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# Rules of Department of Health and Senior Services

## Division 20—Division of Community and Public Health Chapter 26—Sexually Transmitted Diseases

| Title   | Page |
|---|------|
| 19 CSR 20-26.010 Prevention of Blindness .....  | 3    |
| 19 CSR 20-26.020 HIV Treatment Program (Rescinded July 8, 1991) .....   | 3    |
| 19 CSR 20-26.030 Human Immunodeficiency Virus (HIV) Test Consultation and Reporting<br>(Rescinded October 30, 2012) .....   | 3    |
| 19 CSR 20-26.040 Physician Human Immunodeficiency Virus (HIV) Test Consultation<br>and Reporting.....   | 3    |
| 19 CSR 20-26.050 Preventing Transmission of Human Immunodeficiency Virus (HIV) and<br>Hepatitis B Virus (HBV) from Health Care Workers to Patients .....                                | 7    |
| 19 CSR 20-26.060 Voluntary Evaluation for Human Immunodeficiency Virus (HIV)- and<br>Hepatitis B Virus (HBV)-Infected Health Care Professionals Who<br>Perform Invasive Procedures..... | 7    |
| 19 CSR 20-26.070 Notification of Results of Court-Ordered Human Immunodeficiency<br>Virus (HIV) Testing of Sexual Offenders .....   | 9    |



**Title 19—DEPARTMENT OF  
HEALTH AND SENIOR SERVICES**  
**Division 20—Division of Community and  
Public Health**  
**Chapter 26—Sexually Transmitted  
Diseases**

**19 CSR 20-26.010 Prevention of Blindness**

*PURPOSE: This rule prevents the newborn infant from contracting gonococcal ophthalmia neonatorum or chlamydia ophthalmia neonatorum, or both, during birth from an infected mother.*

(1) It shall be the duty of every physician or other person in attendance upon a newborn infant or its mother to instill five-tenths percent (0.5%) erythromycin ophthalmic ointment or drops in single-use tubes or ampules; or tetracycline one percent (1%) ophthalmic ointment or drops in single-use tubes or ampules; or one percent (1%) silver nitrate solution into each eye of the newborn infant immediately after birth and to report this on the birth certificate.

*AUTHORITY: section 192.020, RSMo 1986.\* This rule was previously filed as 13 CSR 50-107.010. Original rule filed April 22, 1955, effective June 21, 1955. Amended: Filed Nov. 4, 1985, effective March 24, 1986.*

*\*Original authority: 192.020, RSMo 1939, amended 1945, 1951.*

**19 CSR 20-26.020 HIV Treatment Program**  
(Rescinded July 8, 1991)

*AUTHORITY: sections 192.005.2 and 192.020, RSMo 1986. Emergency rule filed Sept. 1, 1987, effective Sept. 11, 1987, expired Jan. 9, 1988. Original rule filed Sept. 1, 1987, effective Jan. 9, 1988. Emergency amendment filed June 3, 1988, effective June 13, 1988, expired Oct. 10, 1988. Amended: Filed June 3, 1988, effective Sept. 29, 1988. Amended: Filed July 18, 1989, effective Nov. 11, 1989. Emergency rescission filed March 19, 1991, effective March 31, 1991, expired July 28, 1991. Rescinded: Filed March 19, 1991, effective July 8, 1991.*

**19 CSR 20-26.030 Human Immunodeficiency Virus (HIV) Test Consultation and Reporting**  
(Rescinded October 30, 2012)

*AUTHORITY: sections 191.653, 191.656, and 192.006, RSMo Supp. 1999, and section 192.020, RSMo 1994. Original rule filed March 14, 1989, effective July 13, 1989. Rescinded and readopted: Filed April 14, 1992, effective Dec. 3, 1992. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000. Rescinded: Filed March 1, 2012, effective Oct. 30, 2012.*

**19 CSR 20-26.040 Physician Human Immunodeficiency Virus (HIV) Test Consultation and Reporting**

*PURPOSE: This rule establishes guidelines specific to physicians and other health care professionals working under physician orders for HIV testing, pretest and posttest consultation (client-centered counseling), and for the reporting of persons diagnosed with HIV infection.*

(1) The following definitions shall be used in administering this rule:

(A) Conduct means to direct, lead, order or undertake to perform or to provide guidance as a licensed physician to a patient;

(B) Confirmed HIV infection means the clinical diagnosis and conclusion that a patient is infected with HIV, made in the professional judgment of the physician based upon clinical history, physician examination, diagnostic or laboratory testing, or other available clinical information which allows the physician to make clinical and therapeutic decisions based upon this infected status;

(C) Department means the Missouri Department of Health and Senior Services;

(D) Physician means any person licensed to practice as a physician and surgeon under Chapter 334, RSMo; and

(E) Physician's delegated representative means state-licensed professional involved in direct patient care, other than those persons licensed as physicians under Chapter 334, RSMo.

(2) The physician or the physician's delegated representative shall provide consultation with the patient or his/her legal guardian or custodian prior to conducting HIV testing, and to the patient, guardian, or custodian during the reporting of the test results or diagnosis. The scope of the consultation shall be governed by the physician's professional judgment based on the clinical situation and shall be consistent with Centers for Disease Control and Prevention (CDC) guidelines and recommendations as stated in the CDC's

Morbidity and Mortality Weekly Report, September 22, 2006 / 55(RR14);1-17: Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, which are incorporated by reference. Copies may be found at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm> or by writing to the Department of Health and Human Services, Centers for Disease Control and Prevention, 1600 Clifton Rd., Atlanta, GA 30333. This rule does not include any later amendments or additions.

(A) The physician or the physician's delegated representative shall only be allowed to provide consultation through the use of protocols and standing orders which shall be written, signed, and dated by the physician prior to their implementation or, in the case of a hospital, the policies and procedures as approved by the medical staff.

(3) The physician, or the person who performs or conducts HIV sampling, shall report to the department or its designated representative the identity of any person with confirmed HIV infection along with related clinical and identifying information within three (3) days of receipt of the test results on forms provided by the department (see Form #1) included herein.

(4) Physicians testing persons under the following situations shall be exempt from reporting the identity of the persons testing positive for HIV. In these situations, physicians shall report HIV positive test results as well as related clinical and other information within three (3) days of receipt of the test results on forms provided by the department (see Form #1) included herein, but shall be exempt from reporting the patient's name and street address, instead a unique patient identifier shall be used:

(A) Persons tested anonymously at department-designated anonymous testing sites;

(B) Persons tested as part of a research project which is approved by an institutional review board and in which, as part of the research, subjects are tested for HIV infection. Written documentation of institutional review boards approval must be submitted to the department's HIV surveillance program; or

(C) Where prohibited by federal law or regulation.

(5) If test results are positive, post-test counseling shall include a discussion of the client's responsibility to ensure that sex and needle sharing partners are advised of their potential exposure to HIV. If the test results



are negative, the person shall be advised of the window period and possible need for retesting if exposure has occurred within the window period. If the test result is equivocal, the person shall be counseled on the result and the significance of a retest.

(6) All persons reported with HIV infection to the department or its designated representative can be contacted by public health personnel for partner elicitation/notification services according to protocols and procedures established by the department.

(7) Laboratories which perform HIV testing shall report identifying information as specified in 19 CSR 20-20.080.



**PROVIDER'S CONFIDENTIAL REPORT OF HIV/AIDS INFECTION**

| PATIENT INFORMATION   |        |  |                      |  | PATIENT HISTORY   |  |  |  |  |
|---|--------|--|----------------------|--|---|--|--|--|--|
| 1. PATIENT ID NUMBER (FROM LAB SLIP)  |        |  |                      |  | 15. AFTER 1977, THIS PATIENT HAD: (CHECK ALL THAT APPLY)  |  |  |  |  |
| 2. PATIENT NAME (LAST, FIRST, MI)   |        |  |                      |  | Y N<br><input type="checkbox"/> <input type="checkbox"/> Sex With Male<br><input type="checkbox"/> <input type="checkbox"/> Sex With Female<br><input type="checkbox"/> <input type="checkbox"/> Injected Non-Prescription Drugs<br><input type="checkbox"/> <input type="checkbox"/> Received Clotting Factor <input type="checkbox"/> VIII <input type="checkbox"/> IX <input type="checkbox"/> Other: _____<br><input type="checkbox"/> <input type="checkbox"/> Blood Transfusion: First _____ / _____ Last _____ / _____<br><input type="checkbox"/> <input type="checkbox"/> Worked In Health Care Setting: Occupation: _____<br><input type="checkbox"/> <input type="checkbox"/> Recipient Of Tissue/Organs/Artificial Insemination Date: _____ / _____ |  |  |  |  |
| 3. ADDRESS (STREET, APT. #, P.O. BOX NO.)   |        |  |                      |  | <b>HETEROSEXUAL RELATIONS WITH:</b>   |  |  |  |  |
| CITY, STATE, ZIP CODE   |        |  |                      |  | <input type="checkbox"/> <input type="checkbox"/> Injection Drug User   |  |  |  |  |
| COUNTY  |        |  | 4. TELEPHONE ( ) ( ) |  | <input type="checkbox"/> <input type="checkbox"/> Bisexual Male (Female Only)   |  |  |  |  |
| 5. SS #   |        | 6. OCH #   |                      |  | <input type="checkbox"/> <input type="checkbox"/> Person With Hemophilia/Coagulation Disorder   |  |  |  |  |
| 7. DATE OF BIRTH  | 8. AGE | 9. MARITAL STATUS<br>S M D W   |                      | 10. SEX<br>M F   |   | <input type="checkbox"/> <input type="checkbox"/> Transfusion/Transplant Recipient With Documented HIV Infection |  |  |  |
| 11. RACE<br><input type="checkbox"/> White <input type="checkbox"/> Black   |        | <input type="checkbox"/> Asian/Pacific Is.<br><input type="checkbox"/> Am. Indian/AK Native<br><input type="checkbox"/> Other: _____ |                      | 12. Hispanic Ethnicity<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | <input type="checkbox"/> <input type="checkbox"/> Person With AIDS/HIV Infection Whose Risk Is Not Known         |  |  |  |
| 13. VITAL STATUS <input type="checkbox"/> Living <input type="checkbox"/> Deceased - Date of Death: ____/____/____        |        |  |                      |  | 16. FOR PEDIATRIC/PERINATAL CASES   |  |  |  |  |
| 14. COUNTRY OF BIRTH <input type="checkbox"/> U.S. <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown |        |  |                      |  | <input checked="" type="checkbox"/> <input type="checkbox"/> IF < 13 YEARS OF AGE, MOTHER WITH HIV/AIDS?<br>If Yes, Mother's Name: _____ Mother's DOB: ____/____/____<br>If Newborn, Date Anti-Retroviral Therapy for HIV Prevention Began: ____/____/____  |  |  |  |  |
| 17. FOR ADULT FEMALES Hepatitis B: HBsAg <input type="checkbox"/> Pos <input type="checkbox"/> Neg                        |        |  |                      |  | Number of Live-Born Infants Delivered in the Last 18 Months: _____  |  |  |  |  |
| <input checked="" type="checkbox"/> <input type="checkbox"/> Patient is Currently Pregnant EDC: ____/____/____            |        |  |                      |  | Provide Birth Information for Most Recent Birth(s):   |  |  |  |  |
| If Yes, Week of Pregnancy Antiretroviral Therapy Began: _____   |        |  |                      |  | DOB: ____/____/____ Birth Hospital: _____ Breastfed <input checked="" type="checkbox"/> <input type="checkbox"/>  |  |  |  |  |
| <input type="checkbox"/> ZDV (AZT) <input type="checkbox"/> Other: _____  |        |  |                      |  | DOB: ____/____/____ Birth Hospital: _____ Breastfed <input checked="" type="checkbox"/> <input type="checkbox"/>  |  |  |  |  |

