

**NYC DOHMH Guidance Document for
Development of Protocols for Management of Patients Presenting to
Hospital Emergency Departments and Clinics with
Potentially Communicable Diseases of Public Health Concern**

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Introduction

Emerging communicable diseases worldwide pose a potential threat to the New York City healthcare system. In an increasingly connected world, novel infections can easily be introduced by international travel. Recent outbreaks of Severe Acute Respiratory Syndrome (SARS) (2003), Middle East Respiratory Syndrome (MERS-CoV) (2012-14), measles (2014), and Ebola virus disease (2014) highlight the importance of rapidly identifying, isolating, and appropriately managing the care of patients with highly communicable diseases of public health concern in order to prevent nosocomial spread of illness to other patients, staff, and visitors. Emergency departments (EDs) and clinics are important and vulnerable points of entry into hospitals, and effective strategies for triage applied in these settings will have great impact on minimizing nosocomial transmission within and beyond the ED and clinics. Expertise gained in planning for ED and outpatient communicable disease triage will also be useful in identifying and controlling infectious diseases in other clinical settings.

Background for this guidance document

The following guidance document has been prepared to assist hospitals in developing or updating their protocols for screening and isolation for potentially communicable diseases of public health concern (i.e., diseases with greater likelihood of spread to others, and with higher likelihoods of more severe morbidity or mortality; see Appendix A: *Examples of Potentially Communicable Disease of Public Health Concern*) in their EDs and clinics. This document provides guidance for a single patient presenting to the ED or outpatient clinic with fever and rash, fever and respiratory symptoms, or symptoms and travel history suggestive of a communicable disease of public health concern (e.g., measles, novel severe coronaviruses such as MERS and SARS, novel strains of influenza with pandemic potential such as H7N9, smallpox, viral hemorrhagic fever, or plague)

Purpose of the guidance document

The primary objective of this guidance is to provide a template from which hospitals may operationalize plans for screening, isolation, and reporting of diseases of public health concern in order to:

- 1.) Enhance early recognition of a patient who may have a communicable disease of public health concern upon arrival at the hospital ED or clinic, and
- 2.) Prompt the rapid institution of infection control measures to minimize potential transmission to staff, patients and visitors.

This guidance document is meant to provide a standardized format for hospitals to develop customized ED/clinic screening and isolation protocols. Protocols developed using this guidance document should evolve as needed to fit the needs and culture of each hospital and should be updated or appended as necessary for specific outbreaks or emerging diseases. The NYC DOHMH Health Alert Network (<http://dohmhport/sites/NYCHAN/WebPages/home.aspx>), CDC Health Alert Network (<http://emergency.cdc.gov/HAN/>) and the CDC website (www.cdc.gov) will provide the most up to date information about specific outbreaks and emerging diseases.

This guidance document is not intended to replace or supersede existing New York state rules or regulations relating to infection control in healthcare settings.

Regular trainings and drills for frontline staff (triage, reception, security as well as nursing and medical staff) on the measures outlined in this protocol, including notification procedures, are essential to ensure adherence to these guidelines.

Limitations to the use of this guidance document

The New York City Department of Health and Mental Hygiene (NYC DOHMH) recognizes that there are limitations to these guidelines that may make implementation challenging, especially in certain settings. Factors that may limit the ability to adhere to this guidance include:

- ❑ During the winter respiratory viral season, when larger numbers of patients present with fever and respiratory symptoms, it may be more difficult to recognize patients who may present with nonspecific, prodromal symptoms of communicable diseases that are of greater public health concern (e.g., index patient with SARS presenting at the peak of the winter influenza season)
- ❑ Limitations in hospital surge capacity to handle larger numbers of potentially contagious patients (e.g., limited airborne infection isolation rooms {AIIRs}, or small waiting rooms that do not easily allow hospitals or clinics to separate patients with fever and cough or rash symptoms)

How to use the guidance document

The guidance document contains four sections:

- 1) Initial patient identification
- 2) Initial infection control measures
- 3) Notification and patient evaluation
- 4) Identification and management of exposed persons in ED/clinics.

