



Multi-system Inflammatory Syndrome in Children and Adolescents (MIS-C)

Case Report Form

INSTRUCTIONS

- This form is confidential when completed.
- All SARS-CoV-2 positive laboratory results need to be appended by the physician to this form, when applicable.
- Use the Notes section to include any additional comments that could not be placed in a relevant section.
- Completed forms should be submitted to the health authority pertaining to the residence of the case:
 - Vancouver Coastal Health Authority - Fax: (604) 731-2756
 - Fraser Health Authority - Fax: (604) 930-5414
 - Interior Health Authority - Fax: (250) 549-6310
 - Vancouver Island Health Authority - Fax: (250) 519-3441
 - Northern Health Authority Central Communicable Disease Hub Fax: (250) 649-7071.
- Any updates as to the Outcome section will be reported by the health authority to BCCDC.
- Only Confirmed MIS-C cases are reportable provincially.

HEALTHCARE PROVIDER COLLECTING CASE INFORMATION

Hospital/clinic name: _____

Physician Name: _____ Phone Number: () - ext.

Email: _____ Fax Number: () - ext.

Date of data collection: _____
YYYY / MM / DD

HEALTH AUTHORITY/PUBLIC HEALTH STAFF REPORTING TO BCCDC

Health Authority: FHA FNHA IHA NHA VCH VIHA

Reporter Name: _____ Phone Number: () - ext.

Email: _____ Fax Number: () - ext.

Date report received by health authority: _____
YYYY / MM / DD

A) CASE PERSONAL INFORMATION

Name: _____ Last First Middle

Date of Birth: _____ Sex: Male Female Undifferentiated Unknown
YYYY / MM / DD

Health Card Number: _____ Alternate Name(s): _____

Address: _____ Unit # Street # Street Name City

Postal Code: _____ Province: _____ Country of Residence (if not Canada): _____

B) INDIGENOUS INFORMATION

Do you self-identify as an Indigenous Person?

Asked, not provided No Non-BC Resident Yes

Indigenous Identity: Asked, but unknown Asked, not provided First Nations

First Nations and Inuit First Nations and Métis First Nations, Inuit and Métis Inuit

Inuit and Métis Métis Not asked

First Nations Status: Asked, but unknown Asked, not provided Non-Status Indian

Not Asked Status Indian

Indigenous Organization: _____



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C) COMORBIDITIES / PAST HISTORY

Does the case have a chronic disease or comorbidity? Yes No Not assessed

If yes, specify 1: _____

specify 2: _____

specify 3: _____

D) PATHOGEN TESTING

Was the case tested for bacterial or viral infections (besides COVID-19)? Yes No

specify result: Positive Negative Unknown

If test result was positive, specify pathogen identified: _____

type of specimen collected: _____

specimen collection date (YYYY/MM/DD): ____/____/____

E) COVID-19 EXPOSURE

Was the case tested by RT-PCR/NAT? Yes No

If yes, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

If retest performed, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

comments: _____

Was the case tested by antigen test? Yes No

If yes, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

If retest performed, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

comments: _____

Was the case tested by serology? Yes No

If yes, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

If positive, specify type: Total Ig IgG

If retest performed, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

If positive, specify type: Total Ig IgG

If retest performed, specimen collection date (YYYY/MM/DD): ____/____/____

specify result: Positive Negative Indeterminate

If positive, specify type: Total Ig IgG



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Was the case in close contact with a laboratory confirmed or probable or epi-linked probable COVID-19 case? Yes No Unknown

If yes:

Name <i>Last, First</i>	PHN	First Contact Date or Sustained Contact <i>YYYY / MM / DD</i>	Last Contact Date <i>YYYY / MM / DD</i>	Contact Setting (e.g., household)
		<input type="checkbox"/> Sustained contact		
		<input type="checkbox"/> Sustained contact		
		<input type="checkbox"/> Sustained contact		

F) SIGNS AND SYMPTOMS

Onset of earliest symptom: _____ / _____ / _____
YYYYMMDD

Clinical picture	Yes	No	Unknown	Not Assessed
Fever If yes, total duration of fever: _____ days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Features of hypotension or shock				
Shock (hypotension, tachycardia, prolonged capillary refill time, pale/mottled skin, cold extremities, or urinary output <2 mL/kg/hr)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cutaneous and mucocutaneous				
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis (bilateral, non-purulent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral mucosal inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral signs of inflammation (e.g. erythema and edema or peeling of hands and/or feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal				
Acute abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other				
<i>specify1:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>specify2:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>specify3:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>specify4:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

G) LABORATORY TESTS

Abnormal test result	Yes	No	Unknown	Not Assessed
Elevated ESR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated C-reactive protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated procalcitonin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated PT/PTT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated D-dimers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Elevated troponin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated BNP or NT-proBNP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Ferritin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 1: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 2: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 3: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 4: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

H) CARDIAC IMAGING

Abnormal echocardiogram finding	Yes	No	Unknown	Not Assessed
Features of myocardial dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Features of pericarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Features of valvulitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 1: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I) HOSPITALIZATION

Admitted to hospital: Yes No Not assessed

If yes, name of hospital: _____

Admission date (YYYY / MM / DD): ____/____/____ Discharge date (YYYY / MM / DD): ____/____/____