MO 580-1641 (3-12)

SHP-22

| LABORATORY DATA  |  |  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|--|--|
| 18. CURRENT HIV TEST(S)  |  |  |  |  | 20. IF HIV TESTS ARE NOT DOCUMENTED, IS HIV DIAGNOSED BY A PHYSICIAN?  |  |  |  |  |
| HIV Antibody Tests:  |  |  |  |  | <input checked="" type="checkbox"/> <input type="checkbox"/> If Yes, Diagnosis Date: ____/____/____  |  |  |  |  |
| HIV-1 EIA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done<br>HIV-1 Western Blot/IFA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done<br>HIV-1/HIV-2 Combination EIA <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done<br>Other: _____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done |  |  |  |  | Provider: _____ City/State: _____  |  |  |  |  |
| HIV Antibody Test Specimen Was:  |  |  |  |  | 21. <input checked="" type="checkbox"/> <input type="checkbox"/> Patient is Past or Present HIV Vaccine Trial Participant  |  |  |  |  |
| <input type="checkbox"/> Serum <input type="checkbox"/> Oral Fluid <input type="checkbox"/> Urine <input type="checkbox"/> Other: _____  |  |  |  |  | 22. PREVIOUS HIV TEST? <input checked="" type="checkbox"/> <input type="checkbox"/> If Yes, Most Recent Result: <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |  |  |  |  |
| HIV Detection Tests:   |  |  |  |  | Type of Test: <input type="checkbox"/> Antibody <input type="checkbox"/> Antigen <input type="checkbox"/> PCR <input type="checkbox"/> Culture   |  |  |  |  |
| PCR, DNA or RNA Probe <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done<br>Culture <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done<br>Antigen Test <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done<br>Other: _____ <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Inconclusive <input type="checkbox"/> Not Done                   |  |  |  |  | <input type="checkbox"/> Qualitative PCR <input type="checkbox"/> Quantitative PCR (VL)  |  |  |  |  |
| HIV VIRAL LOAD TESTING: (Record most recent testing)   |  |  |  |  | <input type="checkbox"/> Other (specify) _____ Test Date: ____/____/____   |  |  |  |  |
| <input type="checkbox"/> Detectable <input type="checkbox"/> Non-Detectable  |  |  |  |  | Provider: _____  |  |  |  |  |
| Test Type* _____ Copies/ml _____   |  |  |  |  | City/State: _____  |  |  |  |  |
| Type 11. NASBA (Organon) 12. RT-PCR (Roche) 13. bDNA (Chiron) 18. Other 19. Unspecified  |  |  |  |  | If Previously Tested, Reason for Retest:   |  |  |  |  |
| 19. TESTING LABORATORY NAME(S), ADDRESS(ES), TELEPHONE NUMBER(S):  |  |  |  |  | <input type="checkbox"/> Case Management Eligibility <input type="checkbox"/> Medicaid/Medicare Eligibility  |  |  |  |  |
|  |  |  |  |  | <input type="checkbox"/> High Risk Negative <input type="checkbox"/> Client Request  |  |  |  |  |
|  |  |  |  |  | <input type="checkbox"/> Confirm Diagnosis <input type="checkbox"/> Other: _____   |  |  |  |  |
|  |  |  |  |  | 23. CD4+ LYMPHOCYTE COUNT: TEST DATE MO/YR   |  |  |  |  |
|  |  |  |  |  | Most Recent CD4+ Count ... [ ][ ][ ] cells/ $\mu$ L ____/____  |  |  |  |  |
|  |  |  |  |  | CD4+ Percent ... [ ][ ] % ____/____  |  |  |  |  |
|  |  |  |  |  | First CD4+below 200 $\mu$ L or 14% [ ][ ][ ] cells/ $\mu$ L ____/____  |  |  |  |  |
|  |  |  |  |  | (If Known) [ ][ ] % ____/____  |  |  |  |  |

MO 580-1641 (3-12)

(CONTINUED ON BACK)

