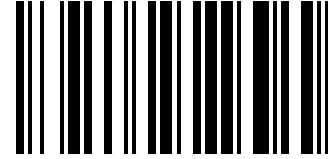

MULTISYSTEM INFLAMMATORY SYNDROME IN CHILDREN (MIS-C) CLINICAL CASE FORM

CASE FORM

FORM UPDATES: ☐ _________________ (YYYY-MM-DD) ☐ ______________ (YYYY-MM-DD)
CIRCLE AND INITIAL CHANGES ON FORM IN DARK PEN OR PENCIL SO UPDATED INFORMATION CAN BE DISTINGUISHED.

I. CASE IDENTIFICATION

full features: subject > client details > client demographics > personal information

1. ***LAST NAME**	2. ***FIRST NAME**		3. ***DATE OF BIRTH** YYYY - MM - DD
4. ***SEX** ○ FEMALE ○ MALE ○ INTERSEX ○ UNKNOWN	5. ***REGISTRATION NUMBER (FORMER MHSC)** 6 DIGITS	6. ***HEALTH NUMBER (PHIN)** 9 DIGITS	7. **ALTERNATE ID** SPECIFY TYPE
8. ***ADDRESS AT TIME OF DIAGNOSIS** ➔ ☐ **ADDRESS IN FIRST NATION COMMUNITY**			9. ***CITY/TOWN/VILLAGE**
10. ***PROVINCE/TERRITORY**	11. ***POSTAL CODE** A#A #A#		12. ***PHONE NUMBER** ### - ### - ####

II. INFECTION INFORMATION

full features: investigation > investigation details > disease summary

13. **DISEASE:** ☐ MIS-C	14. * **CASE CLASSIFICATION** ○ **CLINICAL** ○ **NOT A CASE**

15. *☐ **MEETS ALL 4 CLINICAL CRITERIA GROUPS BELOW (CHECK EACH APPLICABLE SIGN AND SYMPTOM)**

*GROUP 1
○ **CHILD OR ADOLESCENT (AGED 0-19 YEARS) WITH FEVER LASTING 3 DAYS OR LONGER**

*GROUP 2 – AT LEAST 2 OR MORE OF A, B, C, D, OR E:

A. ☐ RASH ☐ BILATERAL NON-PURULENT CONJUNCTIVITIS ☐ MUCO-CUTANEOUS INFLAMMATION SIGNS (ORAL, HANDS, OR FEET)

B. ☐ HYPOTENSION ☐ SHOCK

C. ☐ FEATURES OF MYOCARDIAL DYSFUNCTION ☐ PERICARDITIS ☐ VALVULITIS ☐ CORONARY ABNORMALITIES BY ECHO
☐ CORONARY ABNORMALITIES BY ELEVATED TROPONIN OR NT-PROBNP

D. ☐ EVIDENCE OF COAGULOPATHY (BY PT, PTT, OR ELEVATED D-DIMERS)

E. ☐ ACUTE GASTROINTESTINAL PROBLEMS (DIARRHEA, VOMITING, OR ABDOMINAL PAIN)

*GROUP 3 –
☐ HAS ELEVATED MARKERS OF INFLAMMATIN SUCH AS ESR, C-REACTIVE PROTEIN, OR PROCALCITONIN

*GROUP 4 –
☐ HAS NO OTHER OBVIOUS MICROBIAL CAUSE OF INFLAMMATION, INCLUDING BACTERIAL SEPSIS, STAPHYLOCOCCAL OR STREPTOCOCCAL SHOCK SYNDROMES, OR NO ALTERNATIVE PLAUSIBLE DIAGNOSIS

III. LABORATORY INFORMATION

full features: subject summary > lab summary

16. ***COVID-19 POSITIVE LABORATORY TEST**	○ NO ○ **YES**
17. **TYPE OF TEST**	☐PCR/NAAT ☐ANTIGEN ☐SEROLOGY ☐OTHER, PLEASE SPECIFY______________________

IV. SIGNS AND SYMPTOMS

full features: investigation > signs & symptoms

***SYMPTOM ONSET DATE**	YYYY-MM-DD

* **IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.**

V. RISK FACTOR INFORMATION

full features: subject > risk factors

	YES	NO	UNKNOWN	DECLINED TO ANSWER	NOT ASKED
18. * **CONTACT OF A NEW OR PREVIOUSLY DIAGNOSED COVID-19 CASE (CONFIRMED OR PROBABLE) IN THE LAST 2 MONTHS** **IF YES, PLEASE INCLUDE NAME, DOB AND PHIN OF CASE** **NAME:** **DOB:** **PHIN:**	○	○	○	○	○
19. **OTHER RISK FACTOR**	○	○	○	○	○
20. ***UNDERLYING ILLNESS (SPECIFY)** SPECIFY	○	○	○	○	○

VII. *OUTCOMES

investigation > outcomes

○ HOSPITALIZATION	ADMISSION DATE YYYY-MM-DD	○ ICU	ADMISSION DATE YYYY-MM-DD
SPECIFY FACILITY	DISCHARGE DATE YYYY-MM-DD	SPECIFY FACILITY	DISCHARGE DATE YYYY-MM-DD

○ FATAL	○ PENDING	○ RECOVERED	○ UNKNOWN	○ OTHER SIGNIFICANT OUTCOME/SEQUELAE
SPECIFY DATE OF DEATH YYYY-MM-DD				SPECIFY

OTHER OUTCOMES:

☐DETERIORATING ☐CONVALESCING ☐STABLE

VIII. *REPORTER INFORMATION

investigation > investigation details >
investigation > investigation details > close investigation

21. **FORM COMPLETED BY (PRINT NAME)**	22. **FACILITY NAME / ADDRESS / PHONE NUMBER**	**REPORTER USE ONLY**
23. **SIGNATURE**		
24. **FORM COMPLETION DATE:** YYYY-MM-DD		STAMP HERE

PLEASE SUBMIT THIS INVESTIGATION FORM BY SECURED FAX 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
http://www.gov.mb.ca/health/publichealth/surveillance/forms.html

* **IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.**