



Seafood-Related Illness Report Form

Reporting of case(s)

- All health authorities:** Utilize the [flowchart](#) and [table](#) to determine the most likely diagnosis, and enter all case details into Panorama or PARIS under the specific disease.

Submission of seafood-related illness form and tags

- Submit all pages of completed form to BCCDC via ezvbepi@bccdc.ca.**
- Only submit one form per dining party (cluster).**
- If client consumed bivalve shellfish purchased from a restaurant or store in British Columbia, also submit the shellfish tags and invoices to BCCDC with the form.
- If criteria for reporting shellfish-related illness are met, BCCDC will send deidentified information and the tags to the Canadian Food Inspection Agency.

Supplemental tools for seafood-related illnesses can be found under the “Enteric, Food, and Waterborne” section of <http://www.bccdc.ca/health-professionals/professional-resources/surveillance-forms>.

PERSON REPORTING

Health authority: <input type="checkbox"/> FH <input type="checkbox"/> IH <input type="checkbox"/> ISLH <input type="checkbox"/> NH <input type="checkbox"/> VCH	Contact attempts (date & time)	Interview?
Date report received at health unit: <small>YYYY-MM-DD</small>	1.	<input type="checkbox"/>
Name:	2.	<input type="checkbox"/>
Phone:	3.	<input type="checkbox"/>
Email:	4.	<input type="checkbox"/>
Interviewer:	<input type="checkbox"/> Not located	
Interview conducted with: <input type="checkbox"/> Case <input type="checkbox"/> Proxy, specify:		

A. CLIENT INFORMATION

Name: <small>Last First Middle</small>		
Preferred name:		Date of birth: <small>YYYY-MM-DD</small>
PHN:	Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> X <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown	
Phone:	Type: <small>(cell/home/work/other)</small>	Phone: Type: <small>(cell/home/work/other)</small>
Address: <small>Unit # Street # Street name</small>		City:
Province:	Postal code:	Email:
Do you wish to self-identify as an Indigenous person? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Not asked		
If yes, how do you identify? Select all that apply:	<input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Métis <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Asked, but unknown <input type="checkbox"/> Not asked	
If First Nations, status:	<input type="checkbox"/> Status Indian <input type="checkbox"/> Non-status Indian <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Asked, but unknown <input type="checkbox"/> Not asked	

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B. CLINICAL INFORMATION

Symptom onset:	Onset time:	Duration of symptoms:
YYYY-MM-DD	24hr clock	
<input type="checkbox"/> Clinical gastroenteritis (vomiting, diarrhea)	<input type="checkbox"/> Neurological symptoms (numbness, tingling sensation)	
<input type="checkbox"/> Lab-confirmed pathogen, specify:	<input type="checkbox"/> Other, specify:	

Most likely diagnosis*:

*To be completed by health authority using the [flowchart](#) and [table](#). Consult with BCCDC if required.

C. EXPOSURE INFORMATION

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

Shellfish:	<input type="checkbox"/> Clams	<input type="checkbox"/> Cockles	<input type="checkbox"/> Crab	<input type="checkbox"/> Mussels	<input type="checkbox"/> Oysters
	<input type="checkbox"/> Scallops	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:		
Fish:	<input type="checkbox"/> Barracuda	<input type="checkbox"/> Grouper	<input type="checkbox"/> Mackerel	<input type="checkbox"/> Mahi-Mahi	<input type="checkbox"/> Marlin
	<input type="checkbox"/> Snapper	<input type="checkbox"/> Tuna	<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:	

If multiple seafoods consumed, complete the following table for the suspect source(s) of illness only.

Type of seafood:	Details: (e.g., name of oyster variety)		
Preparation: <input type="checkbox"/> Raw <input type="checkbox"/> Cooked <input type="checkbox"/> Both raw & cooked	Preparation details:		
Amount consumed:	Date consumed:	Time consumed:	
	YYYY-MM-DD	24hr clock	
Number of people at meal:	Number of people eating:	Number of people ill:	
Source: <input type="checkbox"/> Restaurant <input type="checkbox"/> Store/market	<input type="checkbox"/> Self-harvest		
Name:	Location:		
Address:			
Date purchased:	Date harvested:		
YYYY-MM-DD	YYYY-MM-DD		
Available tag/invoice information: <input type="checkbox"/> Attached <input type="checkbox"/> To follow <input type="checkbox"/> Not available			