SHP-22



| CLINICAL STATUS  |                          |                          |              |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
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| <b>24. <input checked="" type="checkbox"/> <input type="checkbox"/> PATIENT MEDICALLY EVALUATED? If Yes, Check All That Apply</b>  |                          |                          |              |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| <input type="checkbox"/> Asymptomatic<br><input type="checkbox"/> Symptomatic, No History of AIDS-Defining Illness<br><input type="checkbox"/> CD4+ is now or has been <200/14%<br><input type="checkbox"/> Symptomatic, AIDS-Defining Illness Diagnosed   |                          |                          |              |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center;"><b>Def.</b></td> <td style="text-align: center;"><b>Pres.</b></td> <td style="text-align: center;"><b>Mo/Yr</b></td> </tr> <tr> <td>• Candidiasis, bronchi, trachea, lungs</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Candidiasis, esophageal</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Carcinoma, invasive cervical</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Coccidioidomycosis, disseminated or extrapulmonary</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Cryptococcosis, extrapulmonary</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Cryptosporidiosis, chronic intestinal</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Cytomegalovirus disease (other than liver, spleen, or nodes)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Cytomegalovirus retinitis (vision loss)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• HIV encephalopathy</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Herpes simplex: chronic ulcer(s); or bronchitis, pneumonitis, esophagitis</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Histoplasmosis, dissem. or extrapulm.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Isosporiasis, chronic intestinal (&gt;1 mo)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> </table> |                          | <b>Def.</b>              | <b>Pres.</b> | <b>Mo/Yr</b> | • Candidiasis, bronchi, trachea, lungs | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Candidiasis, esophageal | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Carcinoma, invasive cervical | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Coccidioidomycosis, disseminated or extrapulmonary | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Cryptococcosis, extrapulmonary | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Cryptosporidiosis, chronic intestinal | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Cytomegalovirus disease (other than liver, spleen, or nodes) | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Cytomegalovirus retinitis (vision loss) | <input type="checkbox"/> | <input type="checkbox"/> | / / | • HIV encephalopathy | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Herpes simplex: chronic ulcer(s); or bronchitis, pneumonitis, esophagitis | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Histoplasmosis, dissem. or extrapulm. | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Isosporiasis, chronic intestinal (>1 mo) | <input type="checkbox"/> | <input type="checkbox"/> | / / |  |  | <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center;"><b>Def.</b></td> <td style="text-align: center;"><b>Pres.</b></td> <td style="text-align: center;"><b>Mo/Yr</b></td> </tr> <tr> <td>• Kaposi's sarcoma</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Lymphoma, Burkitt's (or equivalent)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Lymphoma, immunoblastic (or equiv.)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Lymphoma, primary in brain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• <i>M. avium</i> complex or <i>M. kansasii</i>, disseminated or extrapulmonary</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• <i>M. tuberculosis</i>, pulmonary</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• <i>M. tuberculosis</i>, dissem. or extrapulm.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• <i>Mycobacterium</i>, of other or unidentified species, dissem. or extrapulm.</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• <i>Pneumocystis carinii</i> pneumonia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Pneumonia, recurrent in 12 mo period</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Progressive multifocal leukoencephalopathy</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• <i>Salmonella</i> septicemia, recurrent</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Toxoplasmosis of brain</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Wasting syndrome due to HIV</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> </table> <p><b>Pediatric: (Additional Indicator Diseases)</b></p> <table border="0" style="width: 100%;"> <tr> <td style="width: 80%;"></td> <td style="text-align: center;"><b>Def.</b></td> <td style="text-align: center;"><b>Pres.</b></td> <td style="text-align: center;"><b>Mo/Yr</b></td> </tr> <tr> <td>• Bacterial infections, multiple or recurrent, (incl. <i>Salmonella</i> septicemia)</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> <tr> <td>• Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;">/ /</td> </tr> </table> |  | <b>Def.</b> | <b>Pres.</b> | <b>Mo/Yr</b> | • Kaposi's sarcoma | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Lymphoma, Burkitt's (or equivalent) | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Lymphoma, immunoblastic (or equiv.) | <input type="checkbox"/> | <input type="checkbox"/> | / / | • Lymphoma, primary in brain | <input 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|  | <b>Def.</b>              | <b>Pres.</b>             | <b>Mo/Yr</b> |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Candidiasis, bronchi, trachea, lungs   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Candidiasis, esophageal  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Carcinoma, invasive cervical   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Coccidioidomycosis, disseminated or extrapulmonary   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Cryptococcosis, extrapulmonary   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Cryptosporidiosis, chronic intestinal  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Cytomegalovirus disease (other than liver, spleen, or nodes)   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Cytomegalovirus retinitis (vision loss)  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • HIV encephalopathy   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Herpes simplex: chronic ulcer(s); or bronchitis, pneumonitis, esophagitis  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Histoplasmosis, dissem. or extrapulm.  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Isosporiasis, chronic intestinal (>1 mo)   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
|  | <b>Def.</b>              | <b>Pres.</b>             | <b>Mo/Yr</b> |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Kaposi's sarcoma   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Lymphoma, Burkitt's (or equivalent)  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Lymphoma, immunoblastic (or equiv.)  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Lymphoma, primary in brain   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • <i>M. avium</i> complex or <i>M. kansasii</i> , disseminated or extrapulmonary   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • <i>M. tuberculosis</i> , pulmonary   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • <i>M. tuberculosis</i> , dissem. or extrapulm.   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • <i>Mycobacterium</i> , of other or unidentified species, dissem. or extrapulm.   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • <i>Pneumocystis carinii</i> pneumonia  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Pneumonia, recurrent in 12 mo period   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Progressive multifocal leukoencephalopathy   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • <i>Salmonella</i> septicemia, recurrent  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Toxoplasmosis of brain   | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Wasting syndrome due to HIV  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
|  | <b>Def.</b>              | <b>Pres.</b>             | <b>Mo/Yr</b> |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Bacterial infections, multiple or recurrent, (incl. <i>Salmonella</i> septicemia)  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| • Lymphoid interstitial pneumonia and/or pulmonary lymphoid hyperplasia  | <input type="checkbox"/> | <input type="checkbox"/> | / /          |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| <b>25. If AIDS, Facility of Diagnosis:</b> _____<br>City/State: _____<br><input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Federal   |                          |                          |              |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| <b>TYPE OF FACILITY WHERE AIDS WAS DIAGNOSED: (Check One)</b><br><input type="checkbox"/> Hospital Inpatient <input type="checkbox"/> Hospital Outpatient <input type="checkbox"/> Public Clinic<br><input type="checkbox"/> Physician's Office <input type="checkbox"/> Other: _____  |                          |                          |              |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |
| Def. = definitive diagnosis    Pres. = presumptive diagnosis    Mo/Yr = date of initial diagnosis  |                          |                          |              |              |  |                          |                          |     |                           |                          |                          |     |                                |                          |                          |     |  |                          |                          |     |                                  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                      |                          |                          |     |   |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |  |   |  |             |              |              |                    |                          |                          |     |                                       |                          |                          |     |                                       |                          |                          |     |                              |                          |                          |     |  |                          |                          |     |                                      |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |  |                          |                          |     |  |                          |                          |     |   |                          |                          |     |                          |                          |                          |     |                               |                          |                          |     |  |             |              |              |   |                          |                          |     |   |                          |                          |     |