In each section, this document provides suggested text and/or examples. Sections that the DOHMH considers critical to an effective triage protocol for potentially contagious patients are highlighted in **bold and underlined** text. If appropriate for your facility, the text and/or examples can be incorporated directly into your hospital protocol. If needed, space is provided after each section to allow hospitals to add information from facility-specific plans.

NYC DOHMH recommends that each hospital convene a working group composed of staff from key hospital departments to review and sign off on the finalized hospital screening/isolation protocol. Suggested members for your hospital working group would include Emergency Department, Infection Control/ Infectious Disease, Hospital Administration, Security, Housekeeping, and/or Facility Engineering. A representative from Infection Control or Infectious Disease should always be included.

Hospitals are encouraged to use standard terminology and approaches that are consistent with recommendations by the Centers for Disease Control and Prevention (CDC) and their Healthcare Infection Control Practices Advisory Committee (HICPAC). A copy of the *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings* from HICPAC is available at: <http://www.cdc.gov/hicpac/pdf/isolation/isolation2007.pdf>.

Guidance for development of screening and isolation protocol for a single patient entering the Emergency Department (ED) or outpatient clinic with illness concerning for a highly communicable disease of public health concern

1. Initial Patient Identification:

Effective screening for potentially infectious patients, especially those who may be at risk for airborne, droplet, or contact transmission of infectious agents to others, is critical to ensure prompt identification and isolation as soon as possible after patient arrival. The following measures are recommended to be routinely in place to help decrease transmission of infectious agents to staff, visitors and other patients:

(Note: Sections a and b below should be considered standard measures for all EDs and clinics to have in place at all times.)

- a. **Place signage, surgical masks and alcohol-based hand hygiene products as close as possible to all entranceways to ED/clinics so that they are available to all patients and visitors upon entry to the ED/clinic.**

Signage (described below) should be clearly visible.

Boxes of tissues, waste baskets, and alcohol-based hand hygiene products should be placed throughout the ED/clinic waiting areas and examination rooms.

1. Signage should contain simple, clear messages in large font stating that all patients with fever and/or respiratory symptoms or rash should wear a mask and perform hand hygiene with the alcohol-based hand hygiene products available at the entranceway. They should then proceed directly to the registration desk and/or triage nurse and alert staff to their symptoms.
2. Signage should also indicate, using simple, clear messages in large font, that patients with recent travel outside the US and fever, cough, or rash should alert staff immediately.
3. Signage should show patients how to wear masks and how to use the alcohol-based hand hygiene products correctly.
4. Other options: Show a streaming video on TV/media equipment in ED/clinic waiting areas that demonstrate proper methods for hand hygiene, use of surgical mask, and how patients should alert ED/clinic staff if they have fever and respiratory or rash symptoms.
5. Respiratory hygiene, triage, and hand hygiene posters are available through the NYC DOHMH website in several languages. *[Note: Many are located under the specific disease of concern and are linked on the NYC DOHMH website for health care providers: <http://www.nyc.gov/html/doh/html/hcp/infectious-diseases.shtml>]*

(Note: List other locations in hospital where signage, masks and alcohol hand gels/wipes will be placed):

- b. **Signage should be in all languages that are appropriate for your patient community.**
(Note: List languages that will be used for signage at your facility):

- c. Which title(s) in your hospital will be responsible for posting the signage and determining the location of the signage/alcohol-based hygiene products/masks?

