BC Centre for Disease Control
AN AGENCY OF THE PROVINCIAL HEALTH SERVICES AUTHORITY

Seafood-related illness (excluding *Vibrio* spp.) Case Report Form

Confidential when completed

PERSON REPORTING	
Health Authority:	☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH
Name:	Last First
Phone:	( ) - ext.
Email:	

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

Contact attempts (date and time)	*Interview?*
1.	☐
2.	☐
3.	☐

Interviewer: ☐ *Not located*

A. CLINICAL INFORMATION

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

☐ Clinical gastroenteritis (vomiting, diarrhea) ☐ Neurological symptoms (numbness, tingling sensation)

☐ Lab-confirmed pathogen, *specify*: _____ ☐ Other, *specify:* _____

Most Likely Diagnosis *(to be completed by BCCDC in consultation with HA)*:

B. EXPOSURE INFORMATION

Fish and shellfish exposures in 48 hours prior to onset (check all that apply)**:**

Shellfish: ☐ Mussels ☐ Oysters ☐ Scallops ☐ Crab ☐ Cockles ☐ Other: _____ ☐ Unknown

Fish: ☐ Barracuda ☐ Grouper ☐ Snapper ☐ Mahi-Mahi ☐ Tuna ☐ Mackerel ☐ Marlin

☐ Other: _____ ☐ Unknown

Type and amount consumed	Number of people ill	Preparation	Date and time consumed	Source	Tag/invoice Information:
Type of seafood: **Amount Consumed:** **Details** (e.g. name of oyster variety):	**# of people at meal:** **# of people eating:** **# of people ill:**	☐ Raw ☐ Cooked ☐ Both raw and cooked **Details:**	_____ YYYY/MM/DD _____ 24 hour clock	☐ Restaurant ☐ Store/Market **Name:** **Address:** **Date purchased:** (YYYY/MM/DD) ☐ Self-harvest **Location:** **Date harvested:** (YYYY/MM/DD)	☐ Attached ☐ To follow ☐ Not available

C. INSPECTION AND TAG INFORMATION

Was an inspection of the food service establishment conducted? ☐ Yes ☐ No

If yes, did the inspection find any issues that could have contributed to illness (E.g., handling, temperature abuse)? ☐ Yes ☐ No ☐ Unknown

If yes or unknown, specify issues identified: _____

If no, why was no inspection conducted: _____

Do the tags collected represent the shellfish available to the case? ☐ Yes ☐ No ☐ Unknown

If no, provide explanation (E.g., missing tags, etc.): _____

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D. 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:			

E. ABORIGINAL INFORMATION

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

F. ADDITIONAL RISK FACTORS AND EXPOSURES

Travel during exposure period: ☐ Yes ☐ No ☐ U *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)	Additional detail	Foods brought back
YYYY / MM / DD	*YYYY / MM / DD*			

For infectious diseases only (e.g., norovirus and acute GI)
Did the case have contact with ill individuals during their exposure period (E.g., at home, work, school)?

☐ Yes ☐ No ☐ Unknown

If yes, specify: _____

G. CLINICAL INFORMATION

Signs/Symptoms/Clinical Presentation

Gastrointestinal:	☐ Abdominal discomfort	☐ Diarrhea	☐ Nausea	☐ Vomiting
Neurological:	☐ Blurred vision	☐ Opposite temperature felt for hot/cold items	☐ Difficulty speaking	☐ Difficulty swallowing
	☐ Dizziness	☐ Memory loss	☐ Numbness/tingling of hands or feet	☐ Numbness/tingling of mouth/face/tongue
	☐ Paralysis	☐ Shortness of breath/breathing difficulty	☐ Sweating	☐ Unsteady walking/clumsy
	☐ Weakness			
Other:	☐ Arthralgia	☐ Aching teeth	☐ Fever	☐ Headache
	☐ Metallic taste	☐ Rash	☐ Other: _____	

Does case have known allergy to fish/shellfish? ☐ Yes ☐ No ☐ Unknown

Does case have any other medical conditions? ☐ Yes ☐ No ☐ Unknown *If yes*, specify: _____

Does case take any medications? ☐ Yes ☐ No ☐ Unknown *If yes*, specify: _____

Clinical description (*please provide any details related to clinical presentation or course of illness*):

Hospitalization

Did the individual seek medical care? ☐ Yes ☐ No ☐ Unknown Did the individual visit the ER? ☐ Yes ☐ No ☐ Unknown

Hospitalization greater than 24 hours ☐ Yes ☐ No ☐ Unknown Hospital name: _____

Admission date: _____ *YYYY / MM / DD* Discharge date: _____ *YYYY / MM / DD*

Physician diagnosis: _____

Outcome Death: ☐ Yes ☐ No ☐ Unknown *If yes*, death date: _____ *YYYY / MM / DD*

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H. LABORATORY INFORMATION

Food and Water

Was fish/shellfish linked to case tested? ☐ Yes ☐ No ☐ Unknown *If yes,* type of food tested: _____

Source of food tested: ☐ Leftover ☐ Same lot ☐ Same site ☐ Other: _____

Collection date: _____ *YYYY / MM / DD*

Was water linked to case tested? ☐ Yes ☐ No ☐ Unknown *If yes*, collection date: _____ *YYYY / MM / DD*

Toxin/pathogen*	Tested	Sample 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: http://www.hc-sc.gc.ca/fn-an/securit/chem-chim/contaminants-guidelines-directives-eng.php
U=Unknown

Clinical

Were clinical specimen(s) tested? ☐ Yes ☐ No ☐ Unknown

Specimen Type	Reporting Lab	Collection Date	Result
		YYYY / MM / DD	
		YYYY / MM / DD	

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I. NOTIFICATION

Reporting of case

- **All Health Authorities except VCH:** Enter case details into Panorama under the specific disease (see flowchart and table).
- **Vancouver Coastal 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 (marsha.taylor@bccdc.ca or 604-707-2516)

Submission of tags

If client consumed bivalve shellfish purchased from a restaurant or store in British Columbia, fax or email tags to: Marsha Taylor, BCCDC (604) 707-2516, marsha.taylor@bccdc.ca. Please include the Panorama Investigation ID of the client(s) associated with the tags when faxing the tags (VCH: if the tags are faxed separately from the case report form, please include information to link the tags to the appropriate case).

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