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. Please refer to page 2 for instructions on who to send case report form to.
Resources to assist investigation can be accessed: http://www.bccdc.ca/NR/rdonlyres/42D97FCA-CFBF-45E0-8B30-80CAE3AD8A94/0/Table_seafoodrelatedillness_Feb72014.pdf and http://www.bccdc.ca/NR/rdonlyres/4EBC0A91-1E51-4B8A-A59E-53D028DA9B60/0/seafoodrealtedillnessflowchartFeb72014.pdf

PERSON REPORTING	
Health Authority: ☐ FHA ☐ IHA ☐ VIHA ☐ NHA ☐ VCH	
Name: *Last* *First*	Phone number: ( ) - ext.
Email:	Date completed : *YYYY / MM / DD*

A. CLIENT INFORMATION (Exclude for sending to CFIA)			
Name: *Last* *First* *Middle*			
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.	

B. EXPOSURES

Ask about all fish and shellfish exposures in 24 hours prior to onset

Seafood eaten (check all that apply):

Shellfish: ☐ Mussels ☐ Oysters ☐ Scallops ☐ Crabs ☐ 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 (yyyy/mm/dd; 24 hour clock)	Source	Available tag/invoice Information:
Type: Amount consumed: Details (E.g., name of oyster):	# of people at meal: # of people eating: # of people ill:	☐ Raw ☐ Cooked ☐ Both Raw and Cooked Details:		☐**Restaurant** ☐**Store/Market** Name: Address: Date purchased: ☐**Self-harvest** Location: Date harvested:	☐ attached ☐ to follow ☐ not available Supplier:

C. CLINICAL INFORMATION

Date of onset *YYYY / MM / DD* *Time* *AM / PM* Earliest symptom:

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

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

D. ASSESSMENT	
Was an inspection of the food service establishment where shellfish/fish were purchased/consumed conducted?	☐ Yes ☐ Pending ☐ Will not be conducted
If yes, were any food safety issues associated with shellfish/fish identified during inspection? If yes, please specify:	☐ Yes ☐ No ☐ Unknown
Based on your assessment is shellfish/fish consumed in BC the likely source of illness? ☐ Yes ☐ No ☐ Unsure If yes or Unsure: **Fax or email completed form and tags to:** Marsha Taylor, BCCDC (604) 707-2516, marsha.taylor@bccdc.ca **Fax or email PAGE 1 and 2 of completed form (excluding Section A-client information) and tags to:** (2) Andre Youssef, Canadian Food Inspection Agency (604) 666-4440, pacificshellfish@inspection.gc.ca If no (including illness reports associated with shellfish/fish consumed outside of BC): **Fax or email ALL PAGES of completed form to:** Marsha Taylor, BCCDC (604) 707-2516, marsha.taylor@bccdc.ca	

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THE REMAINING PAGES (3-4) ARE ONLY SENT TO BCCDC

E. FURTHER CLINICAL INFORMATION

Signs/Symptoms/Clinical presentation

1. Gastrointestinal

☐ Diarrhea	☐ Vomiting	☐ Nausea	☐ Abdominal cramps

2. Neurological

☐ Numbness/tingling of mouth/face/tongue	☐ Numbness/tingling of hands or feet	☐ Dizziness	☐ Flushing and sweating
☐ Difficulty breathing	☐ Swallowing or speech difficulty	☐ Vision blurry/doubled	☐ Unsteady walking/clumsy
☐ Difficulty distinguishing hot/cold items	☐ Weakness	☐ Paralysis	☐ Memory loss

3. Other

☐ Skin rash	☐ Fever	☐ Headache	☐ Aching joints/muscles
☐ Aching teeth	☐ Metallic taste	☐ Other: _____	☐ 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 and Outcome

Did the individual seek medial care? ☐ Yes ☐ No ☐ Unknown

Did the individual visit the ER? ☐ Yes ☐ No ☐ Unknown

Hospitalization greater than 24 hours ☐ Yes ☐ No ☐Unknown

Hospital Name:

Date of Admission *YYYY / MM / DD*

Date of Discharge *YYYY / MM / DD*

Physician diagnosis:

Death: ☐ Yes ☐ No ☐ Unknown

F. LABORATORY INFORMATION

1. 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			
Bacteria: (specify) _____	☐ Yes ☐ No ☐ U			
Viruses: (specify)_____	☐ Yes ☐ No ☐ U			
Other:	☐ 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

2. Clinical

Was clinical specimen(s) tested? ☐ Yes ☐ No ☐ U Unknown

Specimen Type	Collection date	Reporting Lab	Reported Date	Results
	YYYY / MM / DD		*YYYY / MM / DD*	
	YYYY / MM / DD		*YYYY / MM / DD*	

G. NOTES

Date	Comment	Initials