- d. **Triage/screening staff should have a reminder system that will prompt them to perform communicable disease screening for respiratory or rash communicable diseases of potential public health concern on ALL patients who present or self-identify with a fever.** Screening should include asking all patients with fever about the presence of respiratory symptoms (cough or shortness of breath) and rash symptoms, as well as epidemiologic risk factors, such as recent travel. Suggested screening questions are provided below. These recommendations are general and may need to be modified based on current events. Consult The NYC DOHMH Health Alert Network (<http://dohmhport/sites/NYCHAN/WebPages/home.aspx>), NYC DOHMH website (<http://www.nyc.gov/html/doh/html/hcp/infectious-diseases.shtml>), CDC Health Alert Network (<http://emergency.cdc.gov/HAN/>) and the CDC website (www.cdc.gov) will provide the most up to date information about specific outbreaks and emerging diseases (see e., below).

The following question should be asked of all patients at initial screening (See attached flow diagram):

- In the past 2 weeks, have you had a fever (elevated temperatures)?

└─→ If afebrile during past 2 weeks, communicable disease triage screen is **negative**

If patient reports fever in the past 2 weeks, ask the following:

- In the past 2 weeks, have you had a rash or unusual skin lesion?

└─→ If patient had fever and rash in past 2 weeks, communicable disease triage screen is **positive**

- In the past 2 weeks, have you traveled outside the United States or had close contact with someone who traveled outside the United States?

└─→ If patient had fever and travel to an area currently experiencing or at risk for a communicable disease outbreak of public health concern (eg, country currently experiencing outbreak of novel influenza or viral hemorrhagic fever), then the communicable disease screen is **positive**

- In the past 2 weeks, have you had cough, shortness of breath, or trouble breathing?
 └─ *If patient reports fever and respiratory symptoms, ask the following questions:*
- Are you a healthcare worker (eg, nurse, physician, ancillary services personnel, allied health services personnel, hospital volunteer) who has had recent exposure to a person with a highly communicable disease or an unexplained, severe febrile respiratory illness or rash disease?
- Do any of the people that you have close contact with at home, work, school, or among your friends have similar symptoms?
 └─ *If patient reports fever and respiratory symptoms and one of the epidemiologic criteria above (HCW with recent exposure or part of a cluster of 2 or more persons with febrile respiratory illness), communicable disease screen is **positive***

Summary of positive screen criteria:

- Fever and rash
 - Fever and travel to outbreak area
 - Fever and respiratory symptoms with epidemiologic risk factors:
 - Healthcare related exposures
 - Part of a cluster of two or more persons with similar symptoms
- e. *Outbreaks or emerging infections may require modifications to your hospital's screening triage questions, or to the countries currently considered to pose a risk for specific infectious diseases in returning travelers. **Which title(s) in your hospital will be responsible for regularly notifying triage, ED, and outpatient clinic staff about current outbreaks, travel advisories, or emerging infections?***
[Note: consult NYC DOHMH website, DOHMH Health Alert Network, and CDC travel website for up to date information on these topics]

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- f. **Patients who meet criteria above for a positive communicable disease triage screen should be prioritized for individual placement in an Airborne Infection Isolation Room (AIIR) or private room with door closed pending clinical evaluation. Both patient and triage staff should perform hand hygiene. Time that patient arrived in the ED/clinic and time that patient was placed in isolation should be documented in the patient chart.**
- g. Hospitals may consider any of the following methods to help prompt staff to routinely use this communicable disease triage screening tool:
- 1 - A poster or desk chart that is placed in a location that is easily seen by the triage or registration staff.
 - 2 – Including the communicable disease triage screening questions on all paper-based registration or triage forms, or a sticker that is placed on all forms for patients who report fever.

3 -- In hospitals with computerized ED or clinic registration systems, adding a computer prompt that asks all patients about fever symptoms. For patients who report fever, the communicable disease triage screening tool will automatically pop-up on the computer screen.

[Note: List methods that your hospital uses or will use to ensure that triage/screening staff queries all patients regarding fever and respiratory/rash symptoms on initial encounter.]

- i. _____
- ii. _____

2. Initial Infection Control Measures:

When a patient with a positive communicable disease triage screen is identified, prompt implementation of Standard Precautions, respiratory hygiene/cough etiquette, and appropriate isolation precautions (ie, contact, extended contact, droplet, or airborne) based on the known or likely routes of transmission of the suspected infection will decrease the risk of transmission to others.

