pharynx, CDC recommends dual therapy (irrespective of concurrent chlamydial infection) using BOTH Ceftriaxone 250mg IM AND Azithromycin 1g PO.

** Licensed health care providers can access current and historical syphilis test results and treatment information in the New York City Syphilis Registry to inform the diagnosis and management of syphilis in their patients. For more information, see the Syphilis Registry check at: http://www1.nyc.gov/assets/doh/downloads/pdf/std/hcp-syphilis-registry-check.pdf, or call 347-396-7201

Comments: