



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

Signs and Symptoms

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

Hospitalization

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

Outcome

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



D. LABORATORY INFORMATION

Specimen type	Reporting lab	Collection date	Reported date	Test Type	Results	Case Classification
		YYYY / MM / DD	YYYY / MM / DD	<input type="checkbox"/> PCR <input type="checkbox"/> Culture		<input type="checkbox"/> Probable <input type="checkbox"/> Confirmed
		YYYY / MM / DD	YYYY / MM / DD	<input type="checkbox"/> PCR <input type="checkbox"/> Culture		<input type="checkbox"/> Probable <input type="checkbox"/> Confirmed

Confirmed Case:

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

Probable Case:

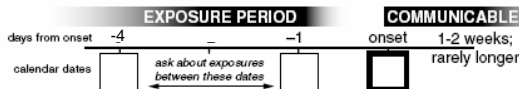
- Laboratory evidence of infection with or without symptoms:
 - Detection of *Shigella spp.* by PCR from an appropriate clinical specimen.

Suspect Case:

- Clinical illness in a person who is epidemiologically linked to a confirmed case.

E. RISK FACTORS AND EXPOSURE INFORMATION

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



Note: Exposure period for *S. dysenteriae* is up to one week.

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 **NOTE:** For *S. dysenteriae*, travel to an endemic area during any part of the exposure period or travel outside HA of residence during the entire exposure period is considered confirmed travel-related.

Dates: DEPARTURE	Dates: RETURN	Locations (e.g., city, country, resort)	Additional Details	Foods brought back
YYYY / MM / DD	YYYY / MM / DD			

Food and Activities

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

If Yes, Details: _____

Food Exposures	Eaten	Details Please specify type/brand where possible	Activities	Details
Oysters	<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
Fresh herbs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U		Pond, stream, lake	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> U
Lettuce/salad	<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
Soft or unpasteurized cheese	<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
			Contact with hospital	<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



E. RISK FACTORS AND EXPOSURE INFORMATION *continued*

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

Sexual Activity

Please ask these questions of male and female adult cases (>18 years):

- Shigellosis can be transmitted sexually. Are you currently sexually active? Yes No (if No, skip to section F) Unanswered
- Shigellosis can be transmitted through oral-anal sexual contact.¹ Is this a possibility in your case in the last 28 days?
 Yes No Unanswered

If yes to both questions, provide education regarding the prevention of sexually transmitted enteric diseases and advice for testing of sexual contacts.

¹Oral-anal sexual contact is defined as contact between the mouth, lips or tongue of one person and the anal or perianal area of another person. It can also include oral contact with sexual toys or other body parts (e.g. penis, finger) which had prior contact with the anal area, rectum or feces. Some people refer to oral-anal sex as rimming and to manual-oral sex as fingering or fisting.

F. CONTACTS

people in household:

Name	Date ill	Nature of contact*	Occupation/Details	Contact phone	^Excluded?

*Household, sexual, close contacts
^ Please complete Contact Exclusion Form for each contact excluded.



G. OCCUPATION AND EXCLUSION

Occupation:

(Prompt for agricultural/animal contact and working in food service industry and specify)

Sensitive Setting (check if applicable):

- Work/volunteer or attend day care
- Work/volunteer in a health care setting
- Work/volunteer as a food handler
- Other (e.g. pool): _____

Facility name:

Excluded Y N Effective date (YYYY/MM/DD):

Details:

Symptom end date (YYYY/MM/DD):

Exclusion lifted (YYYY/MM/DD): MHO:

H. CASE EXCLUSION WORKSHEET*

Antibiotic Use: Y N U Length of treatment: _____ days

Date of Discontinuation (YYYY/MM/DD): _____

Sample No.	Date (YYYY/MM/DD)	Result	Notes
1		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
2		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
3		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	
4		<input type="checkbox"/> Pos <input type="checkbox"/> Neg	

* Refer to CD Control Guidelines on Exclusion of Enteric Cases and their Contacts from High Risk Settings

I. INTERVENTIONS

Type	Implemented	Details	Type	Implemented	Details
Referred for Inspection	<input type="checkbox"/>		Health File Sent	<input type="checkbox"/>	
Hygiene Education	<input type="checkbox"/>		Case excluded	<input type="checkbox"/>	As above
Referred to another HA	<input type="checkbox"/>		Contact excluded	<input type="checkbox"/>	
Other:	<input type="checkbox"/>				

J. Additional Details Related to Case Investigation

Date	Comment	Initials