- a. **The patient should be given a surgical mask immediately, if not already wearing one.** The patient should be shown how to wear the mask and instructed to wear this mask at all times. The patient should keep the mask on at all times while in the isolation room (unless it is an AIIR) in order to minimize contamination of the room. The patient should be instructed on how to perform hand hygiene after coughing or other contact with respiratory secretions, bodily fluids, or their rash.

[NOTE: The following considerations should be made for patients who may have difficulty breathing with a mask on, such as allowing a looser fit of the surgical mask (e.g., surgical masks with ties) or providing them with their own supply of tissues. Strict hand hygiene should be reinforced for these individuals.]

Surgical masks may not be feasible for young children with a positive communicable disease triage screen to wear. In these situations, the child and accompanying adults should be seen as quickly as possible by the triage staff and placed in an appropriate isolation room or an area in the waiting room in a way that allows at least 3 feet separation from other persons. The parents should be instructed to wash their hands and their children's hands with soap and water, or alcohol-based hand hygiene products frequently, especially after the child coughs, sneezes or has other direct contact with oral secretions or other bodily fluids.

- b. **Patients should be separated from other patients, visitors, and non-essential staff pending medical evaluation.** Depending on the space resources available in the hospital ED or clinic, and the transmission of the suspected disease, isolation options in decreasing order of preference include:

- 1. Airborne Infection Isolation Room (AIIR): negative pressure isolation rooms with a minimum of 6-12 air exchanges per hour and direct exhaust to the outside which is located more than 25 feet from an air intake and from where people may

pass (if air cannot be exhausted directly to the outside more than 25 feet from an air intake and from where people may pass, then air should be filtered through an appropriately installed and maintained HEPA filter). These rooms should be tested monthly (and daily when in use) to verify negative airflow.

2. Pre-identified enclosed private room(s): an examination room with a door that is kept closed to the hallway. (Self-closing doors are preferable). **(Note: These rooms should be tested by Facility Engineering beforehand to ensure that the rooms are exhausted appropriately (i.e., not positive pressure and do not share airflow with other rooms.)**
3. Pre-identified examination area, even if not individual rooms, to cohort patients with similar symptoms. Patients should be separated from each others by at least three feet (more if possible).
4. If an AIIR, private room or pre-identified examination area is not available, the patient should be asked to stay in an area of the waiting room that allows at least three feet of separation between the patient and others in the waiting area. The patients should be instructed to keep the surgical mask on at all times while in the waiting area and discouraged from walking around the ED/clinic.
5. Portable isolation chambers can also be considered as an alternative if neither AIIR nor private rooms are available.

[Note: List options that may be available in your hospital to separate or isolate patients with a positive communicable disease triage screen]

6. Limit as much as possible the number of persons who enter the patient's room, as well as the traffic in and out. Entry should be limited to essential hospital staff and public health personnel. Visitors should be excluded, as much as possible, from entering the patient's room.

[Note: Please add any additional information regarding how your hospital will manage individuals who accompany the patients with a positive communicable disease triage screen while awaiting clinical evaluation of the patient. Special consideration may be needed for families with small children that present together.]

- c. **Setup of the AIIR or isolation room should facilitate the use of appropriate PPE and other infection control measures (eg, hand hygiene) by healthcare workers. Appropriate infection control signage based upon the route of transmission for the suspected disease of concern and/or Hospital Infection Control policies should be posted outside the patient's isolation room signifying the need for precautions until a medical evaluation and if indicated, consultation with the**

DOHMH, determines that the patient does not have a contagious disease requiring isolation.

At a minimum, standard, droplet and contact precautions should be used for all patients with a positive communicable disease triage screen. Airborne or extended contact precautions should be used depending on the suspected disease of concern.