MO 580-1641 (3-12)

SHP-22

| INTERVENTION/PREVENTION SERVICES  |   |  |   |
|---|---|--|---|
| <b>26. <input checked="" type="checkbox"/> <input type="checkbox"/> Patient (or Parent/Guardian) Informed of HIV Infection Status</b> <input checked="" type="checkbox"/> <input type="checkbox"/> Physician Requests Support/Referral Information Services<br><input checked="" type="checkbox"/> <input type="checkbox"/> Physician Has Performed Spousal Notification <input checked="" type="checkbox"/> <input type="checkbox"/> Patient is Receiving Treatment for HIV/AIDS<br><input checked="" type="checkbox"/> <input type="checkbox"/> Physician Requests Partner Notification Assistance <b>If Yes,</b> <input type="checkbox"/> Antiretroviral <input type="checkbox"/> OI Prophylaxis |   |  |   |
| <b>27. PATIENT'S MEDICAL TREATMENT PRIMARILY REIMBURSED BY:</b><br><input type="checkbox"/> Private Insurance, HMO <input type="checkbox"/> Medicaid Managed Care <input type="checkbox"/> Medicare <input type="checkbox"/> No Coverage<br><input type="checkbox"/> Private Insurance, Non HMO <input type="checkbox"/> Medicaid Fee-for-Service <input type="checkbox"/> Self Pay <input type="checkbox"/> Other: _____   |   |  |   |
| <b>28. PROVIDER/PHYSICIAN NAME, ADDRESS, TELEPHONE:</b><br><br><br>   |   |  |   |
| <b>29. PERSON COMPLETING HIV REPORT:</b>  | <b>30. DATE:</b>  | <b>Health Department Use Only:</b> Type of Report:    V    S   |   |
| <b>31. COMMENTS:</b>  |   | Initial Source: _____    Report Source: _____<br>NIR Y O Date ____ / ____ / ____    Initials _____                               |   |
| <b>To Report Confirmed HIV/AIDS Infection (within 3 Days of Diagnosis) or Obtain Additional Report Forms, Contact the Missouri Department of Health and Senior Services or Appropriate City Health Department (Addresses Below)</b>   |   |  |   |
| <b>SUBMIT REPORT TO:</b>  | Missouri Department of Health & Senior Serv. - BHSB<br>930 Wildwood, P.O. Box 570<br>Jefferson City, MO 65102-0570<br>Tel: (573) 751-6463 | Kansas City Health Department<br>Suite 2200, Surveillance Unit<br>2400 Troost Ave., Kansas City, MO 64108<br>Tel: (816) 513-6364 | City of St. Louis Department of Health<br>Surveillance Unit<br>1520 Market St., Room 4027, St. Louis, MO 63103<br>Tel: (314) 612-5188 |

MO 580-1641 (3-12)

SHP-22



*AUTHORITY: sections 191.653 and 192.006, RSMo 2000, and sections 191.656 and 192.020, RSMo Supp. 2011.\* Original rule filed April 14, 1992, effective Dec. 3, 1992. Emergency amendment filed June 1, 2000, effective June 15, 2000, expired Dec. 11, 2000. Amended: Filed June 1, 2000, effective Nov. 30, 2000. Amended: Filed March 1, 2012, effective Oct. 30, 2012.*

*\*Original authority: 191.653, RSMo 1988, amended 1996; 191.656, RSMo 1988, amended 1992, 1993, 1996, 1999; 192.006, RSMo 1993, amended 1995; 192.020, RSMo 1939, amended 1945, 1951.*

### **19 CSR 20-26.050 Preventing Transmission of Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV) from Health Care Workers to Patients**

*PURPOSE: This rule establishes training requirements relating to the prevention of transmission of human immunodeficiency virus, hepatitis B virus and other bloodborne pathogens from infected health care workers to patients as defined in section 191.694, RSMo.*

(1) The following definitions shall be used in the interpretation of this rule:

(A) Community-based means practice in any clinic, group practice or solo practice not licensed under Chapters 197 and 198, RSMo where health care, including dentistry and podiatry, is provided;

(B) Department means the Missouri Department of Health;

(C) Director means the director of the department or his/her designee;

(D) Employed means to be professionally affiliated with a facility either by contract, direct employment or extension of professional privileges;

(E) HBV means hepatitis B virus;

(F) Health care facilities means those facilities licensed under Chapters 197 and 198, RSMo;

(G) Health care professional means a member of any of the professional groups regulated by Chapters 330, 332 and 335, RSMo, and sections 334.010–334.265, RSMo;

(H) HIV means human immunodeficiency virus; and

(I) Invasive procedures shall be defined as in 191.650(9), RSMo. Phlebotomy and insertion of intravenous lines which do not involve surgical incision are not considered invasive procedures.

(2) Health care professionals in both health care facility-based and community-based

practice settings shall adhere to the training requirements contained in section 191.694, RSMo. The department shall investigate complaints of noncompliance in facility-based practice settings. Complaints of noncompliance in community-based practice settings shall be referred to the appropriate licensing authority.

(3) Health care professionals performing invasive procedures who do not receive training in a health care facility regarding infection control procedures, universal precautions and prevention of percutaneous injuries shall obtain that training elsewhere on an annual basis. Training shall be in compliance with Occupational Safety and Health Administration (OSHA) requirements in 29 CFR 1910.1030. Training shall be also in compliance with section 191.694, RSMo and with recommendations published by the Centers for Disease Control and Prevention in the *Morbidity and Mortality Weekly Report: Recommendations for Prevention of HIV Transmission in Health-Care Settings*, August 21, 1987; *Update: Universal Precautions for Prevention of Transmission of Human Immunodeficiency Virus, Hepatitis B Virus, and Other Bloodborne Pathogens in Health-Care Settings*, June 24, 1988; and *Guidelines for Prevention of Transmission of Human Immunodeficiency Virus and Hepatitis B Virus to Health-Care and Public-Safety Workers*, June 23, 1989. Documents that validate the completion of that training shall be maintained by the health care professional for a period of three (3) years and shall be made available to the department upon request.

*AUTHORITY: section 191.694.4, RSMo 2000.\* Original rule filed April 17, 1995, effective Nov. 30, 1995. Emergency amendment filed May 10, 2002, effective July 1, 2002, expired Dec. 28, 2002. Amended: Filed May 10, 2002, effective Nov. 30, 2002.*

*\*Original authority: 191.694, RSMo 1992.*

### **19 CSR 20-26.060 Voluntary Evaluation for Human Immunodeficiency Virus (HIV)- and Hepatitis B Virus (HBV)-Infected Health Care Professionals Who Perform Invasive Procedures**

*PURPOSE: This rule establishes procedures for the voluntary evaluation of human immunodeficiency virus- and hepatitis B virus-infected health care professionals who perform invasive procedures in order to determine whether practice restrictions or*

*limitations should be applied, as defined in section 191.700, RSMo.*

(1) The definitions in 19 CSR 20-26.050 shall be used in the interpretation of this rule.

(2) Any health care professional who performs invasive procedures is advised to know his/her human immunodeficiency virus (HIV) antibody status and hepatitis B surface antigen (HBsAg) status. If HBsAg is present, the presence or absence of hepatitis B e antigen (HBeAg) shall be determined. If a significant occupational exposure occurs which could place the health care professional at risk of acquiring HIV or hepatitis B virus (HBV) infection, appropriate post-exposure evaluation should be undertaken.

(3) HIV- or HBV-infected health care professionals who perform invasive procedures may be voluntarily evaluated by an expert review panel appointed by the department according to section 191.700, RSMo. This panel shall follow subsections (3)(A)–(P) of this rule.

(A) Health care professionals infected with HIV or HBV who perform invasive procedures and who choose to be evaluated by an expert review panel appointed by the department according to section 191.700, RSMo shall apply for the evaluation in writing to the director. Directors of health care facilities (chief administrative officers or equivalents) allowed by 191.700.2(1), RSMo to seek evaluation of infected health care professionals who perform invasive procedures shall, with the consent of the infected health care professional and after consultation with the professional's private physician, apply in writing to the director of the Department of Health.

(B) Upon receipt of a written request for evaluation, the director shall appoint an expert review panel by utilizing the following criteria:

1. The panel shall include those individuals specified by 191.700.2(2)(a)–(d), RSMo and may include additional individuals if the director determines this is necessary; and

2. The director shall seek input from appropriate professional organizations in making his/her appointments.

(C) The subject of the evaluation shall provide the director with a list of all health care facilities and community-based practices, regardless of location, where the subject performs invasive procedures.

(D) The expert review panel shall utilize the following to evaluate the health care professional's practice:

1. Criteria specified in 191.700.2(3), RSMo;



2. Verification of the health care professional's licensure status;

3. Current, scientific evidence that is available; and

4. Panel members' professional judgments.

(E) Panel members shall be subject to the requirements of section 191.656, RSMo regarding the confidentiality of information on an HIV-infected health care professional's infection status.

(F) The health care professional shall be allowed to appear before the panel and present any information which s/he believes to be pertinent to the panel's task. The health care professional's personal physician(s) and any other individual(s) the health care professional believes can provide pertinent input into the process shall be allowed to appear before the panel.

(G) The panel may recommend that restrictions or limitations be placed on the practice of the health care professional.

(H) The panel shall require the health care professional to notify any affected patient in a timely manner whenever a parenteral or mucous membrane exposure to the health care professional's blood occurs.

(I) The panel's findings and recommendations shall be conveyed in writing to the health care professional and to the director.

(J) The director shall disclose to the chief administrative officer or equivalent individual in each health care facility or community-based practice where the health care professional is performing invasive procedures any restrictions or limitations placed on his/her practice by the panel.