Admitted to intensive care unit: Yes No Not assessed

Admission date (YYYY / MM / DD): ____/____/____ Discharge date (YYYY / MM / DD): ____/____/____

J) OUTCOME

Fully recovered

Not yet recovered/recovering

Fatal *If died, date of death (YYYY / MM / DD):* ____/____/____

If died, specify cause of death: _____

Permanent disability, specify: _____

Other, specify: _____

Unknown

K) CLASSIFICATION

Person under investigation (non-reportable)

Confirmed

L) NOTES



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M) DEFINITIONS	
COVID-19 Confirmed – lab case	<p>A person with confirmation of infection with SARS-CoV-2 documented by:</p> <ul style="list-style-type: none"> The detection of at least one specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory) <p>OR</p> <ul style="list-style-type: none"> The detection of at least one specific gene target by a validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing) <p>OR</p> <ul style="list-style-type: none"> Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS-CoV-2
COVID-19 Probable – lab case	<ol style="list-style-type: none"> A person who: <ul style="list-style-type: none"> Has symptoms (see Symptoms* below) compatible with COVID-19 <p>AND</p> <ul style="list-style-type: none"> Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19 <p>AND</p> <ul style="list-style-type: none"> Has had a laboratory-based NAAT assay for SARS-CoV-2 and the result is inconclusive <p>OR</p> <ul style="list-style-type: none"> Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset A person who had a POC NAAT or POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive A person who had a validated POC antigen test for SARS-CoV-2 completed and the result is positive <p><i>*Symptoms compatible with COVID-19 include any 1 or more of the following: Fever or chills; Cough; Loss of sense of smell or taste; Difficulty breathing; Sore throat; Loss of appetite; Extreme fatigue or tiredness; Headache; Body aches; Nausea or vomiting; Diarrhea.</i></p>
COVID-19 Probable – epi-linked case	<ul style="list-style-type: none"> A person who has symptoms (see Symptoms* below) compatible with COVID-19 <p>AND</p> <ul style="list-style-type: none"> A person who had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19 <p>AND</p> <ul style="list-style-type: none"> A person who has not had a laboratory-based NAAT assay for SARS-CoV-2 completed. <p>(Note: Cases who had a high-risk exposure with a probable COVID-19 case that had a positive result to validated POC antigen test for SARS-CoV-2 where confirmatory testing was not required (as per the provincial guidelines for POC test in Rural, Remote and Indigenous Communities) should also be considered probable – epi-linked).</p> <p><i>*Symptoms compatible with COVID-19 include any 1 or more of the following: Fever or chills; Cough; Loss of sense of smell or taste; Difficulty breathing; Sore throat; Loss of appetite; Extreme fatigue or tiredness; Headache; Body aches; Nausea or vomiting; Diarrhea.</i></p>
Close contact	<p>A close contact is defined as a person who:</p> <p>provided direct care for the case, including healthcare workers, family members or other caregivers, or who had other similar close physical contact (e.g., intimate partner) without consistent and appropriate use of personal protective equipment, OR</p> <p>lived with or otherwise had close face to face contact (within 2 metres) with a probable or confirmed case for more than 15 minutes (may be cumulative, i.e., multiple interactions) up to 48 hours prior to symptom onset, OR</p> <p>had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended PPE, OR</p> <p>has been identified by the local MHO as a possible contact.</p>
Hospitalization	<p>Any person admitted to a hospital for at least an overnight stay, for reasons directly or indirectly related to their MIS-C, and with no period of complete recovery between illness and admission. If unable to determine whether an admission was related to MIS-C, please report as a hospital admission. Includes persons admitted to hospital but without transfer to a ward/unit.</p>
ICU admission	<p>Any person admitted to an intensive care unit (ICU) for at least an overnight stay, for reasons directly or indirectly related to MIS-C and with no period of complete recovery between illness and admission. If unable to determine whether an admission was related to MIS-C, please report as an ICU admission.</p>
Death	<p>A death occurring in any person with no period of complete recovery between illness and death, unless there is evidence that MIS-C did not contribute to the death (e.g., trauma, poisoning, drug overdose).</p>



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**MIS-C confirmed
case**

Children 0-19 years of age requiring hospitalization with fever for three days or more and two of the following:

- a) Acute gastrointestinal symptoms (abdominal pain, vomiting, diarrhea);
- b) Rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands or feet);
- c) Hypotension or shock;
- d) Features of myocardial dysfunction or pericarditis or valvulitis or coronary abnormalities: ECHO findings or elevated troponin/ brain natriuretic peptide (BNP)/ natriuretic peptide tests (NT-proBNP);
- e) Evidence of coagulopathy: Abnormal prothrombin time/ partial thromboplastin time (PT/PTT), elevated d-dimer;

And

Elevated markers of inflammation such as erythrocyte sedimentation rate, C-reactive protein, or procalcitonin;

And

No other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes, and no alternative plausible obvious diagnosis;

And

Evidence of SARS-CoV-2 infection (positive NAAT test, antigen test and/or serology) or close contact with a confirmed or probable (lab-probable or epi-link probable) COVID-19 case