



Creutzfeldt-Jakob Disease Reporting Form

to be faxed to health authority where patient resided (see attached map)

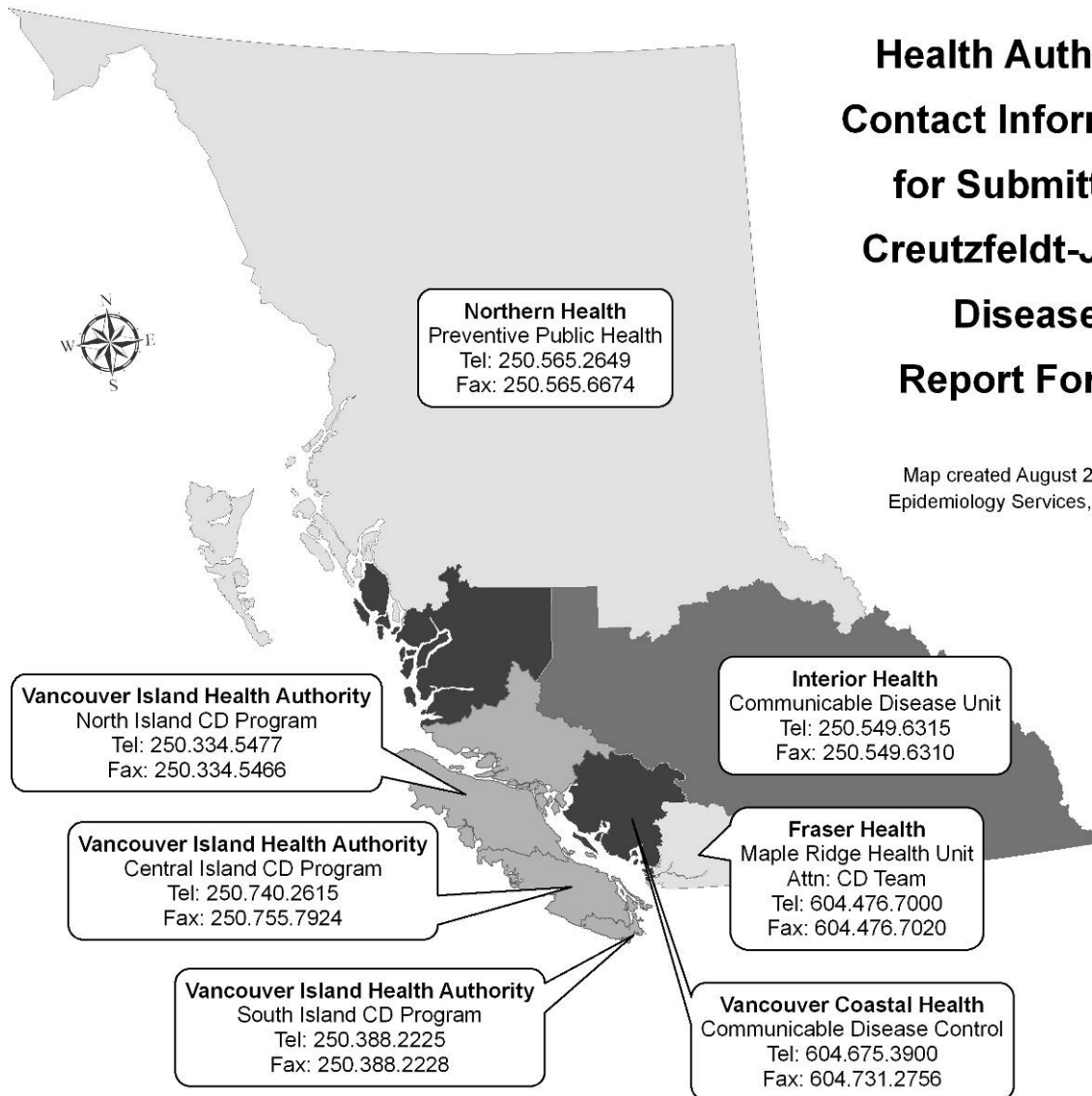
PERSON REPORTING			
Physician last name:		First:	
Office phone number:		Hospital secretary number:	
Street address:		City:	Prov: Postal:

PATIENT INFORMATION			
Patient's last name:		First:	PHN:
Birth date(m/d/y):	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Health Authority: <input type="checkbox"/> FHA <input type="checkbox"/> IHA <input type="checkbox"/> VIHA <input type="checkbox"/> VCH <input type="checkbox"/> NHA	
Street address:		City:	Prov: Postal:

CLINICAL INFORMATION		
CJD Type: <input type="checkbox"/> sporadic <input type="checkbox"/> familial <input type="checkbox"/> iatrogenic <input type="checkbox"/> variant		
Case Status: <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable	Status confirmed date(m/d/y):	
Symptom onset date (m/d/y):		
Signs and symptoms description :		
Potential exposures of the patient to prion infectivity (e.g., growth hormone, dura mater) :		
Has patient been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	If yes, where:	Hospitalized date (m/d/y):
Potential exposures of others to the case i.e., infectivity originating with the patient (e.g., endoscopy, neurosurgery) : <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, where:	when:	
Neurologist Signature:		Date:



Health Authority Contact Information for Submitting Creutzfeldt-Jakob Disease Report Forms



Map created August 2008 by
Epidemiology Services, BCCDC