| ACCESSION NUMBER | ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED) |
|---|---|
| | |

# HEPATITIS B AND C, HIV, AND SYPHILIS INVESTIGATION FORM

**CASE FORM**

## I. *CASE IDENTIFICATION

subject > client details > client demographics

1. ***LAST NAME**

2. ***FIRST NAME**

3. ***DATE OF BIRTH** YYYY - MM - DD

4. **ALTERNATE LAST NAME**

5. **ALTERNATE FIRST NAME**

6. ***SEX**
   - O FEMALE O MALE
   - O INTERSEX O UNKNOWN

7. ***GENDER IDENTITY** (VOLUNTARY, SELF-REPORTED)
   - O CISGENDER (SAME AS SEX AT BIRTH) O TRANSGENDER MAN O DECLINED
   - O TRANSGENDER WOMAN O TRANSGENDER PERSON O OTHER (SPECIFY IN BOX 8)

8. ***IF OTHER GENDER IDENTITY, SPECIFY**

9. ***REGISTRATION NUMBER** (FORMER MHSC) — 6 DIGITS (UPPERCASE ALPHANUMERIC)

10. ***HEALTH NUMBER (PHIN)** — 9 DIGITS

11. **ALTERNATE ID** — SPECIFY TYPE OF ID

12. ***ADDRESS AT TIME OF DIAGNOSIS** ➔ ☐ **ADDRESS IN FIRST NATION COMMUNITY**

13. ***CITY/TOWN/VILLAGE**

14. ***PROVINCE/TERRITORY**

15. ***POSTAL CODE** — A#A #A#

16. ***PHONE NUMBER** — ### - ### - ####

17. ***RACIAL/ETHNIC IDENTITY** (VOLUNTARY, SELF-REPORTED)
   - O AFRICAN O BLACK O CHINESE O DECLINED
   - O FILIPINO O LATIN AMERICAN O NORTH AMERICAN INDIGENOUS O OTHER (SPECIFY)
   - O SOUTH ASIAN O SOUTHEAST ASIAN O WHITE

18. ***INDIGENOUS IDENTITY DECLARATION** (VOLUNTARY, SELF-REPORTED)
   - O FIRST NATIONS O MÉTIS O INUIT
   - O NOT ASKED O DECLINED

19. ***FIRST NATIONS STATUS** (VOLUNTARY, SELF-REPORTED)
   - O STATUS O NON-STATUS
   - O NOT ASKED O DECLINED

20. **ALTERNATE LOCATION INFORMATION** (IF ANY)

21. **IMMIGRATION STATUS AT TIME OF ARRIVAL** (VOLUNTARY - COMPLETE BOXES 22 AND 23 IF BORN OUTSIDE CANADA)
   - O CANADIAN BORN CITIZEN O DECLINED
   - O LANDED IMMIGRANT O NOT ASKED
   - O REFUGEE O OTHER (SPECIFY BELOW)
   - O STUDENT
   - O VISITOR
   - O WORK PERMIT

22. **DATE ARRIVED IN CANADA** — YYYY

23. **COUNTRY EMIGRATED FROM** — SPECIFY

## II. INVESTIGATION INFORMATION

INVESTIGATION > INVESTIGATION DETAILS > INVESTIGATION CLASSIFICATION

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 24. ***INVESTIGATION DISPOSITION** | O FOLLOW-UP COMPLETE | O UNABLE TO COMPLETE INTERVIEW | | O PENDING | | | |
| 25. ***PRIMARY INVESTIGATOR ORGANIZATION** | O WRHA | O NRHA | O PMH | O SH-SS | O IERHA | O FNIHB | O CSC |
| 26. **OTHER ORGANIZATIONS INVOLVED** | ☐ WRHA | ☐ NRHA | ☐ PMH | ☐ SH-SS | ☐ IERHA | ☐ FNIHB | ☐ CSC ☐ DND |

## III. INFECTION INFORMATION

INVESTIGATION > DISEASE SUMMARY > INVESTIGATION INFORMATION

| 27. ***DISEASE** | 28. ***CASE CLASSIFICATION** | 29. ***SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** YYYY – MM - DD |
|---|---|---|
| 30. ☐ **HEPATITIS B** | ☐ LAB CONFIRMED ☐ NOT A CASE | |
| 31. ☐ **HEPATITIS C** | ☐ LAB CONFIRMED ☐ NOT A CASE | |
| 32. ☐ **HIV** | ☐ LAB CONFIRMED ☐ NOT A CASE | |
| 33. ☐ **SYPHILIS** | ☐ LAB CONFIRMED ☐ NOT A CASE | |

| ACCESSION NUMBER | ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED) |
|---|---|
| | |

