Protected B when complete

CORONAVIRUS DISEASE (COVID-19) CASE REPORT FORM

SECTION 1: CASE PROTECTED INFORMATION – Local / Provincial / Territorial use only

DO NOT FORWARD THIS SECTION TO PHAC

CASE Information	**PROXY Information**
Last name:	Is respondent a proxy? (e.g. for deceased patient, child)
First name:	◯ No ◯ Yes (complete information below)
Usual residential address:	Last name:
City: Province/Territory:	First name:
Postal code: Local Health Region:	Relationship to case:
Phone number #1:	Phone number #1:
Phone number #2:	Phone number #2:
Date of Birth (dd/mm/yyyy)	
Local Case ID:	
P/T Case ID:	

Contact information for person reporting

First and Last Names:

Telephone #:

Email:

Instructions for Completion

- Please complete as much detail as possible on this form at the time of the initial report.
- It is not expected that all fields will be completed during the initial report, but that updates will be made when information becomes available.

Instructions to local public health authorities

- **Reporting:** Please report cases using normal local/provincial/territorial methods
- **Travel:** The Office of Quarantine Services at the Public Health Agency of Canada may be of assistance with requesting passenger manifests from conveyance operators, when requested to do so, by a local public health authority. Local public health authorities can contact the manager on-call 1-416-MANAGER (626-2437).

Instructions to provincial / territorial public health authorities

- **Reporting of probable and confirmed cases:** Please report cases electronically using secure methods or fax to 1-613-952-4723. For fax, an email notification should be sent to phac.hsfluepi.aspc@canada.ca (do not attach form). *Provinces and territories are asked to report all confirmed and probable cases within 24 hours of P/T notification to PHAC*.
- After regular business hours (8:00am-5:00pm ET), please contact the PHAC's Health Portfolio Operations Centre at phac-aspc.hpoc-cops@canada.ca.

P/T Case ID: **Reported Date:** (DD/MM/YYY)

ADMINISTRATIVE INFORMATION

◯ **INITIAL REPORT** ◯ **UPDATED REPORT**

Reporting Province/Territory

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

Contact information for P/T person reporting

First Name: Email:

Last Name: Telephone #:

Reason for testing:

◯ Individual sought healthcare ◯ Contact of a case ◯ Routine respiratory disease surveillance ◯ Other, specify:

SURVEILLANCE CASE CLASSIFICATION *(refer to national case definition)*

◯ **Confirmed** ◯ **Probable** ◯ **Person Under Investigation** ◯ **Does not meet**

CASE DETAILS

Residency: ◯ Canadian resident ◯ Non-Canadian Resident, Country:

Detected at Point of Entry? ◯ No ◯ Yes, location of entry: Date of entry: (dd/mm/yyyy)

Gender: ◯ Male ◯ Female ◯ Other ◯ Unknown **Age:** ◯ years ◯ months

Does the case identify as Indigenous? ◯ Yes ◯ No ◯ Refused to Answer ◯ Unknown

If yes, indicate which group: ◯ First Nations ◯ Metis ◯ Inuit ◯ Refused to Answer ◯ Unknown

Does the case reside on a First Nations Reserve most of the time? ◯ Yes ◯ No ◯ Refused to Answer ◯ Unknown

Case is:

◯ Healthcare worker/volunteer with direct patient contact
◯ Laboratory worker handling biological specimens
◯ Veterinary/animal worker
◯ Other, specify: _____
◯ School or daycare worker/attendee
◯ Farm worker
◯ Resident of long-term care facility/institutional facility