(K) If the health care professional seeks to affiliate with an additional health care facility or community-based practice, regardless of its location, where s/he will be performing invasive procedures, s/he shall disclose to the chief administrative officer or equivalent individual in that facility or practice the findings of the review panel, and any restrictions or limitations placed on his/her practice by the panel, prior to the affiliation and the provision of patient care. S/he shall also advise the department of the new practice location.

(L) If the health care professional plans to begin performing invasive procedures at a health care facility or community-based practice where s/he is currently affiliated but not presently performing those procedures, s/he shall disclose to the chief administrative officer or equivalent individual in that facility or practice the findings of the review panel, and any restrictions or limitations placed on his/her practice by the panel, prior to the performance of any invasive procedures, and report his/her intention to begin performing

invasive procedures in writing to the director prior to beginning to perform these procedures.

(M) If the review panel places restrictions or limitations on the health care professional's practice, it shall be the responsibility of each health care facility where s/he is employed and performing invasive procedures to monitor him/her for compliance at appropriate intervals, at least annually, based on his/her medical status and the types and frequencies of invasive procedures s/he performs. If a facility finds the health care professional to be noncompliant, it shall report this in writing to the appropriate state board, as provided under Chapters 330, 332, 334 or 335, RSMo, and to the director.

(N) If the review panel places restrictions or limitations on the practice of a health care professional who performs invasive procedures in a community-based setting, it shall be the responsibility of the department to monitor him/her for compliance in this setting at appropriate intervals, at least annually, based on his/her medical status and the types and frequencies of invasive procedures s/he performs. If the department finds the health care professional to be noncompliant, it shall report this in writing to the appropriate state board, as provided under Chapters 330, 332, 334 or 335, RSMo, and to the director.

(O) If the director becomes aware that the infected health care professional is noncompliant with practice restrictions or limitations at any location where s/he is performing invasive procedures, the director shall report this noncompliance to the chief administrative officer or equivalent individual in each health care facility and community-based practice where the health care professional performs invasive procedures.

(P) The panel shall require, as necessary, that the infected health care professional undergo periodic reviews to determine if the decision to place or not to place restrictions or limitations on his/her practice needs to be modified because of changes in his/her medical condition or some other relevant circumstance. If a review results in the panel making such a modification, this modification shall be conveyed in writing to the health care professional and the director. If the modification results in restrictions or limitations, or further restrictions or limitations, being placed on the health care professional, the director shall disclose this modification to the chief administrative officer or equivalent individual in each health care facility or community-based practice where the health care professional is performing invasive procedures.

(Q) If restrictions or limitations have been

placed on a health care professional's practice by the panel and if later there is a change in the individual's medical condition or some other relevant circumstance, and as a result s/he believes that the restrictions or limitations should be modified, s/he may request in writing to the director that the panel consider such a modification. A similar written request may also be made by the director or chief administrative officer of a health care facility with the consent of the infected health care professional and after consultation with his/her private physician. The panel shall review the information and determine whether modification is necessary. If a modification is made, this shall be conveyed in writing to the health care professional and the director. If the modification results in further restrictions or limitations being placed on the health care professional, the director shall disclose this modification to the chief administrative officer or equivalent individual in each health care facility or community-based practice where the health care professional is performing invasive procedures.

(4) As described in 191.700.2(5)(d), RSMo, a health care facility peer review panel may evaluate HIV- or HBV-infected health care professionals who perform invasive procedures. This evaluation process may be accessed directly by an infected health care professional, or by the director of a health care facility with the consent of the infected health care professional and after consultation with his/her private physician. This evaluation shall take place as follows:

(A) If a health care facility regulated under sections 197.010–197.120, RSMo maintains or establishes an internal peer review panel for the evaluation of HIV- or HBV-infected health care professionals who perform invasive procedures, this panel shall—

1. Maintain the confidentiality of the infected health care professional. Panel members shall be subject to the requirements of section 191.656, RSMo regarding the confidentiality of information on an HIV-infected health care professional's infection status;

2. Conduct an evaluation of the infected health care professional and his/her practice. This evaluation and any recommendations shall be based on the premise that HIV or HBV infection alone does not justify limiting the health care professional's duties;

3. Allow the health care professional to appear before the peer review panel and present any information which s/he believes to be pertinent to the panel's task. The health care professional's personal physician(s), as well as any other individual(s) the health care professional believes can provide input into



the process, shall be allowed to appear before the panel;

4. Establish, utilizing the criteria specified in subsection (3)(D) of this rule, whether restrictions or limitations shall be placed on the practice of the health care professional. If the panel is uncertain about whether a specific procedure may pose some risk of HIV or HBV transmission, it may recommend that this procedure be performed only after the patient has been informed of the health care professional's infection status;

5. Require the health care professional to notify any affected patient in a timely manner whenever a parenteral or mucous membrane exposure to the health care professional's blood occurs;

6. Report its findings and recommendations in writing to the health care professional;

7. Report its findings and recommendations in writing to the director including how the evaluation process was conducted. The department shall review the report to determine concurrence with 191.700.2(5)(d), RSMo and this rule. Results of the department's review shall be reported back to the facility. In the event the health care professional later seeks an evaluation by a department-appointed panel, the findings and recommendations of the facility's peer review panel shall be included as part of this evaluation; and

8. Require, as necessary, that the infected health care professional undergo periodic reviews to determine if the decision to place or not to place restrictions or limitations on his/her practice needs to be modified because of changes in his/her medical condition or some other relevant circumstance. If a review results in the panel making such a modification, this modification shall be conveyed in writing to the health care professional and the director; and

(B) When a facility's internal peer review panel conducts a review in concurrence with 191.700.2(5)(d), RSMo and this rule, the following shall be performed:

