

Communicable Disease Control Investigation Form:

Manitoba
Health



Date: ___/___/___
y m d

A: Notified by: _____ Phone number: _____
This is a: ☐ New report or ☐ Update of previous report

B: Diagnosis: _____
Patient name: _____ Date of birth: ___/___/___ Age: _____
Address: _____ Sex: ☐ M ☐ F
Phone number: Work: _____ - _____ Home: _____ - _____
Physician/Clinic: _____ Phone number: _____ - _____
Address: _____
Region: _____ Health Unit: _____
Race/Ethnicity:
Aboriginal: ☐ Status Indian ☐ Inuit
Nonaboriginal: ☐ Born in Canada: ☐ Immigrant Family
☐ Unknown Foreign Born:
Country of Origin/Birth: _____
Resident Here: _____ Years
School or Day Care attended: _____
Occupation: _____ Place of employment: _____

C: Disease: _____ Symptomatic: ☐ Y ☐ N ☐ U
Date of onset of symptoms: ___/___/___ Duration of symptoms: _____ (days)
Clinical history: _____

Clinical course: Treatment: ☐ Y ☐ N ☐ U If yes, list:

| Drug | Dose | Duration |
|------|------|----------|
| | | |
| | | |
| | | |

Hospitalized: ☐ Y ☐ N ☐ U If yes, _____ days
Sequelae: ☐ Y ☐ N ☐ U If yes, specify: _____
Permanent: ☐ Y ☐ N ☐ U Died: ☐ Y ☐ N ☐ U
Underlying illness: ☐ Y ☐ N ☐ U
If yes, specify: _____

D: Laboratory Investigation
Organism identified: _____ Specimen date: ___/___/___
Site/Source: _____
Antigen detection: ☐ Y ☐ N ☐ U Culture: ☐ Y ☐ N ☐ U
Serologic findings: ☐ Y ☐ N ☐ U Other: Specify: _____
First specimen date: ___/___/___ Result: _____
Second specimen date: ___/___/___ Result: _____
Serogroup: _____ Serotype: _____ Phage type: _____
Biotype: _____

E: Source of infection

1. ☐ Food – specify: _____
2. ☐ Water – specify: _____
3. ☐ Person to person _____
4. ☐ Other – specify: _____
5. ☐ Unknown

Transmission setting

1. Unknown
2. Day care
3. School
4. Hospital
5. Travel*
6. Home – Urban
7. Home – Rural
8. Residential facility: Specify: _____
15. Other: Specify: _____
9. MD office
10. Workplace
11. Sexual contact
12. Wound
13. Camping
14. Restaurant

*Travel history available: ☐ Y ☐ N

| Country/City/Area visited | Arrival date | Length of stay | Accommodation code** |
|------------------------------|-----------------|-------------------|-------------------------|
| | | | |
| | | | |
| | | | |

** 1. Urban/Hotel/Business/Hostel 2. Rural/Backpack/Trek

F: Immunization history (if relevant)

Immunization status known: ☐ Y ☐ N

| If yes: | Dose | Date | Agent |
|---------|------|------|-------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |

If not immunized, reason:

- ☐ Medical contraindication
☐ Religious/philosophical exemption
☐ Previous disease documented
☐ Not recommended/not eligible
☐ Other – specify _____
☐ Unknown

G: Outbreak associated ☐ Y ☐ N ☐ U

If yes, outbreak name: _____ Number: _____

Comments: _____

Signature: _____

H: For use by CDC

Case type: ☐ Confirmed ☐ Clinical ☐ Carrier

Reportable: ☐ Y ☐ N Reported: ☐ Y ☐ N Date reported: ____/____/____

Contact person: _____

Notified by phone: ____/____/____

Date investigation report received: ____/____/____

Date closed: ____/____/____