BC Centre for Disease Control

Creutzfeldt-Jakob Disease Reporting Form

to be faxed to health authority where patient resided (see attached map)

PERSON REPORTING			
Physician last name:	First:		
Office phone number:	Hospital secretary number:		
Street address:	City:	Prov:	Postal:

PATIENT INFORMATION				
Patient's last name:		First:	PHN:	
Birth date(m/d/y):	Gender: ☐ M ☐ F	Health Authority: ☐ FHA ☐ IHA ☐ VIHA ☐ VCH ☐ NHA		
Street address:		City:	Prov:	Postal:

CLINICAL INFORMATION		
CJD Type: ☐sporadic ☐ familial ☐ iatrogenic ☐ variant		
Case Status: ☐ Confirmed ☐ Probable	Status confirmed date(m/d/y):	
Symptom onset date (m/d/y):		
Signs and symptoms description :		
Potential exposures of the patient to prion infectivity (e.g., growth hormone, dura mater) :		
Has patient been hospitalized? ☐ Yes ☐ No ☐ Unknown	If yes, where:	Hospitalized date (m/d/y):
Potential exposures of others to the case i.e., infectivity originating with the patient (e.g., endoscopy, neurosurgery : ☐ Yes ☐ No ☐ Unknown		
If yes, where:	when:	
Neurologist Signature:	**Date**:	

BC Centre for Disease Control
655 West 12th Ave, Vancouver BC, V5Z 4R4
604-707-2517 (ph) 604-707-2516 (fax)
www.bccdc.ca

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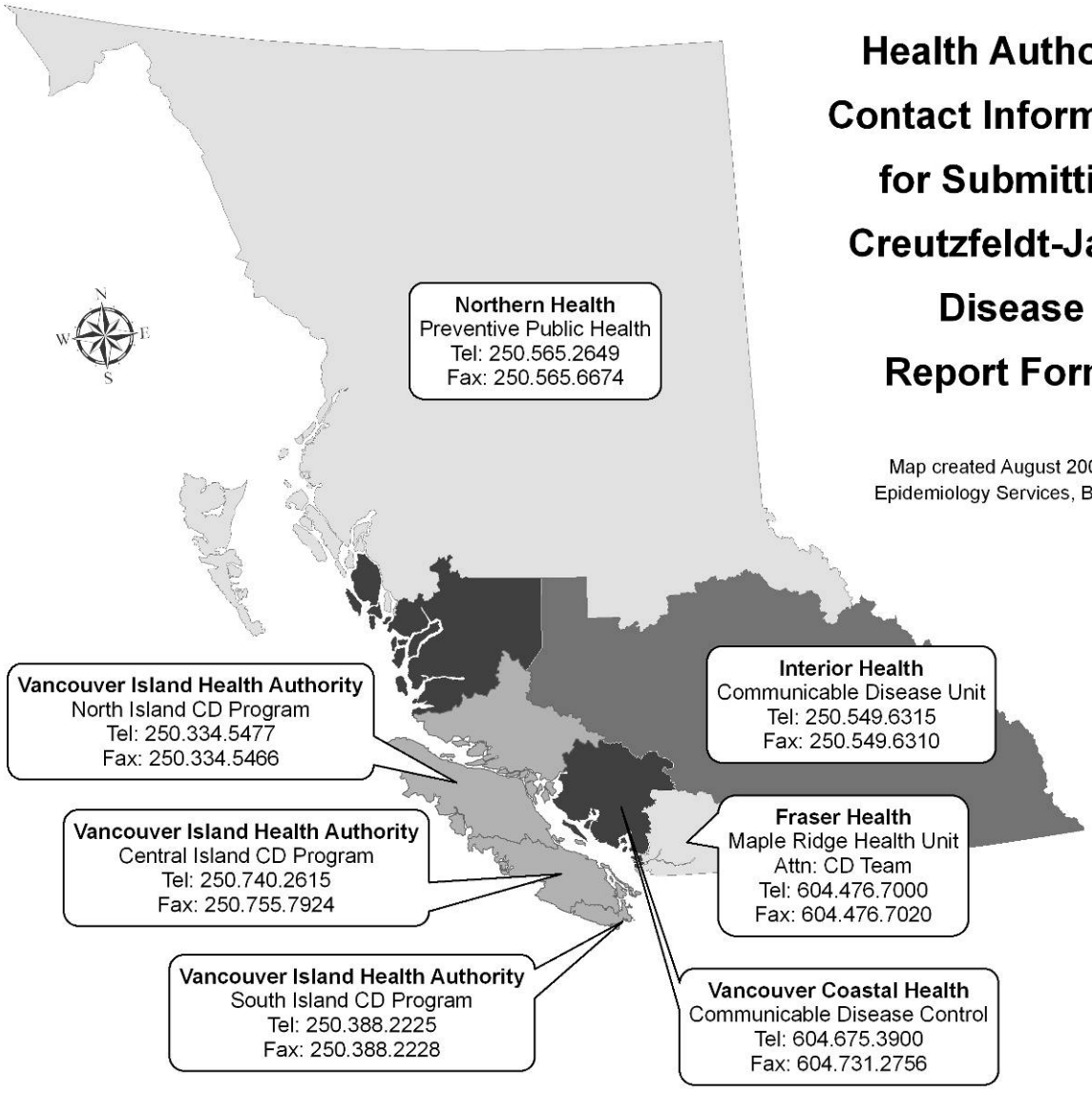
Health Authority Contact Information for Submitting Creutzfeldt-Jakob Disease Report Forms



Map created August 2008 by
Epidemiology Services, BCCDC

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