SYMPTOMS

Symptom Onset Date: (mm/dd/yyyy) ◯ **Asymptomatic**

Symptom	Yes	No	Unknown	Not asked/assessed
Cough	◯	◯	◯	◯
Fever (≥38°C)	◯	◯	◯	◯
Feverish/chills (temperature not taken)	◯	◯	◯	◯
Sore throat	◯	◯	◯	◯
Runny nose	◯	◯	◯	◯
Shortness of breath/difficulty breathing	◯	◯	◯	◯
Nausea/vomiting	◯	◯	◯	◯
Headache	◯	◯	◯	◯
General weakness	◯	◯	◯	◯
Pain (muscular, chest, abdominal, joint, etc.)	◯	◯	◯	◯

Irritability/confusion	◯	◯	◯	◯
Diarrhea	◯	◯	◯	◯
Other, specify:	◯	◯	◯	◯

PRE-EXISTING CONDITIONS and RISK FACTORS

Condition	Yes	No	Unknown	Not asked	**Comments** (specify disease)
Cardiac disease	◯	◯	◯	◯	
Chronic neurological or neuromuscular disorder	◯	◯	◯	◯	
Diabetes	◯	◯	◯	◯	
Immunodeficiency disease/condition	◯	◯	◯	◯	
Liver Disease	◯	◯	◯	◯	
Malignancy	◯	◯	◯	◯	
Post-partum (≤6 weeks)	◯	◯	◯	◯	
Pregnancy	◯	◯	◯	◯	If yes, trimester :
Renal Disease	◯	◯	◯	◯	
Respiratory Disease	◯	◯	◯	◯	
Other, specify:	◯	◯	◯	◯	

CLINICAL EVALUATIONS, COMPLICATIONS, and DIAGNOSES

Clinical evaluation/diagnoses	Yes	No	Unknown	Not assessed	Comments
Abnormal lung auscultation	◯	◯	◯	◯	
Altered mental status	◯	◯	◯	◯	
Clinical or radiological evidence of pneumonia	◯	◯	◯	◯	
Coma	◯	◯	◯	◯	
Conjunctival injection	◯	◯	◯	◯	
Diagnosed with Acute Respiratory Distress Syndrome	◯	◯	◯	◯	
O_2 saturation <95%	◯	◯	◯	◯	
Encephalitis	◯	◯	◯	◯	
Hypotension	◯	◯	◯	◯	
Pharyngeal exudate	◯	◯	◯	◯	
Renal failure	◯	◯	◯	◯	
Seizure	◯	◯	◯	◯	
Sepsis	◯	◯	◯	◯	
Tachypnea (accelerated respiratory rate)	◯	◯	◯	◯	
Other, specify:	◯	◯	◯	◯	

CLINICAL COURSE and OUTCOMES *(complete if applicable)*

Clinical Course	Yes	No	Unknown	Admission/Start Date	Discharge/End Date
Hospitalization	◯	◯	◯		
Intensive Care Unit (ICU)	◯	◯	◯		
Isolation (e.g. negative pressure)	◯	◯	◯		
Mechanical ventilation	◯	◯	◯		

Current Disposition: ◯ Recovered* ◯ Stable ◯ Deteriorating ◯ Deceased Disposition date: (mm/dd/yyyy)

If deceased: Death attributed/linked to respiratory illness? ◯ Yes ◯ No ◯ Unknown

Cause of death *(as listed on death certificate):* Date of Death: (mm/dd/yyyy)

*Definition: resolution of symptoms followed by two negative tests at least 24 hours apart

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

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 ◯ Refused to Answer ◯ Unknown

If yes, specify the following (submit additional information on a separate page if required):

#	Departure Country (city/country)	Destination Country (city/country)	Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)	Hotel/Residence	Flight/Carrier Details (carrier name, flight #, seat #)
1						
2						
3						
4						

Was the case in close contact* with a symptomatic confirmed or probable case in the 14 days prior to symptom onset?

◯ Yes ◯ No ◯ Unknown

If yes, complete the following (submit additional information on a separate page if required):

Case ID(s)	Date of First Contact (mm/dd/yyyy)	Date of Last Contact (mm/dd/yyyy)	Contact Setting	Comments
	Sustained contact: ◯ Y ◯ N ