

			C	onfidential whe	n comple	eted	
PERSO	N REPORTING					Date Papart Pagained at IIA agreement	
Health Au		A □ IHA	□ VIHA □ N	HA □ VCH		Date Report Received at HA(YYYY/MI Contact attempts (date and time)	M/DD): Interview?
Name:		A 1111A		TIA D VOIT		1.	
	Last		First			2.	
Phone:	( ) -	ext.				3.	
Email:						Interviewer:	☐ Not located
A. CLIN	NICAL INFORMA	ATION					
Date of c	onset: YYY	Y/MM/DD	Onset time:	AM /	PM [	Ouration of Symptoms:	
☐ Clinic	cal gastroenteritis	(vomiting, diarrh	nea)		leurologica	al symptoms (numbness, tingling sens	ation)
☐ Lab-d	confirmed pathoge	n, specify:			Other, spec	eify:	
Most Like	ely Diagnosis (to be	completed by BCC	DC in consultation with F	HA):			
B. FXPC	OSURE INFORM	IATION					
			s prior to onset (	check all that apply	y):		
Shellfisl	h:   Mussels	☐ Oysters	☐ Scallops	☐ Crab	□ Cockle	es   Other:	□ Unknown
Fish:	☐ Barracuda	a □ Grouper	☐ Snapper	☐ Mahi-Mahi	☐ Tuna	☐ Mackerel ☐ Marlin	-
	☐ Other:	·		☐ Unknown			
	e and amount consumed	Number of people ill	Preparation	Date and time consumed		Source	Tag/invoice Information:
Type of	f seafood:	# of people	☐ Raw		☐ Resta	aurant   Store/Market	☐ Attached
		at meal:	☐ Cooked		Nam	e:	☐ To follow
Amoun	t Consumed:		☐ Both raw	YYYY/MM/DD	Addr	ress:	☐ Not available
Amoun	it consumed.	# of people eating:	and cooked		Date	purchased: (YYYY/MM/DD)	
Deteile	(a a nama of	caung.	Details:	24 hour clock	☐ Self-h		
oyster v	(e.g. name of variety):			24 HOUR CIOCK	Loca	ition:	
		# of people ill:			Date	harvested:	
			1	1		(YYYY/MM/DD)	
C. INSF	PECTION AND T	AG INFORM	ATION				
Was an inspection of the food service establishment conducted? ☐ Yes ☐ No							
If no, why was no inspection conducted:							
				tributed to this illne			dditional issues not
☐ Yes	□ No □ Un	known	·				
Do the ta	ags collected repre	esent the shellfi	sh available to the	case? ☐ Yes I	□ No □	] Unknown	
, ,	, ,	•	ellfish consumed b	•	lfish availa	ble on date of exposure	

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D. CLIENT INFORMATION							
Name:	st	Middle		Alternate	e Name(s	):	
PHN:		te of Birth:	YYYY/MM/DD	Sex:			
Home Address:	Street # Stre	eet Name	YYYY/IMM/DD	City:			
Postal code:	Province:	Phone number	(home/office/cell)	( )		-	ext.
Email:		nysician nme <sub>Last</sub>	Firs	rt	Physic Phone	cian e Number:	
Interview conducted with:							
E. ABORIGINAL INFORMATION	ON						
Do you wish to self-identify as an A	boriginal Person?		☐ Asked, not pre	ovided	□ No	□ No	
			□ Not asked		☐ Ye	es	
Aboriginal Identity:	Aboriginal Identity:   Asked, but unknown			vided			
☐ First Nations and Inuit ☐ First Nation		ons and Métis   First Nations		Inuit and Métis	☐ Inc	uit	
☐ Inuit and Métis		☐ Not asked					
First Nations Status:		nknown	☐ Asked, not pro	ovided			
☐ Not Asked			☐ Status Indian				
F. ADDITIONAL RISK FACTO	RS AND EXPOS	SURES					
Travel during exposure period:	□ Yes □ No	□ U If Y	'es: ☐ within BC	□ outside BC but	within Ca	anada 🗆 outsid	de Canada
Was travel confirmed as the most li	kely source of infe	ection?   Yes					
Dates: DEPARTURE Dates	s: RETURN		cations country, resort)	Additional	detail	Foods brought	back
YYYY/MM/DD YYY	YY/MM/DD						
For infectious diseases only (e.g Did the case have contact with ill in  ☐ Yes ☐ No ☐ Unknown  If yes, specify:			od (E.g., at home, v	work, school)?			



G. CLINICAL I	NFORMATION						
Signs/Symptom	s/Clinical Presentation						
Gastrointestinal:	☐ Abdominal discomfort	t 🗆 Diarrhea			☐ Nausea	а	☐ Vomiting
Neurological:	eurological:   Blurred vision  Dizziness		<ul><li>☐ Opposite temperature felt for hot/cold items</li><li>☐ Memory loss</li></ul>		<ul><li>□ Difficulty speaking</li><li>□ Numbness/tingling of hands or feet</li></ul>		☐ Difficulty swallowing
							☐ Numbness/tingling of mouth/face/tongue
	☐ Paralysis		rtness of ath/breathing diff	ficulty	☐ Sweati	ng	☐ Unsteady walking/clumsy
	☐ Weakness						
Other:	☐ Arthralgia	☐ Ach	ing teeth		☐ Fever		☐ Headache
	☐ Metallic taste	☐ Ras	h		☐ Other:		
Does case have	known allergy to fish/shellfish	n? □ Yes	□ No □	Unknow	'n		
Does case have	? □ Yes	☐ Yes ☐ No ☐ Unknown		'n	If yes, specify:		
Does case take a	☐ Yes	□ No □	No 🗆 Unknown If yes, specify:				
Clinical description (please provide any details related to clinical presentation or course of illness):							
Hospitalization							
Did the individua	I seek medical care? 🛚 🗎 Ye	es 🗆 No	☐ Unknown	Did the	individual v	visit the ER?	s 🗆 No 🗆 Unknown
Hospitalization g	reater than 24 hours 🔲 Ye	es 🗆 No	☐ Unknown	Hospita	al name:		
Admission date:		2000//		Dischar —	rge date:		
Physician diagnosis:							
Outcome Death: Yes No Unknown If yes, death date:							



H. LABORATORY INFORMATION								
Food and Water								
Was fish/shellfish linked to case tested	d? □ Yes □ No	☐ Unknown	If yes, type of food tested:					
Source of food tested:	☐ Leftover	☐ Same lot ☐	Same site					
Collection date:								
	YYYY/MM/DD	_						
Was water linked to case tested?	☐ Yes ☐ No	☐ Unknown	If yes, collection date:					
		Sample		YYYY/MM/DD				
Toxin/pathogen*	Tested	description	Results	Notes				
PSP	☐ Yes ☐ No ☐ U							
DSP	☐ Yes ☐ No ☐ U							
ASP	☐ Yes ☐ No ☐ U							
NSP	☐ Yes ☐ No ☐ U							
Dinoflagellates (water only)	☐ Yes ☐ No ☐ U							
Histamine	☐ Yes ☐ No ☐ U							
Ciguatera toxin	☐ Yes ☐ No ☐ U							
Bacteria: (specify)	☐ Yes ☐ No ☐ U							
Viruses: (specify)	☐ Yes ☐ No ☐ U							
Other: (specify)	☐ Yes ☐ No ☐ U							
*Toxins are tested by CFIA laboratories. Virus, bacteria and parasites are tested by BC Public Health Microbiology and Reference Laboratory Limits for marine toxins can be found here: <a href="http://www.hc-sc.gc.ca/fn-an/securit/chem-chim/contaminants-guidelines-directives-eng.php">http://www.hc-sc.gc.ca/fn-an/securit/chem-chim/contaminants-guidelines-directives-eng.php</a> U=Unknown								
Clinical								
Were clinical specimen(s) tested? ☐ Yes ☐ No ☐ Unknown								
Specimen Type	Reporting Lab	Collection Date	Resu	ılt				
		YYYY/MM/DD						
	<u> </u>	YYYY/MM/DD	<u> </u>					



### I. NOTIFICATION

### Reporting of case

- All Health Authorities except VCH & FHA: Enter case details into Panorama under the specific disease (see flowchart and table).
- Vancouver Coastal Health & Fraser Health: Enter case into PARIS under the specific disease (see flowchart and table). Fax or email ALL PAGES of completed form to BCCDC

### Submission of form

Fax or email all pages of completed form to BCCDC Enteric Epi (ezvbepi@bccdc.ca or 604-707-2516) if screening criteria are met

### Submission of tags

If client consumed bivalve shellfish purchased from a restaurant or store in British Columbia, fax or email tags to: Enteric Epi, BCCDC (604) 707-2516, <a href="mailto:example-exampl

If criteria for reporting shellfish-related illnesses to CFIA are met, BCCDC will send page 1 of form and tags to CFIA.

J. Additional Details Related to Case Investigation					
Date	Comment	Initials			

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