



Confidential when completed

PERSON REPORTING

Health Authority: FHA IHA VIHA NHA VCH

Name: _____
Last First

Phone: () - ext.

Email: _____

Date Report Received at HU (YYYY/MM/DD): _____

Contact attempts (date and time)	Interview?
1.	<input type="checkbox"/>
2.	<input type="checkbox"/>
3.	<input type="checkbox"/>
4.	<input type="checkbox"/>

Interviewer: _____ Not located

A. CLIENT INFORMATION

Name: _____ Last First Middle Alternate Name(s): _____

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

Home Address: _____ Unit # Street # Street Name City: _____

Postal code: _____ Province: _____ Phone number (home/office/cell) () - ext.

Email: _____ Physician Name _____ Last First Physician Phone Number: _____

Interview conducted with: _____

B. ABORIGINAL INFORMATION

Do you wish to self-identify as an Aboriginal Person? Asked, not provided No
 Not asked Yes

Aboriginal 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

C. CLINICAL INFORMATION

Date of onset of symptoms: _____ Onset time: _____ AM / PM
YYYY / MM / DD

Signs and Symptoms

Abdominal discomfort Diarrhea Bloody diarrhea Other: _____
 Fever Nausea Vomiting

Hospitalization

Admitted to hospital: Yes No DK Hospital name: _____
Admission date: _____ Discharge date: _____
YYYY / MM / DD YYYY / MM / DD

Outcome

Death: Yes No DK If yes, death date: _____ Antibiotic use: Yes No DK
YYYY / MM / DD

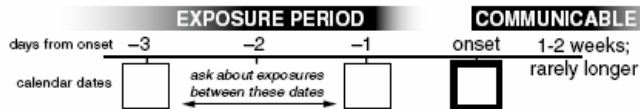


D. LABORATORY INFORMATION

Specimen type	Reporting lab	Collection date	Reported date	Results
		YYYY / MM / DD	YYYY / MM / DD	Serotype:

E. RISK FACTORS AND EXPOSURE INFORMATION

Enter onset date in heavy box.
Count back to figure the
probable exposure period.



NOTE: If Salmonella was isolated from blood or urine, exposure period should be adjusted to reflect most likely onset of initial enteric symptoms.

Travel

Travel during exposure period: Yes No DK If Yes: within BC outside BC but within Canada outside Canada

Was travel confirmed as the most likely source of infection? Yes

Dates: DEPARTURE	Dates: RETURN	Locations (e.g., city, country, resort)	Mode of travel	Foods brought back
YYYY / MM / DD	YYYY / MM / DD			

Animal Contact

In the 3 days prior to onset...	Response	Details (include location, type or frequency of contact)
Did you have contact with any animals (e.g., reptiles, rodents, farm animals, pets)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you have contact with reptiles or rodents	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you have contact with poultry (e.g., chicks, goslings, ducklings, turkeys)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you have contact with other animals including wildlife?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you have contact with or visit a farm/petting zoo/agricultural facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you have contact with any raw pet food or treats derived from animal parts (e.g., pig ears, rawhide, cow hooves)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	



E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Food Exposures

Vegetarian? Yes No DK

Food allergies / avoidances / special diet? Yes No DK

If Yes, Details: _____

In the 3 days prior to onset did you eat...	Response	Details (E.g., where consumed, type, brand, location)
Any chicken meat?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Any whole chicken pieces/parts (e.g. whole chicken, breasts, wings, thighs, in soups, or as part of a dish, not including deli-meat)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Breaded chicken (e.g. chicken nuggets, strips or burgers)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Other chicken or poultry meat (e.g., deli meat, ground chicken, turkey, quail, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you handle or prepare any raw chicken?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Any eggs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Were the eggs raw/soft/undercooked?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Did you handle/ prepare any eggs or foods containing raw eggs?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Foods or beverages that contain raw, soft, undercooked eggs (raw cookie dough, desserts, drinks, dressings, stir fry, hot pot)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	



E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Food Exposures *continued*

In the 3 days prior to onset did you eat...	Response	Details (E.g., where consumed, type, brand, location)
Pork, including sausage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Beef, including hamburger patties, other ground beef (meatballs, chilli, spaghetti sauce), steak, roast, donair	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Seafood, including fish or shellfish (cooked / raw / smoked)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Sprouts (e.g. bean or alfalfa or any other kind), including any sprouts on a sandwich or salads	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Lettuce or leafy greens (including pre-packaged greens)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Cucumbers	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Tomatoes	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Cantaloupe	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Papaya	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Fresh herbs (e.g., cilantro, parsley, basil)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Nuts, (either on their own, in granola bar, as a garnish or as part of a dish)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Peanut butter or other nut butter or spread	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Seeds (e.g., sunflower, sesame, chia, flax, hemp, sprouted seeds)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Tahini, halva, or other products made from sesame seeds	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	
Cheese made with unpasteurized (raw) milk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	

In the 3 days prior to onset...

Event/Social gathering	Location	Date (YYYY/MM/DD)	Foods Eaten
Restaurants (including: take-out, cafeteria, bakery, deli, kiosk)	Location	Date (YYYY/MM/DD)	Foods Eaten
Grocery stores for food consumed during the incubation period	Location	Foods Purchased	Brands/Other details



F. CONTACTS

people in household:

Name	Date ill	Nature of contact*	Occupation/Details	Contact phone	^Excluded?

*Household, sexual, close contacts

^ Please complete Contact Exclusion Form for each contact excluded.

G. INTERVENTIONS

Type	Implemented	Details
Referred for Inspection	<input type="checkbox"/>	
Hygiene Education	<input type="checkbox"/>	
Referred to another HA	<input type="checkbox"/>	
Health File Sent	<input type="checkbox"/>	
Other:	<input type="checkbox"/>	

H. OCCUPATION AND EXCLUSION

Occupation:
(Prompt for agricultural/animal contact and working in food service industry and specify)

Sensitive Setting (check if applicable):

- Work/volunteer or attend day care
- Work/volunteer in a health care setting
- Work/volunteer as a food handler
- Other (e.g. pool): _____

Facility name:

Excluded Y N Effective date (YYYY/MM/DD):

Details:

Symptom end date (YYYY/MM/DD):

Exclusion lifted: (YYYY/MM/DD):

MHO:

I. NOTES

Date	Comment	Initials