1. The infected health care professional shall provide a list to the director of all other health care facilities and community-based practices, regardless of location, where s/he performs invasive procedures. The director shall disclose to the chief administrative officer or equivalent individual in each of these other facilities and practices any restrictions or limitations placed on the health care professional's practice by the panel;

2. If the health care professional seeks to affiliate with an additional health care facility or community-based practice, regardless of its location, where s/he will be performing

invasive procedures, s/he shall disclose to the chief administrative officer or equivalent individual in that facility or practice the findings of the peer review panel, and any restrictions or limitations placed on his/her practice by the panel, prior to the affiliation and the provision of patient care, and notify the department of the new practice location;

3. If the health care professional plans to begin performing invasive procedures at a health care facility or community-based practice where s/he is currently affiliated but not presently performing those procedures, s/he shall disclose to the director or chief administrative officer in that facility or practice the findings of the peer review panel, and any restrictions or limitations placed on his/her practice by the panel, prior to the performance of any invasive procedures, and report the change in practice to the department;

4. It shall be the responsibility of each health care facility where the health care professional is employed and performing invasive procedures to monitor him/her for compliance with the practice restrictions or limitations at appropriate intervals, at least annually, based on his/her medical status and the types and frequencies of invasive procedures s/he performs. If a facility finds the health care professional to be noncompliant, it shall report this in writing to the appropriate state board, as provided under Chapters 330, 332, 334 or 335, RSMo, and to the director;

5. If the health care professional also performs invasive procedures in a community-based setting, it shall be the responsibility of the department to monitor him/her for compliance with the restrictions or limitations in this setting at appropriate intervals, at least annually, based on his/her medical status and the types and frequencies of invasive procedures s/he performs. If the department finds the health care professional to be noncompliant, it shall report this in writing to the appropriate state board, as provided under Chapters 330, 332, 334 or 335, RSMo, and to the director;

6. If the director becomes aware that the infected health care professional is noncompliant with practice restrictions or limitations at any location where s/he is performing invasive procedures, the director shall report this noncompliance to the director or chief administrator in each health care facility and community-based practice where the health care professional performs invasive procedures;

7. If the peer review panel, as a result of a periodic review of the infected health care professional's status, makes a modification in its recommendations that results in restric-

tions or limitations, or further restrictions or limitations, being placed on the health care professional, the director shall disclose this modification to the chief administrative officer or equivalent individual in any other health care facilities or community-based practices where the health care professional is performing invasive procedures; and

8. If restrictions or limitations have been placed on a health care professional's practice by the peer review panel and if later there is a change in the health care professional's medical condition or some other relevant circumstance, and as a result s/he believes that the restrictions or limitations should be modified, s/he may request that the panel consider the modification. The panel shall review the pertinent evidence and determine whether such modification shall be made. If a modification is made, this shall be conveyed in writing to the health care professional and the director. If the modification results in further restrictions or limitations being placed on the health care professional, the director shall disclose the modification to the chief administrative officer or equivalent individual in any other health care facilities or community-based practices where the health care professional is performing invasive procedures.

*AUTHORITY: section 191.700.2, RSMo 2000.\* Original rule filed April 17, 1995, effective Nov. 30, 1995. Emergency amendment filed May 10, 2002, effective July 1, 2002, expired Dec. 28, 2002. Amended: Filed May 10, 2002, effective Nov. 30, 2002.*

*\*Original authority: 191.700.2, RSMo 1992.*

### **19 CSR 20-26.070 Notification of Results of Court-Ordered Human Immunodeficiency Virus (HIV) Testing of Sexual Offenders**

*PURPOSE: This rule establishes the procedure for notifying victims and jail or correctional facility administrators and the offenders of results when sexual offenders undergo court-ordered testing for human immunodeficiency virus.*

(1) If a court orders a person to undergo HIV testing under section 191.663, RSMo, the following information shall be reported by the court to the Section of STD/HIV/AIDS Prevention and Care Services:

(A) The identity of the person to be tested;  
(B) The name and address of the facility which will submit the sample for testing;

(C) The name and address of the laboratory which will conduct the testing, if known;



(D) The name, address and telephone number of each victim who has a right to access the HIV test results under section 191.663, RSMo; and

(E) The name, address and telephone number of the administrator of the jail or correctional facility where the sexual offender is confined.

(2) All results of HIV testing performed under the provisions of section 191.663, RSMo, shall be reported by the laboratory performing the test to the Office of Surveillance.

(3) Section of STD/HIV/AIDS Prevention and Care Services counseling and intervention staff shall convey the results of the testing, along with appropriate counseling and any necessary referral assistance, to each victim.

(4) Section of STD/HIV/AIDS Prevention and Care Services staff shall convey the results of the testing, along with any necessary educational information relative to those results, to the administrator of the jail or correctional facility in which the sexual offender is confined.

(5) Section of STD/HIV/AIDS Prevention and Care Services staff shall ensure that the results of the HIV testing are conveyed to the sexual offender appropriately and confidentially.

*AUTHORITY: section 191.663, RSMo Supp. 1999.\* Emergency rule filed Nov. 2, 1994, effective Nov. 12, 1994, expired March 11, 1995. Emergency rule filed March 1, 1995, effective March 12, 1995, expired July 9, 1995. Original rule filed Nov. 2, 1994, effective May 28, 1995. Amended: Filed June 1, 2000, effective Nov. 30, 2000.*

*\*Original authority: 191.663, RSMo 1990, amended 1992, 1993, 1996, 1999.*