



**TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF LABORATORY SERVICES**

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ASSISTANT LABORATORY DIRECTOR

JOHN J. DREYZEHNER, MD, MPH
COMMISSIONER

October 26, 2010

To: Tennessee Clinical Laboratories

Re: **Fungal Isolates Associated with the Meningitis Outbreak**

The Tennessee Department of Health is working with other state and federal health officials to investigate a multi-state outbreak of infections first identified September 18, 2012. The outbreak has been associated with products from New England Compounding Center (NECC). The Tennessee Department of Health requests that clinical laboratories report to the State Epidemiologist all sterile site fungal isolates (except Candida) found since January 1, 2012.

In addition, the Tennessee Department of Health requests clinical laboratories to send to the Tennessee Public Health Laboratory fungal culture isolates from patients associated with the recalled products from NECC. We are using the attached CDC Specimen Submission Form to collect pertinent information. Please include all lumbar puncture results, both positive and negative, from patients exposed to NECC product by epidural steroid injection. Ship a slant of the NECC related fungal isolate to the following address (based on the mode of transportation used).

BY FEDEX, OVERNIGHT CARRIERS, and HAND DELIVERY

Special Microbiology
Tennessee Department of Health
Laboratory Services
630 Hart Lane
Nashville, TN 37216-2006

BY U.S. POSTAL SERVICE

Special Microbiology
Tennessee Department of Health
Laboratory Services
PO Box 305130
Nashville, TN 37230-5130

Thank you for your assistance.

James A. Gibson, MPH

Justification must be completed by State health department laboratory before specimen can be accepted by CDC. Please check the first applicable statement and when appropriate complete the statement with the *.

1. Disease suspected to be of public health importance. Specimen is:
 (a) from an outbreak. (b) from uncommon or exotic disease.
 (c) an isolate that cannot be identified, is atypical, shows multiple antibiotic resistance, or from a normally sterile site(s) (d) from a disease for which reliable diagnostic reagents or expertise are unavailable in State.
2. Ongoing collaborative CDC/State project.
 3. Confirmation of results requested for quality assurance.

*Prior arrangement for testing has been made.
 Please bring to the attention of:

(Name): _____

Completed by: _____

Date: _____

STATE HEALTH DEPARTMENT LABORATORY ADDRESS:

STATE HEALTH DEPT. NO.: _____ DATE SENT TO CDC: (MM/DD/YYYY) _____

PATIENT IDENTIFICATION: (Hospital No.) _____

NAME: (LAST, FIRST, MI) _____

BIRTHDATE: (MM/DD/YYYY) _____ SEX: MALE FEMALE

CLINICAL DIAGNOSIS: _____

ASSOCIATED ILLNESS: _____

DATE OF ONSET: (MM/DD/YYYY) _____ FATAL? YES NO

Name, Address and Phone Number of Physician or Organization:

(FOR CDC USE ONLY)		CDC NUMBER		DATE RECEIVED		
UNIT	FY	NUMBER	SUF	MO	DA	YR

**THIS FORM MUST BE EITHER PRINTED OR TYPED
 PLEASE PREPARE A SEPARATE FORM FOR EACH SPECIMEN**

D.A.S.H.

DATE REPORTED

MO DA YR

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Comments:

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
 Public Health Service
 Centers for Disease Control
 Center for Infectious Diseases
 Atlanta, Georgia 30333



The Centers for Disease Control (CDC), an agency of the Department of Health and Human Services, is authorized to collect this information, including the Social Security number (if applicable), under provisions of the Public Health Service Act, Section 301 (42 U.S.C. 241). Supplying the information is voluntary and there is no penalty for not providing it. The data will be used to increase understanding of disease patterns, develop prevention and control programs, and communicate new knowledge to the health community. Data will become part of CDC Privacy Act system 09-20-0106, "Specimen Handling for Testing and Related Data" and may be disclosed: to appropriate State or local public health departments and cooperating medical authorities to deal with conditions of public health significance; to private contractors assisting CDC in analyzing and refining records; to researchers under certain limited circumstances to conduct further investigations; to organizations to carry out audits and reviews on behalf of HHS; to the Department of Justice in the event of litigation, and to a congressional office assisting individuals in obtaining their records. An accounting of the disclosures that have been made by CDC will be made available to the subject individual upon request. Except for permissible disclosures expressly authorized by the Privacy Act, no other disclosure may be made without the subject individual's written consent.

