



Confidential when completed

This form is intended to capture the exposure information related to cases of non-cholera *Vibrio* infection.
Send all pages of completed forms and tags to BCCDC (ezvbepi@bccdc.ca or fax: 604-707-2516)

PERSON REPORTING	
Health Authority:	<input type="checkbox"/> FHA <input type="checkbox"/> IHA <input type="checkbox"/> VIHA <input type="checkbox"/> NHA <input type="checkbox"/> VCH
Name:	<small>Last</small> _____ <small>First</small> _____
Phone:	() - ext.
Email:	
Date case report form completed:	YYYY / MM / DD

Date Report Received at HA (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:	<input type="checkbox"/> Not located

A. CLIENT INFORMATION

Name: <small>Last</small> _____ <small>First</small> _____ <small>Middle</small> _____		
PHN:	Date of birth: YYYY / MM / DD	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Home address: <small>Unit #</small> _____ <small>Street #</small> _____ <small>Street Name</small> _____		City: _____
Postal code: _____	Province: _____	Phone number (home/office/cell): () - ext.

B. ABORIGINAL INFORMATION

Do you wish to self-identify as an Aboriginal Person?	<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> No
	<input type="checkbox"/> Not asked	<input type="checkbox"/> Yes
Aboriginal Identity:	<input type="checkbox"/> Asked, but unknown	<input type="checkbox"/> Asked, not provided
<input type="checkbox"/> First Nations and Inuit	<input type="checkbox"/> First Nations and Métis	<input type="checkbox"/> First Nations, Inuit and Métis
<input type="checkbox"/> Inuit and Métis	<input type="checkbox"/> Métis	<input type="checkbox"/> Not asked
First Nations Status:	<input type="checkbox"/> Asked, but unknown	<input type="checkbox"/> Asked, not provided
	<input type="checkbox"/> Not Asked	<input type="checkbox"/> Non-Status Indian
		<input type="checkbox"/> Status Indian

C. CLINICAL INFORMATION

Date of onset: _____ <small>YYYY / MM / DD</small>	Onset time: _____	AM / PM	Duration of Symptoms: _____
Clinical syndrome:	<input type="checkbox"/> Gastrointestinal	<input type="checkbox"/> Wound infection, <i>specify site:</i> _____	
	<input type="checkbox"/> Ear infection	<input type="checkbox"/> Other, <i>specify:</i> _____	



D. LABORATORY INFORMATION

Specimen Type	Reporting Lab	Collection Date	Test Type	Result	Case Classification
		YYYY/MM/DD	<input type="checkbox"/> PCR <input type="checkbox"/> Culture	<input type="checkbox"/> <i>Vibrio parahaemolyticus</i> <input type="checkbox"/> Other <i>Vibrio</i> , specify species: _____	<input type="checkbox"/> Probable <input type="checkbox"/> Confirmed
		YYYY/MM/DD	<input type="checkbox"/> PCR <input type="checkbox"/> Culture	<input type="checkbox"/> <i>Vibrio parahaemolyticus</i> <input type="checkbox"/> Other <i>Vibrio</i> , specify species: _____	<input type="checkbox"/> Probable <input type="checkbox"/> Confirmed

Confirmed Case:

- Laboratory confirmation of infection with or without symptoms:
 - Culture isolation of *Vibrio* spp. from an appropriate clinical specimen.

Probable Case:

- Laboratory evidence of infection with or without symptoms:
 - Detection of *Vibrio* spp. by PCR from an appropriate clinical specimen.

E. EXPOSURES

Travel within 96 hours prior to onset:

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, prove/state, country, hotel/resort)
YYYY/MM/DD	YYYY/MM/DD	

Exposures within 96 hours prior to onset:

Bivalve shellfish*: Yes No Unknown _____

Other shellfish: Yes No Unknown Specify: _____

Ocean/sea water: Yes No Unknown Details: _____

Other: Yes No Unknown Specify: _____

* Bivalve shellfish have a shell that consists of two valves hinged at one side (e.g., mussels, clams, oysters, scallops, cockles).

If consumed **bivalve shellfish** within 96 hours prior to onset (use 1 line per food eaten):

Type and amount consumed	Number of people ill	Preparation	Date and time consumed	Source	Available tag/invoice Information:
Type of bivalve: <input type="checkbox"/> Oysters <input type="checkbox"/> Mussels <input type="checkbox"/> Clams <input type="checkbox"/> Scallops <input type="checkbox"/> Other, specify: _____ Amount Consumed: Details (e.g. name of oyster variety): <input type="checkbox"/> Tick if Platter/sampler	# of people at meal: # of people eating: # of people ill:	<input type="checkbox"/> Raw <input type="checkbox"/> Cooked <input type="checkbox"/> Both raw and cooked Details:	_____ YYYY/MM/DD 24 hour clock	<input type="checkbox"/> Restaurant <input type="checkbox"/> Store/Market Name: Address: Date purchased: (YYYY/MM/DD) <input type="checkbox"/> Self-harvest Location: Date harvested: (YYYY/MM/DD)	<input type="checkbox"/> Attached <input type="checkbox"/> To follow <input type="checkbox"/> Not available



G. NOTIFICATION

All Health Authorities except Vancouver Coastal Health & Fraser Health: Enter all case details into Panorama.
Vancouver Coastal Health & Fraser Health: Fax or email ALL PAGES of completed form to BCCDC Enteric Epi (604) 707-2516, ezvbepi@bccdc.ca.

If bivalve shellfish purchased from a restaurant or store in British Columbia was consumed:

1. **Fax or email tags to:** Enteric Epi, BCCDC (604) 707-2516, ezvbepi@bccdc.ca. Please include the Panorama Investigation ID of the client(s) associated with the tags when faxing the tags (VCH & FHA: if the tags are faxed separately from the case report form, please include information to link the tags to the appropriate case).
2. **BCCDC will use criteria for reporting shellfish related illness to CFIA and send only page 1 to CFIA if criteria are met.**

H. Additional Details Related to Case Investigation

Date	Comment	Initials