D. INSPECTION & TAG INFORMATION

Was an inspection of the food service establishment conducted?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, why was no inspection conducted: _____	
If yes, did the inspection find any issues that could have contributed to this illness?* (e.g., handling, temperature abuse)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes or unknown, specify issues identified: _____	
*If additional issues not related to this investigation are identified, use space in section H to record.	
Do the tags collected represent the shellfish available to the case?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
If yes, specify what tags represent:	<input type="checkbox"/> Shellfish consumed by case
<input type="checkbox"/> Shellfish available on date of exposure <input type="checkbox"/> Other:	_____
If no, provide explanation (e.g., missing tags): _____	

E. EXPOSURE INFORMATIONTravel during exposure period: ☐ Yes ☐ No ☐ UnknownIf yes: ☐ Within BC ☐ Outside BC but within Canada ☐ Outside CanadaWas travel confirmed as the most likely source of infection? ☐ Yes

Dates	Details (e.g., city, country, hotel or residence, foods brought back)
Departure: YYYY-MM-DD	
Return: YYYY-MM-DD	

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

☐ Yes ☐ No ☐ Unknown If yes, specify:

F. CLINICAL INFORMATION**Gastrointestinal Signs, Symptoms, or Clinical Presentation**☐ Abdominal discomfort ☐ Diarrhea ☐ Nausea ☐ Vomiting**Neurological Signs, Symptoms, or Clinical Presentation**

<input type="checkbox"/> Blurred vision	<input type="checkbox"/> Difficulty speaking
<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Memory loss	<input type="checkbox"/> Numbness/tingling of hands or feet
<input type="checkbox"/> Numbness/tingling of mouth/face/tongue	<input type="checkbox"/> Opposite temperature felt for hot/cold items
<input type="checkbox"/> Paralysis	<input type="checkbox"/> Shortness of breath/breathing difficulty
<input type="checkbox"/> Sweating	<input type="checkbox"/> Unsteady walking/clumsy
<input type="checkbox"/> Weakness	

Other Signs, Signs, Symptoms, or Clinical Presentation

<input type="checkbox"/> Aching teeth	<input type="checkbox"/> Arthralgia	<input type="checkbox"/> Fever	<input type="checkbox"/> Headache
<input type="checkbox"/> Metallic taste	<input type="checkbox"/> Rash	<input type="checkbox"/> Other:	

Does case have known allergy to fish or shellfish? ☐ Yes ☐ No ☐ UnknownDoes 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 ☐ UnknownDid the individual visit the ER? ☐ Yes ☐ No ☐ UnknownHospitalization greater than 24 hours? ☐ Yes ☐ No ☐ Unknown

Hospital name:

Admission:

YYYY-MM-DD

Discharge:

YYYY-MM-DD

Physician diagnosis:

Death: ☐ Yes ☐ No ☐ Unknown If yes, date of death:

YYYY-MM-DD

G. LABORATORY INFORMATION**Food and Water Specimens**Was fish/shellfish linked to case tested? ☐ Yes ☐ No ☐ Unknown

If yes, type of food tested:

Collection date:

YYYY-MM-DD

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

Was water linked to case tested?

☐ Yes ☐ No ☐ Unknown

Collection date:

YYYY-MM-DD

Toxin* or pathogen	Tested	Sample description	Results	Notes
Paralytic Shellfish Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Diarrhetic Shellfish Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Amnesic Shellfish Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Neurotoxic Shellfish Poisoning	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Dinoflagellates (water only)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Histamine	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Ciguatera toxin	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Bacteria, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Viruses, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Other, specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			

*Toxins are tested by Canadian Food Inspection Agency laboratories. Viruses, bacteria and parasites are tested by BC Public Health Microbiology and Reference Laboratory. Limits for marine toxins can be found at: <http://www.hc-sc.gc.ca/fn-an/securit/chem-chim/contaminants-guidelines-directives-eng.php>

Clinical SpecimensWere clinical specimen(s) tested? ☐ Yes ☐ No ☐ Unknown

Specimen type	Reporting lab	Collection date	Result
		YYYY-MM-DD	
		YYYY-MM-DD	

H. ADDITIONAL DETAILS RELATED TO CASE INVESTIGATION

Include date and name or initials with any additional details.