



California Serogroup Viruses Case Report Form

The California serogroup encompasses viruses such as Jamestown Canyon and Snowshoe hare virus. Confidential once completed. If requested by BCCDC, email to ezvbepi@bccdc.ca or fax to 604-707-2516.

PERSON REPORTING

Health authority: <input type="checkbox"/> FHA <input type="checkbox"/> IHA <input type="checkbox"/> ISLH <input type="checkbox"/> NHA <input type="checkbox"/> VCH	Date report received: _____
Name: _____	Phone: _____
	Email: _____
Contact attempt 1: _____	Outcome: _____
<small>YYYY-MM-DD 24hr clock</small>	
Contact attempt 2: _____	Outcome: _____
<small>YYYY-MM-DD 24hr clock</small>	
Contact attempt 3: _____	Outcome: _____
<small>YYYY-MM-DD 24hr clock</small>	
Contact attempt 4: _____	Outcome: _____
<small>YYYY-MM-DD 24hr clock</small>	
Interviewer: _____	Interviewed: <input type="checkbox"/> Client <input type="checkbox"/> Proxy, specify: _____

A. CLIENT INFORMATION

Name: _____	<small>Last</small>	<small>First</small>	<small>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: _____	Phone: _____	Type: _____
	<small>(cell/home/work/other)</small>		<small>(cell/home/work/other)</small>
Address: _____	<small>Unit #</small>	<small>Street #</small>	<small>Street name</small>
			City: _____
Province: _____	Postal code: _____	Email: _____	
Physician name: _____	Physician phone number: _____		
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, but unknown <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Not asked			
If First Nations, status:			
<input type="checkbox"/> Status Indian <input type="checkbox"/> Non-status Indian <input type="checkbox"/> Asked, but unknown <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Not asked			

B. CLINICAL INFORMATION

Admitted to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Admission: _____	Discharge: _____
	<small>YYYY-MM-DD</small>	<small>YYYY-MM-DD</small>
Hospital name: _____	Admitted to intensive care: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
Underlying medical conditions: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, specify: _____		
Immunocompromised: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, specify: _____		

B. CLINICAL INFORMATION

Outcome: Death Recovering Fully recovered Recovered with complications

If died, date of death: Specify complications:

If died, cause of death: Died from disease Disease contributed to death (secondary cause)
 Died – other causes Died – unknown cause

C. SIGNS AND SYMPTOMS

Symptom onset date: Asymptomatic

Response	Symptom
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Abdominal pain
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Abnormal movements
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Altered reflexes
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Arthralgia
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Chills
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Coma
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Confusion or altered sensorium
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Diarrhea
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Encephalitis
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fatigue
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Fever
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Headache
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Myalgia
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Nausea
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Rash
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Seizures
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Speech difficulties
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Stiff neck
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Visual disorders
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Vomiting
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Other, specify:

D. LABORATORY INFORMATION

Specimen type	Reporting lab	Collection	Test	Result (titres if applicable)	Etiologic agent
		<input type="text" value="YYYY-MM-DD"/>			
		<input type="text" value="YYYY-MM-DD"/>			
		<input type="text" value="YYYY-MM-DD"/>			
		<input type="text" value="YYYY-MM-DD"/>			

E. RISK FACTORS AND EXPOSURE INFORMATION

In the 8 weeks prior to symptom onset did you donate or receive blood, plasma, or blood components?*

Yes, donated Yes, received No Unknown If yes, date: YYYY-MM-DD

Hospital/clinic/physician:

City: Province/territory:

Additional details:

***If client was a donor and/or recipient of blood/plasma/platelets or bone marrow**, please notify Canadian Blood Services via the 24-hour call line 604-876-7219 or fax 604-879-6669.

In the 8 weeks prior to symptom onset did you donate or receive organs or tissues?^

Yes, donated Yes, received No Unknown If yes, date: YYYY-MM-DD

Hospital/clinic/physician:

City: Province/territory:

Additional details:

^If client was a donor and/or recipient of organs or tissues, please notify the local Medical Health Officer.

In the 3 weeks prior to symptom onset did you experience a mosquito bite?

Yes No Unknown If yes, date of mosquito bite: YYYY-MM-DD

If yes, please describe where you were when the bite occurred (e.g., name and location of park or walking trail in addition to any identifiable landmarks such as a lake, picnic area, playground):

In the 3 weeks prior to symptom onset did you travel more than 100km (approximately 1 hour drive on highway roads) from your residence? Yes No Unknown

If yes: Within BC Outside BC but within Canada Outside Canada

Dates	Details (e.g., city, country, outdoor activities while travelling)
Departure: YYYY-MM-DD	
Return: YYYY-MM-DD	
Departure: YYYY-MM-DD	
Return: YYYY-MM-DD	
Departure: YYYY-MM-DD	
Return: YYYY-MM-DD	

F. ADDITIONAL DETAILS RELATED TO CASE INVESTIGATION

Include date and name or initials with any additional details.