LABORATORY EXAMINATION(S) REQUESTED: <input type="checkbox"/> Antimicrobial Susceptibility <input type="checkbox"/> Histology <input type="checkbox"/> Identification <input type="checkbox"/> Isolation <input type="checkbox"/> Serology (Specific Test) _____ <input type="checkbox"/> Other (Specify) _____	CATEGORY OF AGENT SUSPECTED: <input type="checkbox"/> Bacterial <input type="checkbox"/> Viral <input type="checkbox"/> Fungal <input type="checkbox"/> Rickettsial <input type="checkbox"/> Parasitic <input type="checkbox"/> Other (Specify) _____
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SPECIFIC AGENT SUSPECTED: _____	OTHER ORGANISM(S) FOUND: _____	ISOLATION ATTEMPTED? <input type="checkbox"/> YES <input type="checkbox"/> NO	NO. OF TIMES ISOLATED: _____	NO. OF TIMES PASSED: _____	SPECIMEN SUBMITTED IS: <input type="checkbox"/> Original Material <input type="checkbox"/> Mixed Isolate <input type="checkbox"/> Pure Isolate
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DATE SPECIMEN TAKEN: MO DA YR	ORIGIN: <input type="checkbox"/> Human <input type="checkbox"/> Soil <input type="checkbox"/> Food <input type="checkbox"/> Animal <input type="checkbox"/> Other (Specify) _____
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SOURCE OF SPECIMEN: <input type="checkbox"/> Blood <input type="checkbox"/> CSF <input type="checkbox"/> Wound (Site) _____ <input type="checkbox"/> Gastric <input type="checkbox"/> Hair <input type="checkbox"/> Exudate (Site) _____ <input type="checkbox"/> Serum <input type="checkbox"/> Skin <input type="checkbox"/> Tissue (Specify) _____ <input type="checkbox"/> Sputum <input type="checkbox"/> Stool <input type="checkbox"/> Tissue (Specify) _____ <input type="checkbox"/> Urine <input type="checkbox"/> Throat <input type="checkbox"/> Other (Specify) _____	SUBMITTED ON: <input type="checkbox"/> Medium _____ <input type="checkbox"/> Animal _____ <input type="checkbox"/> Tissue Culture (Type) _____ <input type="checkbox"/> Egg <input type="checkbox"/> Other (Specify) _____
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SERUM INFORMATION: <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent	MO DA YR <input type="checkbox"/> S3 <input type="checkbox"/> S4 <input type="checkbox"/> S5
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IMMUNIZATIONS: (1.) _____ MO YR (2.) _____ MO YR (3.) _____ MO YR (4.) _____ MO YR

TREATMENT: DRUGS USED <input type="checkbox"/> None (1.) _____ (2.) _____ (3.) _____	DATE BEGUN MO DA YR DATE COMPLETED MO DA YR
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EPIDEMIOLOGICAL DATA: <input type="checkbox"/> Single Case <input type="checkbox"/> Sporadic <input type="checkbox"/> Contact <input type="checkbox"/> Epidemic <input type="checkbox"/> Carrier Family Illness _____ Community Illness _____ Travel and Residence (Location) <input type="checkbox"/> Foreign _____ <input type="checkbox"/> USA _____ Animal Contacts (Species) _____ Arthropod Contacts: <input type="checkbox"/> None <input type="checkbox"/> Exposure Only <input type="checkbox"/> Bite Type of Arthropod: _____ Suspected Source of Infection: _____
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SIGNS AND SYMPTOMS: <input type="checkbox"/> Fever Maximum Temperature: _____ Duration: _____ Days <input type="checkbox"/> Chills	CENTRAL NERVOUS SYSTEM: <input type="checkbox"/> Headache <input type="checkbox"/> Meningismus <input type="checkbox"/> Microcephalus <input type="checkbox"/> Hydrocephalus <input type="checkbox"/> Seizures <input type="checkbox"/> Cerebral Calcification <input type="checkbox"/> Chorea <input type="checkbox"/> Paralysis <input type="checkbox"/> Other _____
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SKIN: <input type="checkbox"/> Maculopapular <input type="checkbox"/> Hemorrhagic <input type="checkbox"/> Vesicular <input type="checkbox"/> Erythema Nodosum <input type="checkbox"/> Erythema Marginatum <input type="checkbox"/> Other _____	MISCELLANEOUS: <input type="checkbox"/> Jaundice <input type="checkbox"/> Myalgia <input type="checkbox"/> Pleurodynia <input type="checkbox"/> Conjunctivitis <input type="checkbox"/> Chorioretinitis <input type="checkbox"/> Splenomegaly <input type="checkbox"/> Hepatomegaly <input type="checkbox"/> Liver Abscess/cyst <input type="checkbox"/> Lymphadenopathy <input type="checkbox"/> Mucous Membrane Lesions <input type="checkbox"/> Other _____
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RESPIRATORY: <input type="checkbox"/> Rhinitis <input type="checkbox"/> Pulmonary <input type="checkbox"/> Pharyngitis <input type="checkbox"/> Calcifications <input type="checkbox"/> Otitis Media <input type="checkbox"/> Pneumonia (type) _____ <input type="checkbox"/> Other _____	STATE OF ILLNESS: <input type="checkbox"/> Symptomatic <input type="checkbox"/> Asymptomatic <input type="checkbox"/> Subacute <input type="checkbox"/> Chronic <input type="checkbox"/> Disseminated <input type="checkbox"/> Localized <input type="checkbox"/> Extraintestinal <input type="checkbox"/> Other _____
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CARDIOVASCULAR: <input type="checkbox"/> Myocarditis <input type="checkbox"/> Pericarditis <input type="checkbox"/> Endocarditis <input type="checkbox"/> Other _____	GASTROINTESTINAL: <input type="checkbox"/> Diarrhea <input type="checkbox"/> Blood <input type="checkbox"/> Mucous <input type="checkbox"/> Constipation <input type="checkbox"/> Abnormal Pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Other _____
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PREVIOUS LABORATORY RESULTS/OTHER CLINICAL INFORMATION: (Information supplied should be related to this case and/or specimen(s) and relative to the test(s) requested.)
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