



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: _____ YYYY / MM / DD Onset time: _____ AM / PM Unknown

Signs and Symptoms Earliest symptom: _____

Other Symptoms: Abdominal discomfort Diarrhea Bloody diarrhea Fever
 HUS Nausea Vomiting Other: _____

Hospitalization

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

Outcome

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

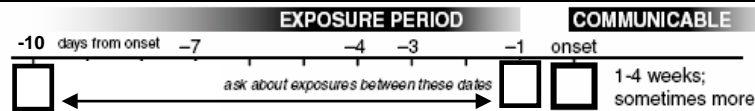


D. LABORATORY INFORMATION

Specimen Type	Reporting Lab	Collection Date	Result
		YYYY / MM / DD	Species: <input type="checkbox"/> O103 <input type="checkbox"/> O111 <input type="checkbox"/> O118 <input type="checkbox"/> O121 <input type="checkbox"/> O157 <input type="checkbox"/> O157:H7 <input type="checkbox"/> O26 <input type="checkbox"/> Other non-O157 <input type="checkbox"/> shiga-toxin positive only PFGE:

E. RISK FACTORS AND EXPOSURE INFORMATION

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



Travel

Travel during exposure period: Yes No Unknown *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 Details	Foods brought back
YYYY / MM / DD	YYYY / MM / DD			

Animal Exposures

Exposure	Response	Details Dates, Location, Type of Animal(s), Types of Pet Food/treats
Farm, Petting zoo, Agricultural fair, Wildlife	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Pets (including reptiles)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Pet treats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Raw pet food (store bought or home-made)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	

Food and Activities

Vegetarian? Yes No Unknown Food allergies / avoidances / special diet? Yes No Unknown

If Yes, Details: _____

Exposure	Exposed	Details Please specify type/brand where possible	Exposure	Exposed	Details Please specify type/brand where possible
Ground beef	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Other beef (e.g., steak, roast, donair)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Hamburger patties	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Salami/ sausage	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	



E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

Exposure	Exposed	Details Please specify type/brand where possible	Exposure	Exposed	Details Please specify type/brand where possible
Cold cuts	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Unpasteurized ciders/juices	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Handle raw meats	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Melon	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Cheese	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Prepared salads (e.g., coleslaw, pasta, potato)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Unpasteurized dairy (e.g., cheese, milk)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Recreational water (e.g., pool, beach, spray park)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Lettuce	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		'At risk' water supply	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Bagged, pre-washed greens	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Contact with daycare	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Spinach	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Contact with LTCF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U	
Sprouts (e.g., alfalfa, bean, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U				

Attend any social functions (e.g., parties, weddings, showers, potlucks, community events)? Yes No Unknown

Event/Social gathering	Location	Date (YYYY/MM/DD)	Foods Eaten

Attend any restaurants (including: take-out, cafeteria, bakery, deli, kiosk)? Yes No Unknown

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