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## IV. *DISEASE-SPECIFIC INFORMATION

investigation > investigation details > disease summary > add > disease event history

Refer to disease protocol at https://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

| | | |
|---|---|---|
| 34. ☐ HEPATITIS B | 35. STAGING | O ACUTE O CHRONIC O PERINATAL O PREVIOUS DIAGNOSIS- CHRONIC O UNKNOWN OR UNDETERMINED |
| 36. ☐ HEPATITIS C | 37. STAGING | O ACUTE O CHRONIC O PERINATAL O PREVIOUS DIAGNOSIS – CHRONIC O PREVIOUS DIAGNOSIS – RESOLVED O RESOLVED O UNKNOWN OR UNDETERMINED |
| 38. ☐ HIV | 39. STAGING | O NEW DIAGNOSIS O OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB O PERINATAL O PREVIOUS DIAGNOSIS- NEW TO MANITOBA |
| 40. ☐ SYPHILIS | 41. STAGING | INFECTIOUS: O PRIMARY O SECONDARY O EARLY LATENT<br>NON-INFECTIOUS: O LATE LATENT (≥ 1 YEAR AFTER INFECTION) O TERTIARY<br>OTHER: O PREVIOUS DIAGNOSIS O UNKNOWN/UNDETERMINED |
| | 42. ADDITIONAL PRESENTATIONS | ☐ CARDIOVASCULAR SYPHILIS ☐ NEUROSYPHILIS ☐ GUMMATOUS SYPHILIS |
| | 43. DATE OF FIRST DIAGNOSIS IF PREVIOUSLY DIAGNOSED<br>YYYY – MM | 44. LOCATION OF FIRST DIAGNOSIS IF NOT IN MANITOBA<br>SPECIFY COUNTRY OR PROVINCE IN CANADA |

IF THE CASE IS NON-INFECTIOUS SYPHILIS (BOX 42), SKIP TO SECTION XII, "REPORTER INFORMATION".

## V. SIGNS AND SYMPTOMS

investigation > signs and symptoms

| 45. SYMPTOMS | 46. EARLIEST SYMPTOM ONSET DATE |
|---|---|
| O ASYMPTOMATIC O SYMPTOMATIC (COMPLETE BOX 47 FOR HEPATITIS B/C, BOX 48 FOR SYPHILIS, OR BOX 49 FOR HIV) | YYYY-MM-DD |

| 47. HEPATITIS B/C (CHECK ALL SIGNS/SYMPTOMS THAT APPLY) | 48. SYPHILIS (CHECK ALL SIGNS/SYMPTOMS THAT APPLY) | 49. HIV SIGNS/ SYMPTOMS |
|---|---|---|
| ☐ ABDOMINAL PAIN/CRAMPING (RUQ)<br>☐ ANOREXIA<br>☐ DARK URINE<br>☐ FATIGUE<br>☐ FEVER<br>☐ JAUNDICE<br>☐ NAUSEA<br>☐ STOOL, PALE<br>☐ VOMITING | ☐ ANAL ULCERATIVE LESIONS<br>☐ CHANCRE (OTHER SITE)<br>☐ CONDYLOMATA LATA<br>☐ GENITAL ULCER<br>☐ HAIR LOSS (ALOPECIA)<br>☐ HEADACHE<br>☐ LYMPH NODES ENLARGED – GENERALIZED<br>☐ LYMPH NODES ENLARGED - REGIONAL<br>☐ MENINGITIS<br>☐ OCULAR INVOLVEMENT<br>☐ ORAL ULCERATIVE LESIONS<br>☐ OTHER MUCOSAL LESIONS<br>☐ RASH - UNSPECIFIED | ☐ CD4 COUNT, FIRST<br>DATE: YYYY-MM-DD<br>ABSOLUTE VALUE: (SEE FORM INSTRUCTIONS) |
| ☐ OTHER<br>SPECIFY | ☐ OTHER<br>SPECIFY | |

