* CASE ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

Manitoba
Health, Seniors and Active Living

HEPATITIS B AND C, HIV, AND SYPHILIS INVESTIGATION FORM

CASE FORM

I. NON-NOMINAL HIV TEST RESULTS**

subject > client details > personal information

1. CURRENT NON-NOMINAL HIV CODE (IF APPLICABLE)	2. PREVIOUS NON-NOMINAL CODE(S) OR NAME(S) USED FOR POSITIVE HIV TESTS
SPECIFY	SPECIFY COUNTRY/PROVINCE, CODE/NAME, AND DATES YYYY-MM-DD IF KNOWN

**NOTE: FOR HIV, ONLY COMPLETE SECTION II PART A IF CURRENT HIV TEST IS NOMINAL, OR IF CLIENT PROVIDES CONSENT TO LINK CURRENT OR PREVIOUS NON-NOMINAL RESULTS WITH A NOMINAL RECORD. IF NON-NOMINAL, COMPLETE SECTION I AND II PART B ONLY.

II. *CASE IDENTIFICATION

subject > client details > personal information

PART A – CLIENT IDENTIFIERS (COMPLETE FOR NOMINAL CASES ONLY)

3. LAST NAME	4. FIRST NAME	5. DATE OF BIRTH
		YYYY - MM - DD

6. ALTERNATE LAST NAME	7. ALTERNATE FIRST NAME

8. REGISTRATION NUMBER (FORMER MHSC)	9. HEALTH NUMBER (PHIN)	10. ALTERNATE ID
6 DIGITS	9 DIGITS	SPECIFY TYPE OF ID

11. ADDRESS AT TIME OF DIAGNOSIS ➔ ☐ ADDRESS IN FIRST NATION COMMUNITY	12. CITY/TOWN/VILLAGE

13. PROVINCE/TERRITORY	14. POSTAL CODE	15. PHONE NUMBER
	A#A #A#	### - ### - ####

16. ALTERNATE LOCATION INFORMATION (IF ANY)

PART B – CLIENT INFORMATION (COMPLETE FOR NOMINAL AND NON-NOMINAL CASES)

17. SEX	18. GENDER IDENTITY (VOLUNTARY, SELF-REPORTED)	19. IF OTHER GENDER IDENTITY, SPECIFY	20. AGE (YRS)
○ FEMALE ○ MALE ○ INTERSEX ○ UNKNOWN	○ CISGENDER (SAME AS SEX AT BIRTH) ○ TRANSGENDER MAN ○ TRANSGENDER WOMAN ○ TRANSGENDER PERSON ○ DECLINED ○ OTHER (SPECIFY IN BOX 19)		(IF DOB NOT COMPLETED)

15. RACIAL/ETHNIC IDENTITY (VOLUNTARY, SELF-REPORTED)

☐ AFRICAN ☐ BLACK ☐ CHINESE ☐ DECLINED
☐ FILIPINO ☐ LATIN AMERICAN ☐ NORTH AMERICAN INDIGENOUS ☐ OTHER (SPECIFY):
☐ SOUTH ASIAN ☐ SOUTHEAST ASIAN ☐ WHITE

22. INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED)	23. FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED)	MHSU USE ONLY
○ FIRST NATIONS ○ MÉTIS ○ INUIT ○ NOT ASKED ○ DECLINED	○ STATUS ○ NON-STATUS ○ NOT ASKED ○ DECLINED	

24. IMMIGRATION STATUS AT TIME OF ARRIVAL (VOLUNTARY - COMPLETE BOXES 25 AND 26 IF BORN OUTSIDE CANADA)	25. DATE ARRIVED IN CANADA	26. COUNTRY EMIGRATED FROM
○ CANADIAN BORN CITIZEN ○ LANDED IMMIGRANT ○ REFUGEE ○ STUDENT ○ VISITOR ○ WORK PERMIT ○ DECLINED ○ NOT ASKED ○ OTHER (SPECIFY BELOW)	YYYY	SPECIFY

III. INVESTIGATION INFORMATION

27. *INVESTIGATION DISPOSITION	○ FOLLOW-UP COMPLETE ○ UNABLE TO COMPLETE INTERVIEW ○ PENDING
28. *RESPONSIBLE ORGANIZATION	○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC
29. OTHER ORGANIZATIONS INVOLVED	☐ WRHA ☐ NRHA ☐ PMH ☐ SH-SS ☐ IERHA ☐ FNIHB ☐ CSC ☐ DND

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

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IV. *INFECTION INFORMATION/STAGING

investigation > investigation details > disease summary > update > disease event history

30. ☐ **HEPATITIS B** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

☐ LAB CONFIRMED
☐ NOT A CASE

31. **HEPATITIS B STAGING**
○ ACUTE
○ CHRONIC
○ UNKNOWN OR UNDETERMINED
○ OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB
○ PREVIOUS DIAGNOSIS- NEW TO MANITOBA

32. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** YYYY – MM - DD

33. ☐ **HEPATITIS C** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

☐ LAB CONFIRMED
☐ NOT A CASE

34. **HEPATITIS C STAGING**
○ ACUTE
○ CHRONIC
○ UNKNOWN OR UNDETERMINED
○ OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB
○ PREVIOUS DIAGNOSIS- NEW TO MANITOBA

35. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** YYYY – MM - DD

36. ☐ **HIV** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

☐ LAB CONFIRMED
☐ NOT A CASE

37. **HIV STAGING**
○ NEW DIAGNOSIS
○ OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB
○ PREVIOUS DIAGNOSIS- NEW TO MANITOBA

38. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** YYYY – MM - DD

39. ☐ **SYPHILIS** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

☐ LAB CONFIRMED
☐ NOT A CASE

40. **SYPHILIS STAGING INFORMATION**
○ STAGING PENDING
○ STAGING COMPLETED (SPECIFY IN BOXES 41 OR 42)
○ OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB
○ UNKNOWN/UNDETERMINED

41. **INFECTIOUS STAGES**
○ PRIMARY
○ SECONDARY
○ EARLY LATENT (< 1 YEAR AFTER INFECTION)

42. **NON-INFECTIOUS STAGES**
○ LATE LATENT (≥ 1 YEAR AFTER INFECTION)
○ TERTIARY

43. **ADDITIONAL PRESENTATIONS** ☐ CARDIOVASCULAR SYPHILIS ☐ NEUROSYPHILIS ☐ GUMMATOUS SYPHILIS

44. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** YYYY – MM - DD

45. **DATE OF FIRST DIAGNOSIS IF PREVIOUSLY DIAGNOSED** YYYY – MM

46. **LOCATION OF FIRST DIAGNOSIS IF NOT IN MANITOBA** SPECIFY COUNTRY OR PROVINCE IN CANADA

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

V. METHOD OF DETECTION

investigation > investigation details > investigation information

47. **METHOD OF DETECTION FOR CURRENT INVESTIGATION (REASON FOR TESTING)**
○ CONTACT INVESTIGATION
○ IMMIGRATION MEDICAL SURVEILLANCE
○ PRENATAL SCREENING
○ ROUTINE TESTING (INCIDENTAL FINDING)
○ SYMPTOMS

48. **OTHER METHOD OF DETECTION** SPECIFY

VI. SIGNS AND SYMPTOMS

investigation > signs and symptoms

49. **SYMPTOMS**
○ ASYMPTOMATIC
○ SYMPTOMATIC (COMPLETE BOX 51 FOR HEPATITIS B/C, BOX 52 FOR SYPHILIS, OR BOX 53 FOR HIV)

50. **EARLIEST SYMPTOM ONSET DATE** YYYY-MM-DD

51. **HEPATITIS B/C (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)**
☐ ABDOMINAL PAIN/CRAMPING (RUQ)
☐ ANOREXIA
☐ DARK URINE
☐ FATIGUE
☐ FEVER
☐ JAUNDICE
☐ NAUSEA
☐ STOOL, PALE
☐ VOMITING
☐ OTHER SPECIFY

52. **SYPHILIS (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)**
☐ ANAL ULCERATIVE LESIONS
☐ CHANCRE (OTHER SITE)
☐ CONDYLOMATA LATA
☐ GENITAL ULCER
☐ HAIR LOSS (ALOPECIA)
☐ HEADACHE
☐ LYMPH NODES ENLARGED – GENERALIZED
☐ LYMPH NODES ENLARGED - REGIONAL
☐ MENINGITIS
☐ OCULAR INVOLVEMENT
☐ ORAL ULCERATIVE LESIONS
☐ OTHER MUCOSAL LESIONS
☐ RASH
☐ OTHER SPECIFY

53. **HIV SIGNS/ SYMPTOMS** SPECIFY IF NEEDED FOR CASE MANAGEMENT

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

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VII. RISK FACTOR INFORMATION

subject > risk factors

A. BLOOD AND PERCUTANEOUS EXPOSURES (COMPLETE FOR HEP B, HEP C, AND HIV CASES ONLY)

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
ACUPUNCTURE SPECIFY LOCATION AND DATE YYYY-MM-DD	○	○	○	○	○
BLOOD/TISSUE DONATION (E.G. BLOOD, PLASMA, ORGANS, BREAST MILK) SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	○	○	○	○	○
BLOOD/TISSUE RECIPIENT (E.G. BLOOD, PLASMA, TISSUE, ORGANS) SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	○	○	○	○	○
BODY PIERCING, SCARIFICATION, TATTOO APPLICATION SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD	○	○	○	○	○
DIALYSIS (HEMODIALYSIS OR PERITONEAL) SPECIFY START DATE YYYY-MM-DD	○	○	○	○	○
MEDICAL OR SURGICAL PROCEDURE SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD	○	○	○	○	○
OCCUPATIONAL EXPOSURE (E.G. NEEDLE STICK, SHARPS) SPECIFY TYPE AND DATE YYYY-MM-DD	○	○	○	○	○
RECIPIENT OF POOLED CONCENTRATES OF FACTOR VIII OR IX FOR TREATMENT OF HEMOPHILIA/COAGULATION DISORDER SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY-MM-DD	○	○	○	○	○

B. SEXUAL EXPOSURE (COMPLETE ROUTINELY FOR HEP B, HIV, AND SYPHILIS CASES ONLY)

☐ PREGNANT AT TIME OF DIAGNOSIS
SPECIFY EDC: YYYY-MM-DD

☐ DATE OF LAST SEXUAL EXPOSURE
SPECIFY DATE YYYY-MM-DD

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
HAS GIVEN GOODS IN EXCHANGE FOR SEX	○	○	○	○	○
HAS RECEIVED GOODS IN EXCHANGE FOR SEX	○	○	○	○	○
MALE WHO HAS SEX WITH MEN	○	○	○	○	○
NEW SEX PARTNER IN PERIOD OF COMMUNICABILITY	○	○	○	○	○
SEXUAL ASSAULT (NON-CONSENSUAL SEX)	○	○	○	○	○
SEXUAL EXPOSURE TYPE: ANAL	○	○	○	○	○
SEXUAL EXPOSURE TYPE: ORAL	○	○	○	○	○
SEXUAL EXPOSURE TYPE: VAGINAL	○	○	○	○	○

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C. HISTORY OF STBBI AND EXPOSURE RISKS (COMPLETE FOR ALL CASES EXCEPT WHERE INDICATED)

☐ BORN TO INFECTED MOTHER — SPECIFY INFECTION(S)

CONTACT TO A CASE OF: ○ HEPATITIS B ○ HEPATITIS C ○ HIV ○ SYPHILIS

SPECIFY DATE OF INITIAL CONTACT: YYYY-MM-DD YYYY-MM-DD YYYY-MM-DD YYYY-MM-DD

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
HISTORY OF INCARCERATION — SPECIFY LOCATION AND DATE RANGE	○	○	○	○	○
HISTORY OF RESIDENCE IN AN ENDEMIC COUNTRY (FOR CASES OF HEP B/C AND HIV) — SPECIFY COUNTRY AND DATES	○	○	○	○	○
HISTORY OF STI — SPECIFY INFECTION(S) AND DATE(S)	○	○	○	○	○
HOUSEHOLD CONTACT WITH CONFIRMED OR SUSPECTED CASE (HEP B CASES ONLY)	○	○	○	○	○
INJECTION DRUG USE — SPECIFY SUBSTANCE(S) AND DATE OF LAST IDU EXPOSURE	○	○	○	○	○
INJECTION DRUG USE OUTSIDE CANADA — SPECIFY SUBSTANCE(S), DATES, AND COUNTRY	○	○	○	○	○
PREVIOUS ANTI-RETROVIRAL THERAPY (HIV CASES ONLY) — SPECIFY PROVINCE/COUNTRY AND DATE(S)	○	○	○	○	○
PREVIOUSLY DIAGNOSED HEPATITIS B CASE — SPECIFY PROVINCE/COUNTRY AND DATE OF DIAGNOSIS YYYY-MM	○	○	○	○	○
PREVIOUSLY DIAGNOSED HEPATITIS C CASE — SPECIFY PROVINCE/COUNTRY AND DATE OF DIAGNOSIS YYYY-MM	○	○	○	○	○
PREVIOUSLY DIAGNOSED HIV CASE — SPECIFY PROVINCE/COUNTRY AND DATE OF FIRST POSITIVE TEST YYYY-MM	○	○	○	○	○
PREVIOUS TREATMENT FOR SYPHILIS (SYPHILIS CASES ONLY) — SPECIFY PROVINCE/COUNTRY AND DATE(S)	○	○	○	○	○
SAFER INJECTION PROGRAM USE (COMPLETE ONLY IF INJECTION DRUG USE REPORTED) ☐ ALWAYS ☐ NEVER ☐ SOMETIMES	○	○	○	○	○
SHARED NEEDLES — SPECIFY LOCATION	○	○	○	○	○
SHARED OTHER DRUG PARAPHERNALIA — SPECIFY TYPE	○	○	○	○	○
OTHER RISK FACTOR — SPECIFY	○	○	○	○	○
NO IDENTIFIABLE RISK FACTORS IN SECTIONS A, B, OR C	○	○	○	○	○

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VIII. TREATMENT INFORMATION (COMPLETE FOR SYPHILIS ONLY)

investigation > prescriptions > prescription summary

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

IX. OUTCOMES AT TIME OF INVESTIGATION

investigation > outcomes

◯ FATAL	◯ OTHER SIGNIFICANT OUTCOME/SEQUELAE
SPECIFY DATE OF DEATH YYYY-MM-DD	SPECIFY

X. EVIDENCE-BASED INTERVENTIONS

investigation > treatment and interventions >interventions summary

57. **RECOMMENDED IMMUNIZATIONS**

☐ **HBV**	◯ RECOMMENDED	◯ ADMINISTERED	◯ IMMUNE	◯ DECLINED	☐ **HAV**	◯ RECOMMENDED	◯ ADMINISTERED	◯ IMMUNE	◯ DECLINED

58. **STBBI TESTING RECOMMENDED/COMPLETED**				59. **LOCATION OF TESTING IF KNOWN**	60. **DATE (YYYY-MM-DD)**
☐ CHLAMYDIA	◯ POSITIVE	◯ NEGATIVE	◯ UNKNOWN		
☐ GONORRHEA	◯ POSITIVE	◯ NEGATIVE	◯ UNKNOWN		
☐ HEPATITIS B	◯ POSITIVE	◯ NEGATIVE	◯ UNKNOWN		
☐ HEPATITIS C	◯ POSITIVE	◯ NEGATIVE	◯ UNKNOWN		
☐ HIV	◯ POSITIVE	◯ NEGATIVE	◯ UNKNOWN		
☐ SYPHILIS	◯ POSITIVE	◯ NEGATIVE	◯ UNKNOWN		

61. **OTHER INTERVENTIONS**	62. **DATE (YYYY-MM-DD)**
☐ REFERRAL FOR TREATMENT (SPECIFY)	
☐ REFERRAL TO PEDIATRIC INFECTIOUS DISEASES (SPECIFY DATE)	
☐ FOLLOW-UP STBBI TESTING IN 6 MONTHS	
☐ NOTIFICATION OF CANADIAN BLOOD SERVICES (IF APPLICABLE)	
☐ IMMUNIZATION: NEWBORN PROPHYLAXIS FOR HEPATITIS B (IF APPLICABLE)	
☐ OTHER (SPECIFY)	

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Subject > imms history interpretation
Immunization

XI. HEPATITIS B IMMUNIZATION HISTORY INTERPRETATION

63. INTERPRETATION OF HEPATITIS B IMMUNITY PRIOR TO INVESTIGATION	64. REASON FOR IMMUNITY/ IMMUNIZATION INTERPRETATION
○ IMMUNITY- LAB EVIDENCE ○ SUSCEPTIBLE – LAB EVIDENCE ○ INDETERMINATE- LAB EVIDENCE ○ FULLY IMMUNIZED ○ PARTIALLY IMMUNIZED ○ UNIMMUNIZED ○ UNKNOWN/NOT DETERMINED	**SOURCE OF SEROLOGY/ IMMUNIZATION RECORD:** ○ CLIENT/PARENT/GUARDIAN ○ CLIENT/PARENT/GUARDIAN – OFFICIAL RECORD ○ HEALTH RECORD/ HEALTHCARE PROVIDER **REASON IF NOT FULLY IMMUNIZED OR UNKNOWN:** ○ GENERAL OBJECTION (NON-PHILOSOPHICAL) ○ IMMUNOCOMPROMISED ○ MEDICAL CONTRAINDICATION ○ NOT ELIGIBLE FOR ROUTINE IMMUNIZATION ○ NOT UP TO DATE WITH IMMUNIZATIONS ○ PHILOSOPHICAL OBJECTION ○ UNKNOWN/ NOT DETERMINED

65. HEPATITIS B VACCINES AND DATES (LIST AGENTS AND DATES ONLY IF NOT ALREADY ENTERED IN MB IMMUNIZATION REGISTRY)			
	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD
	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD

XII. CONTACTS

investigation > exposure summary > transmission event details

66. NUMBER OF CONTACTS IDENTIFIED BY NAME ➔	SPECIFY NUMBER	67. NUMBER OF ANONYMOUS CONTACTS ➔	SPECIFY NUMBER	68. EARLIEST ANONYMOUS EXPOSURE START DATE ☐ ESTIMATED YYYY-MM-DD

☐ CASE DECLINED TO IDENTIFY CONTACTS

XIII. * REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

69. FORM COMPLETED BY (PRINT NAME)	70. FACILITY NAME/ADDRESS/PHONE#	REPORTER USE ONLY
71. SIGNATURE		
72. FORM COMPLETION DATE YYYY-MM-DD	73. ORGANIZATION (IF APPLICABLE) ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC	STAMP HERE

XIV. * RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE USE ONLY

74. FORM COMPLETED BY (PRINT NAME)	75. SIGNATURE	76. FORM COMPLETION DATE YYYY-MM-DD
77. FORM REVIEWED BY (PRINT NAME)	78. FORM REVIEWED DATE YYYY-MM-DD	RHA USE ONLY
79. INVESTIGATION STATUS ○ ONGOING ○ CLOSED TO THE REGION	80. ORGANIZATION ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ 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
http://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
http://www.gov.mb.ca/health/publichealth/surveillance/forms.html