The management of PPE disposal should be consistent with your hospital's infection control policies.

1. All appropriate PPE should be stocked outside the door to the patient's AIIR or isolation room. Appropriate PPE for select pathogens can be found at the CDC website: <http://www.cdc.gov/ncidod/hip/ISOLAT/ISOLAT.HTM> as well as in the *2007 HICPAC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: Appendix A. Type and duration of precautions needed for selected infections and conditions* (<http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>).

Signage on the proper method of donning and removing PPE should be prominently displayed outside or nearby all AIIRs in the ED and clinics. [Note: posters detailing the sequence for donning and doffing PPE are available at: <http://www.cdc.gov/vhf/ebola/pdf/ppe-poster.pdf>] Alcohol hand hygiene products or a sink with hot water, soap and paper towels should be available.

2. **Please note that PAPRs should not be considered a higher level of protection and their use should be limited to men with facial hair or for those individuals who have documented poor fit for N95 respirators.**
3. If available, patients with a positive communicable disease triage screen should be placed in an AIIR with an anteroom that has a sink, so that persons leaving the room can dispose of PPE immediately and wash their hands before exiting to the hallway.
4. **In the absence of an anteroom, gowns and gloves should be removed inside the patient's room and discarded in a waste receptacle just inside the room by the door. Hand hygiene products should be placed right outside the door so that staff can use immediately after removal of respiratory protection and other PPE. Doing this prevents staff from wearing the same gloves and gowns after leaving the isolation room and contaminating other areas of the ED/clinic. Recommended sequence of doffing/donning PPE and caution when removing PPE should be strictly followed.** Signage should be placed to remind staff of hospital protocols regarding PPE. A separate waste receptacle should be placed immediately outside the suspect case-patient's room for disposal of respirators.

d. **Procedures for handling medical waste and environmental decontamination should minimize the risk of healthcare worker or other staff exposure to contaminated waste or equipment.**

1. After use, all personal protective equipment should be placed into a plastic biohazard bag and left in the suspect case-patient's room (gowns and gloves) or outside of the room (respirators). Use an anteroom if available.
2. If positive air pressure respirators (PAPR) are used, the PAPR must be cleaned and disinfected following manufacturer's prior to entering another patient's room.
3. Use disposable items whenever possible.
4. As much as possible, when contact precautions are indicated, dedicated patient care equipment (e.g., blood pressure cuffs and stethoscopes) should be assigned to and left in the patient's room. **If equipment must be used on other patients (e.g., portable X-ray machine), meticulously clean and disinfect the equipment with EPA-registered hospital disinfectants with label claims for non-enveloped viruses (eg, norovirus, rotavirus, adenovirus, poliovirus), following manufacturer instructions, after each use.**
5. Dispose of all non-sharps waste in biohazard bags for disposal or transport for incineration or other approved disposal method.
6. All used laundry and linens should be handled carefully to prevent aerosolization or direct contact with potentially infectious material. Place soiled linen in clearly labeled, leak proof bags while in the patient's room and transport directly to the laundry. **Anyone directly handling the suspect case-patient's linen or laundry should wear appropriate PPE.**

[Note: Handling of medical waste and laundry and cleaning/disinfection of environmental surfaces and medical equipment may vary depending on the specific pathogen of concern. Consult your institution's infection control department for specific guidance. List contact information below.]

3. Notification and Evaluation:

Once triage staff has identified a patient with a positive communicable disease triage screen, prompt notification of appropriate staff should be instituted to ensure rapid evaluation of the patient for a potentially communicable disease of public health concern.

It is crucial to identify key staff ahead of time to ensure notification occurs rapidly.

[NOTE: The following notification format should be revised for your own hospital.]

- a. Triage/screening staff (or other person who has initial encounter with the patient and identifies a positive communicable disease triage screening) notifies

ED/clinic Supervisor (i.e., person in leadership position in ED/clinic) who ensures that the appropriate infection control measures have been put into place.

Title of Supervisor: (Business Hours): _____

Title of Supervisor: (After-Business Hours): _____

- b. ED/clinic Supervisor designates a physician in the ED or clinic to conduct the initial patient evaluation. The physician should don the appropriate PPE outside the patient's AIIR/isolation room before examining the patient. The physician's history and physical examination should be used to determine if the patient is at risk for a communicable disease of public health concern.

- c. If the ED or clinic physician feels that the patient potentially has a communicable disease of public health concern, the physician or his/her designee will notify the Infectious Disease Consult/Infection Control Practitioners, Hospital Administrator On-Duty, Nursing Head, Housekeeping, and Security, as needed.

[Note: Please list your institution's notification policy and contact information below.]

Contact Information for Infectious Disease Consult

(Business Hours): _____

(After-Business Hours): _____

Contact Information for Infection Control Practitioners

(Business Hours): _____

(After-Business Hours): _____

Contact Information for Administrator On-Call

(Business Hours): _____

(After-Business Hours): _____

Contact Information for Nursing Administration

(Business Hours): _____

(After-Business Hours): _____

Contact Information for Housekeeping

(Business Hours): _____

(After-Business Hours): _____

Contact Information for Security

(Business Hours): _____
(After-Business Hours): _____

- d. Infection Control or the ED/clinic physician who evaluated the patient will notify the NYC DOHMH. NYC DOHMH will provide guidance on the clinical and laboratory assessment of the patient, management of ED or clinic contacts, necessary infection control precautions for disease of concern, and/or prophylaxis/treatment. Depending on the situation, a medical epidemiologist from the DOHMH may need to come on site to coordinate the case and contact investigation with the hospital staff.

24/7 Contact Information for NYC DOHMH
Provider Access Line: 1-866-NYC-DOH1 (692-3641)

Which title(s) in your hospital will be responsible for notifying NYC DOHMH?

- e. If the physician determines that the patient is at risk for a communicable disease of public health concern, continue to limit the number of staff and visitors who enter the patient's room. **A log should be kept to track the names and contact information for all persons who enter the room, in the event that follow up is needed.**
- f. Individuals who accompanied the patient to the hospital should be quickly evaluated for signs/symptoms and their own travel history, counseled, asked for contact information, and asked to remain in the facility until the physician discusses the case with the DOHMH medical epidemiologist, in case further evaluation suggests a communicable disease of increased public health concern.

4. Identification and Management of Exposed Persons in the ED/clinic:

As soon as it is determined that a patient has a suspected or confirmed communicable disease of public health concern, it will be essential to identify all contacts in the ED or clinic (including other patients and visitors in the waiting area during the time the patient was there). The need for and extent of contact tracing will depend on both the disease and the patient's condition and symptoms. Clinical laboratory workers who had contact with patient specimens may also need to be identified. This should be done in coordination with the NYC DOHMH. (NOTE: The NYC DOHMH will be responsible for identifying close contacts outside of the hospital or clinic setting, such as home, social and workplace contacts).

- a. If not already done, the Infection Control Practitioner or his/her designee notifies the NYC DOHMH. Contact Information for NYC DOHMH:
Provider Access Line: 1-866-NYC-DOH1 (692-3641)

Determination of the need for identification, monitoring and preventive care for potential contacts will be based on the epidemiology of the suspected or confirmed communicable disease and its probable mode of transmission.