## VI. RISK FACTOR INFORMATION

subject > risk factors

| 50. COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:<br>REQUIRED RISK FACTORS INDICATED WITH * MUST HAVE A RESPONSE DOCUMENTED IN PHIMS | YES | NO | UN-KNOWN | DECLINED TO ANSWER | NOT ASKED |
|---|---|---|---|---|---|
| *BLOOD/TISSUE DONATION (INCLUDES TISSUE, BLOOD PRODUCTS, PLASMA, ORGANS, BREAST MILK) (NOT REQUIRED FOR SYPHILIS)<br>SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD | O | O | O | O | O |
| *BLOOD /TISSUE RECIPIENT (INCLUDES BLOOD PRODUCTS, PLASMA, TISSUE, ORGANS, POOLED CONCENTRATES) (NOT REQUIRED FOR SYPHILIS)<br>SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD | O | O | O | O | O |
| BODY PIERCING/TATTOOING/SCARIFICATION/ACUPUNCTURE ( INDICATE IF NON-LICENSED) (NOT REQUIRED FOR SYPHILIS)<br>SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD | O | O | O | O | O |
| BORN TO INFECTED MOTHER/ BIRTH PARENT (NOT REQUIRED FOR SYPHILIS, USE CONGENITAL SYPHILIS CASE FORM)<br>SPECIFY INFECTION(S) | O | O | O | O | O |
| CONTACT TO A NEW OR PREVIOUSLY DIAGNOSED CASE OF: (INCLUDES CLIENT REPORT)<br>SPECIFY INFECTION(S) AND DATE OF INITIAL CONTACT | O | O | O | O | O |
| *HAS GIVEN GOODS IN EXCHANGE FOR SEX (NOT REQUIRED FOR HEPATITIS C) | O | O | O | O | O |

| ACCESSION NUMBER | ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED) |
|---|---|
| | |

Manitoba
Health, Seniors and Long-Term Care

| COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED: REQUIRED RISK FACTORS INDICATED WITH * MUST HAVE A RESPONSE DOCUMENTED IN PHIMS | YES | NO | UN-KNOWN | DECLINED TO ANSWER | NOT ASKED |
|---|---|---|---|---|---|
| *HAS RECEIVED GOODS IN EXCHANGE FOR SEX (NOT REQUIRED FOR HEPATITIS C) | ○ | ○ | ○ | ○ | ○ |
| *HISTORY OF INCARCERATION<br>SPECIFY LOCATION AND DATERANGE OF LAST INCARCERATION | ○ | ○ | ○ | ○ | ○ |
| HISTORY OF STBBI (HISTORY OF HIV, SYPHILIS, HEPATITIS B OR C, OR OTHERS RELEVANT TO INVESTIGATION)<br>SPECIFY INFECTION(S) AND DATE(S) | ○ | ○ | ○ | ○ | ○ |
| *HOUSING UNSTABLE (IN THE PAST 12 MONTHS) | ○ | ○ | ○ | ○ | ○ |
| *INJECTION DRUG USE (SINCE LAST NEGATIVE TEST OR EVER IF NEVER TESTED BEFORE)<br>SPECIFY SUBSTANCE(S) AND DATE OF LAST IDU | ○ | ○ | ○ | ○ | ○ |
| INVASIVE MEDICAL/SURGICAL/DENTAL PROCEDURE (E.G. HEMODIALYSIS, EXTRACTION) *(NOT REQUIRED FOR SYPHILIS)*<br>SPECIFY TYPE, LOCATION, AND DATE | ○ | ○ | ○ | ○ | ○ |
| *MEN WHO HAVE SEX WITH MEN (NOT REQUIRED FOR HEPATITIS C) | ○ | ○ | ○ | ○ | ○ |
| NO IDENTIFIABLE RISK FACTORS (EXPLORE NON-REQUIRED RISK FACTORS) | ○ | ○ | ○ | ○ | ○ |
| OCCUPATIONAL EXPOSURE (E.G. NEEDLE STICK, SHARPS) (NOT REQUIRED FOR SYPHILIS)<br>SPECIFY TYPE AND DATE YYYY-MM-DD | ○ | ○ | ○ | ○ | ○ |
| OTHER RISK FACTOR<br>SPECIFY | ○ | ○ | ○ | ○ | ○ |
| *PREGNANT AT TIME OF DIAGNOSIS<br>SPECIFY EDC: YYYY-MM-DD | ○ | ○ | ○ | ○ | ○ |
| PREVIOUS TREATMENT FOR SYPHILIS *(SYPHILIS CASES ONLY)*<br>SPECIFY PROVINCE/COUNTRY AND DATE(S) | ○ | ○ | ○ | ○ | ○ |
| *PROBABLE ACQUISITION IN ANOTHER COUNTRY<br>SPECIFY COUNTRY AND DATES | ○ | ○ | ○ | ○ | ○ |
| SEXUAL ASSAULT (NON-CONSENSUAL SEX; SPECIFIC TO ACQUISITION/INTERVIEW PERIOD OR REASON FOR TESTING) | ○ | ○ | ○ | ○ | ○ |
| *SEXUAL PARTNER AT RISK (PERSON WHO INJECTS DRUGS, MSM, SEX WORKER, ANONYMOUS) (NOT REQUIRED FOR HEPATITIS C)<br>SPECIFY RISK GROUP AND LAST EXPOSURE | ○ | ○ | ○ | ○ | ○ |
| *SHARED NEEDLES OR OTHER INJECTION EQUIPMENT (ONLY REQUIRED IF "YES" FOR INJECTION DRUG USE)<br>SPECIFY DATES AND LOCATION | ○ | ○ | ○ | ○ | ○ |
| *SUBSTANCE USE- NON-INJECTION DRUG USE DURING SEXUAL EXPOSURE (SEE FORM INSTRUCTIONS) NOT REQUIRED FOR HEPATITIS C<br>SPECIFY SUBSTANCE | ○ | ○ | ○ | ○ | ○ |

