

ADMINISTRATIVE INFORMATION

Reporting Province / Territory:

BC AB SK MB ON QC NB NS PE NL YK NT NU

Contact information for P/T person reporting

First and Last Names:

Telephone #:

Email:

P/T Case ID:

Initial Report

Updated Report

Report Date:

(dd/mm/yyyy)

Outbreak or cluster related? Yes No

If yes, local Outbreak ID:

Has the outbreak been declared and made public?

Yes No

If case is related to a provincial /territorial outbreak, P/T Outbreak ID:

Number of ill persons affected by the outbreak:

CASE TYPE

Unknown at this time

Severe Acute Respiratory Infection

Novel Coronavirus *Specify:*

Other Novel Respiratory Pathogen

Specify:

Novel Influenza A

H1 H3 H5 H7

Other:

Novel Influenza B

SURVEILLANCE CASE CLASSIFICATION *(please refer to case definitions if available)*

Suspect / Patient Under Investigation

Probable

Confirmed

DEMOGRAPHIC INFORMATION

Gender: Male Female Unknown

Age: years *If under 2 years* months Unknown

Does the case identify as Aboriginal? Yes No Refused to answer Unknown

If yes, please indicate which group: First Nations Metis Inuit

Does the case reside on a First Nations reserve most of the time? Yes No Refused to answer Unknown

SYMPTOMS *(check all that apply)*

Date of onset of first symptom(s):

(dd/mm/yyyy)

Asymptomatic

Abdominal pain	Dizziness	Nausea	Sore throat
Anorexia/decreased appetite	Fatigue	Nose bleed	Sputum production
Arthralgia	Fever ($\geq 38^{\circ}\text{C}$)	Otitis	Swollen lymph nodes
Chest pain	Feverish/chills (temp. not taken)	Rhinorrhea/nasal congestion	Vomiting
Conjunctivitis	Headache	Rash	Other, specify:
Cough	Malaise	Seizures	
Diarrhea	Myalgia	Shortness of breath / difficulty breathing	
		Sneezing	

CLINICAL COURSE, HOSPITALIZATIONS, COMPLICATIONS and OUTCOME

Date of first presentation to medical care:		(dd/mm/yyyy)	
Clinical Evaluations (check all that apply)		Encephalitis	Renal Failure
Altered mental status		Hypotension	Sepsis
Arrhythmia		Meningismus / nuchal rigidity	Tachypnea (accelerated respiratory rate)
Clinical or radiological evidence of pneumonia		O2 saturation $\leq 95\%$	Other (specify):
Diagnosed with Acute Respiratory Distress Syndrome			
Case Hospitalized?	Yes	No	Unknown
Admission Date:	(dd/mm/yyyy)		
Diagnosis at time of admission:	Re Admission Date: (dd/mm/yyyy)		
Case admitted to Intensive Care Unit (ICU)	ICU Admission Date: (dd/mm/yyyy)		
Yes	No	Unknown	
ICU Discharge Date:	(dd/mm/yyyy)		
Patient isolated in hospital?	Yes	No	Unknown
If yes, specify type of isolation (e.g. respiratory droplet precaution, negative pressure):			
Supplemental oxygen therapy	Yes	No	Unknown
Mechanical ventilation	Yes	No	Unknown
If yes, number of days on ventilation			
Case Discharged from Hospital	Yes	No	Unknown
Discharge Date 1:	(dd/mm/yyyy)		
Discharge Date 2:	(dd/mm/yyyy)		
Case Transferred to another hospital	Transfer Date: (dd/mm/yyyy)		
Yes	No	Unknown	
Current Disposition	Recovered	Stable	Deteriorating
Deceased	(dd/mm/yyyy)		

If deceased, is post-mortem:		Performed	Pending	None	Unknown
Death attributed/linked to respiratory illness?		Yes	No	Unknown	
Cause of death (as listed on death certificate):					
PRE-EXISTING CONDITIONS and RISK FACTORS (check all that apply)					None identified
Cardiac Disease	Yes	No	Unknown	Hemoglobinopathy/Anemia	Yes No Unknown
<i>If yes, please specify:</i>				<i>If yes, please specify:</i>	
Hepatic Disease	Yes	No	Unknown	Receiving immunosuppressive medications	Yes No Unknown
<i>If yes, please specify:</i>				<i>If yes, please specify:</i>	
Metabolic Disease	Yes	No	Unknown	Substance use	Yes No Unknown
<i>If yes, please specify:</i>				<i>If yes, please specify:</i>	
Diabetes				Smoker (current)	
Obese (BMI > 30)				Alcohol abuse	
Other:				Injection drug use	
Other:				Other:	
Renal Disease	Yes	No	Unknown	Malignancy	Yes No Unknown
<i>If yes, please specify:</i>				<i>If yes, please specify:</i>	
Respiratory Disease	Yes	No	Unknown	Other Chronic Conditions	Yes No Unknown
<i>If yes, please specify:</i>				<i>If yes, please specify:</i>	
Asthma					
Tuberculosis					
Other:					
Neurologic Disorder	Yes	No	Unknown	Pregnancy	Yes No Unknown
<i>If yes, please specify:</i>				<i>If yes, week of gestation:</i>	
Neuromuscular Disorder				Estimated birth date: (dd/mm/yyyy)	
Epilepsy					
Other:				GPA (gravida, para, aborta):	
Immunodeficiency disease / condition	Yes	No	Unknown	Post-Partum (≤6 weeks)	Yes No Unknown
<i>If yes, please specify:</i>					

PROPHYLAXIS

Did the case receive prescribed prophylaxis prior to symptom onset? Yes No Unknown

Specify name:

date of first dose: (dd/mm/yyyy)

date of last dose: (dd/mm/yyyy)

TREATMENT *(submit additional information on a separate page if required)*

In the treatment of this infection, is the case taking:

Antiviral medication

Specify name (1):

Antibiotic/antifungal medication

date of first dose (1): (dd/mm/yyyy)

Immunosuppressant/immunomodulating medication

date of last dose (1): (dd/mm/yyyy)

Unknown

None

Specify name (2):

date of first dose (2): (dd/mm/yyyy)

date of last dose (2): (dd/mm/yyyy)

VACCINATION

Did the case receive the current year's seasonal influenza vaccine?

Yes No Unknown Not yet available

If yes, date of vaccination:
(dd/mm/yyyy)

Did the case receive the previous year's seasonal influenza vaccine?

Yes No Unknown

Did the case receive pneumococcal vaccine in the past? Yes No Unknown

If yes, year of most recent dose: (dd/mm/yyyy)

If yes, type polysaccharide or conjugate: 7 or 13

LABORATORY INFORMATION

Microbiology / Virology / Serology *(complete if applicable)*

Lab ID	Date Specimen Collected	Specimen Type & Source	Test Method	Test Result	Test Date

Antimicrobial Resistance of suspect etiological agent(s) <i>(complete if applicable)</i>					
Lab ID	Name of Antimicrobial	Specimen Type & Source	Test Method	Test Result	Test Date

SOURCE IDENTIFICATION: EXPOSURES *(add additional details in the comments section as necessary)*

Travel

In the 14 days prior to symptom onset, did the case travel outside of their province/territory of residence or outside of Canada? Yes No Unknown
If yes, please specify the following (submit additional information on a separate page if required)

	Country/ City Visited	Hotel or Residence	Dates of Travel
Trip 1			
Trip 2			

In the 14 days prior to symptom onset, did the case travel on a plane or other public carrier(s)? Yes No Unknown
If yes, please specify the following

Travel Type	Carrier Name	Flight / Carrier #	Seat #	City of Origin	Date of Travel

Human

In the 14 days prior to symptom onset, was the case in close contact *(cared for, lived with, spent significant time within close quarters (e.g. co-worker) or had direct contact with respiratory secretions)* with:

A confirmed case of the same disease? If yes, specify the Case ID:	Yes No Unknown
A probable or suspect case of the same disease? If yes, specify the Case ID:	Yes No Unknown

A person who had fever, respiratory symptoms (such as cough or sore throat), or respiratory illness (such as pneumonia)?	Yes	No	Unknown
<i>If yes, specify the type of contact:</i>			
Household member	Person who travelled outside of Canada		
Person who works in a healthcare setting	Person who works in a laboratory		
Works with patients	Other (specify):		
Person who works with animals			
Occupational			
The case is a:			
Healthcare worker or volunteer	If yes, with direct patient contact?	Yes	No
Laboratory Worker handling biological specimens	School or Daycare Worker/Attendee	Unknown	
Veterinary Worker	Farm Worker		
Other:			
Residential			
Resident of a retirement residence or long-term care facility			
Resident in an institutional facility (<i>dormitory, shelter/group home, prison etc.</i>)			
Other:			
Animal			
A. Direct Contact (<i>touch or handle</i>)			
In the 14 days prior to symptom onset, did the case have direct contact with any animals or animal products (<i>faeces or urine, bedding/nests, carcass/fresh meat, fur/skins etc.</i>)? Yes No Unknown			
If yes, specify date of last direct contact:		(dd/mm/yyyy)	
What type of animals did the case have direct contact with? (<i>check all that apply</i>)			
Cat(s)	Dogs	Horses	Cows
	Poultry	Sheep / Goat	Wild Birds
			Rodents
			Swine
Wild game (eg. Deer)	Bats	Camels or Dromedary camels	Other:
Did the animal display any symptoms of illness or was the animal dead? Yes No Unknown			
Where did the direct contact occur? (<i>check all that apply</i>)			
Home	Work (<i>confirm occupation above</i>)	Agricultural Fair or event / Petting Zoo	