- b. The following measures may need to be taken after consultation with the NYC DOHMH regarding the risk of transmission to contacts in the ED/clinic.
 - i. Create a line list of patients and staff exposed to the index case prior to the index case being placed in isolation (should be completed by Infection Control or designee). The line list should include the following information on all contacts: full name, address, telephone contacts (home, work, cell, email) and description of type of contact with the ill patient (e.g., shared waiting room). If the infectious agent involves a vaccine preventable agent (e.g., measles, chickenpox), a column on the line list should include the vaccine status for the agent of concern. (*A sample Contact Identification Form for Exposure to Communicable Disease of Public Health Concern is included in the Appendix.*)
 - ii. Consistent with your hospital's policy, the number of persons who enter the patient's room should be limited, as well as the traffic in and out. Entry should be limited to necessary hospital staff and public health personnel. Visitors should be excluded from entering the patient's room. A log should be kept to track the names and contact information for all persons who enter the room, in the event that follow up is needed.
 - iii. Individuals who accompanied the patient to the hospital should be quickly evaluated for signs/symptoms and their own travel history, counseled, asked for contact information, and asked to remain in the facility until the physician discusses the case with the DOHMH medical epidemiologist, in case further evaluation suggests a communicable disease of increased public health concern.

Appendix A.
Empiric Precautions for Communicable Diseases of Public Health Concern

Appendix A. Examples of Communicable Diseases of Public Health Concern: Diseases with greater likelihood to spread to others, and with higher likelihood of more severe morbidity or mortality (Taken from HICPAC Guideline for Isolation Precautions).		
	Potential Pathogens: <i>The organisms listed in this column are not intended to represent the complete, or even most likely, diagnoses, but rather possible etiologic agents that require additional precautions beyond Standard Precautions until they can be ruled out.</i>	Empiric Precautions: <i>Infection control professionals should modify or adapt this table according to local conditions.</i>
Rash or Exanthems, generalized, etiology unknown		
Petechial/ecchymotic with fever	Neisseria meningitidis	Droplet for first 24 hours of antimicrobial therapy
If positive history of travel to an area with an ongoing outbreak of VHF in the 10 days before onset of fever	Ebola, Lassa, Marburg viruses	Droplet Precautions plus Contact Precautions, with face/eye protection, emphasizing safety sharps and barrier precautions when blood exposure likely. Use N95 or higher respiratory protection when aerosol-generating procedure performed
Vesicular	Varicella, smallpox, or vaccinia virus	Airborne infection isolation plus Contact; Contact if vaccinia
Maculopapular with cough, coryza and fever	Rubeola (measles) virus	Airborne infection isolation
Respiratory Infections		
Cough/fever/upper lobe pulmonary infiltrate in HIV-negative patient or a patient at low risk for HIV	<i>M. tuberculosis</i> , Respiratory viruses	Airborne Precautions plus Contact precautions; add eye protection if history of SARS exposure or travel
Cough/fever/ pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection	<i>M. tuberculosis</i> , Respiratory viruses	Airborne Precautions plus Contact Precautions Use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions Tuberculosis more likely in HIV-infected individual than in HIV negative individual

Appendix B.

Example Contact Identification Form for Communicable Diseases of Public Health Concern

Appendix C. Contact Identification Form for Exposure to Communicable Diseases of Public Health Concern											
1. SUSPECT CASE information					a. Suspect Case Initials: _____ (IF MORE THAN ONE SUSPECT CASE, USE SEPARATE FORMS)						
b. Date Suspect Case Entered Hospital/Clinic: _____ / _____ / _____											
c. Location(s) in Hospital/Facility of Suspect Case and Time Suspect Case Entered Each Location (best estimate):											
Location 1:					Time entered:		Location 4:			Time entered:	
Location 2:					Time entered:		Location 5:			Time entered:	
Location 3:					Time entered:		Location 6:			Time entered:	
2. POTENTIAL CONTACTS information											
	Last Name	First Name	Age	Gender	Address (street, apt #, city, borough, state, zip code)	Alt Address (e.g., work)	Home phone/ Cell phone Email Address	Alternate Phone/Cell (e.g., next of kin)	Type of Exposure to Suspect Case (include location)	Duration of Exposure to Suspect Case	If known, vaccine status (note which vaccine preventable illness of concern)
1							-----				
2							-----				
3							-----				
4							-----				
5							-----				
6							-----				
7							-----				
8							-----				
9							-----				
10							-----				
11							-----				
12							-----				