## VII. OUTCOMES

investigation > outcomes

| 51. ○ FATAL (INCLUDE UNKNOWN OR NON COMMUNICABLE DISEASE CAUSES)<br>SPECIFY DATE OF DEATH YYYY-MM-DD | 52.<br>○ OTHER SIGNIFICANT OUTCOME/SEQUELAE (SPECIFY)<br>○ RECOVERED (FOR HEPATITIS C CASES WITH SUBSEQUENT RESOLVED INFECTION AFTER INITIAL STAGING) |
|---|---|

| ACCESSION NUMBER | ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED) |
|---|---|
| | |

Manitoba
Health, Seniors and Long-Term Care

## VIII. TREATMENT INFORMATION (COMPLETE FOR SYPHILIS ONLY)

investigation > medications> medication summary

| 53. **PRESCRIBER NAME** | 54. **TREATMENT FACILITY** | |
|---|---|---|
| ☐ BENZATHINE PENICILLIN G 2.4 million units IM as single dose<br>SPECIFY START DATE: YYYY-MM-DD | ☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 2 doses<br>SPECIFY START DATE: YYYY-MM-DD | ☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 3 doses<br>SPECIFY START DATE: YYYY-MM-DD |
| ☐ CEFTRIAXONE 1 g OD for 10 days<br>○ IV<br>○ IM<br>SPECIFY IM OR IV AND START DATE: YYYY-MM-DD | ☐ CEFTRIAXONE 2 G OD FOR 10 DAYS<br>○ IV<br>○ IM<br>SPECIFY IM OR IV AND START DATE: YYYY-MM-DD | ☐ DOXYCYCLINE 100 mg PO BID X 14 days<br>SPECIFY START DATE: YYYY-MM-DD |
| ☐ DOXYCYCLINE 100 mg PO BID X 28 days<br>SPECIFY START DATE: YYYY-MM-DD | ☐ PENICILLIN G 3-4 MILLION UNITS IV Q4H X 10-14 days<br>SPECIFY START DATE: YYYY-MM-DD | ☐ OTHER (SPECIFY TREATMENT AND START DATE):<br>SPECIFY START DATE: YYYY-MM-DD |
| 55. **ALLERGIES**<br>SPECIFY | | |

## IX. EVIDENCE-BASED INTERVENTIONS

investigation > treatment and interventions >interventions summary

| 56. **INTERVENTIONS** | 57. **DATE (YYYY-MM-DD)** |
|---|---|
| ☐ PREVENTION EDUCATION/COUNSELLING PER DISEASE PROTOCOL | |
| ☐ INTERVIEW FOR CONTACTS | |
| ☐ IMMUNIZATION RECOMMENDED (SPECIFY)<br>☐ HBV ☐ HAV ☐ HPV ☐ MPOX | |
| ☐ PUBLIC HEALTH SUPPORT TO ENGAGE WITH CARE (HIV/HCV) DATE OF REFERRAL TO PH IF APPLICABLE | |
| ☐ REFERRAL/ NOTIFICATION OF CANADIAN BLOOD SERVICES (IF APPLICABLE) | |
| ☐ REFERRAL TO HEPATITIS CARE PROVIDER **START DATE** (DATE OF REFERRAL)<br>**END DATE** (DATE INTAKE APPOINTMENT ATTENDED | |
| ☐ REFERRAL TO MANITOBA HIV PROGRAM **START DATE** (DATE OF REFERRAL)<br>**END DATE** (DATE INTAKE APPOINTMENT ATTENDED) | |
| ☐ REFERRAL TO INFECTIOUS DISEASE SPECIALIST (SPECIFY DATE) | |
| ☐ REFERRAL FOR TREATMENT (SPECIFY - INCLUDING REFERRAL FOR HIV PREP OR PEP) | |
| ☐ NEWBORN PROPHYLAXIS FOR HEPATITIS B | |
| ☐ STBBI TESTING RECOMMENDED<br>☐ CT/GC ☐ SYPHILIS ☐ HBV ☐ HCV ☐ HIV | |
| ☐ SYPHILIS SEROLOGY RECOMMENDED AS PER PROTOCOL | |
| ☐ ADDITIONAL TREATMENT RECOMMENDED | |
| ☐ TREATMENT RECOMMENDED | |
| ☐ TREATMENT NOT RECOMMENDED | |
| ☐ OTHER (SPECIFY) | |

| ACCESSION NUMBER | ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED) |
|---|---|
| | |

## X. HEPATITIS B IMMUNIZATION HISTORY INTERPRETATION (FOR HEPATITIS B CASES ONLY – ENTER IMMS RECORDS IF MISSING DOSES IN PHIMS)

Subject > imms history interpretation

| 58. **INTERPRETATION OF HEPATITIS B IMMUNITY PRIOR TO INVESTIGATION** | O IMMUNITY- LAB EVIDENCE<br>O SUSCEPTIBLE – LAB EVIDENCE<br>O INDETERMINATE- LAB EVIDENCE<br>O FULLY IMMUNIZED<br>O PARTIALLY IMMUNIZED<br>O UNIMMUNIZED<br>O UNKNOWN/NOT DETERMINED | 59. **REASON FOR IMMUNITY/ IMMUNIZATION INTERPRETATION** | SOURCE OF SEROLOGY/ IMMUNIZATION RECORD:<br>O CLIENT/PARENT/GUARDIAN<br>O CLIENT/PARENT/GUARDIAN – OFFICIAL RECORD<br>O HEALTH RECORD/ HEALTHCARE PROVIDER<br>**REASON IF NOT FULLY IMMUNIZED OR UNKNOWN:**<br>O GENERAL OBJECTION (NON-PHILOSOPHICAL)<br>O IMMUNOCOMPROMISED<br>O MEDICAL CONTRAINDICATION<br>O NOT ELIGIBLE FOR ROUTINE IMMUNIZATION<br>O NOT UP TO DATE WITH IMMUNIZATIONS<br>O PHILOSOPHICAL OBJECTION<br>O UNKNOWN/ NOT DETERMINED |
|---|---|---|---|

## XI. CONTACTS

investigation > exposure summary > transmission event summary

| 60. **NUMBER OF CONTACTS IDENTIFIED BY NAME ➔** | SPECIFY NUMBER | 61. **NUMBER OF ANONYMOUS CONTACTS ➔** | SPECIFY NUMBER | 62. **EARLIEST ANONYMOUS EXPOSURE START DATE**<br>☐ ESTIMATED YYYY-MM-DD |
|---|---|---|---|---|
| ☐ CASE DECLINED TO IDENTIFY CONTACTS | | | | |

## XII. * REPORTER INFORMATION

| 63. **FORM COMPLETED BY (PRINT NAME)** | | 64. **FACILITY NAME/ADDRESS/PHONE#** | **REPORTER USE ONLY** |
|---|---|---|---|
| 65. **FORM COMPLETION DATE**<br>YYYY-MM-DD | 66. **INVESTIGATION STATUS**<br>☐ ONGOING<br>☐ CLOSED TO THE REGION | 67. **ORGANIZATION** (IF APPLICABLE)<br>O WRHA O NRHA O PMH O SH-SS<br>O IERHA O FNIHB O CSC | STAMP HERE |

**PLEASE SUBMIT THIS INVESTIGATION FORM BY SECURED FAX OR COURIER TO THE SURVEILLANCE UNIT AT MANITOBA HEALTH**
**AFTER HOURS EMERGENCY PHONE FOR PUBLIC HEALTH ISSUES: (204) 788-8666.**

**THIS FORM IS ALSO AVAILABLE FOR DOWNLOAD IN A FILLABLE PDF FORMAT AT**
**https://www.gov.mb.ca/health/publichealth/surveillance/docs/mhsu_6780.pdf**

**A USER GUIDE FOR COMPLETION OF SURVEILLANCE FORMS FOR REPORTABLE DISEASES AND INSTRUCTIONS FOR THIS FORM ARE AVAILABLE FOR DOWNLOAD AT**
**https://www.gov.mb.ca/health/publichealth/surveillance/forms.html**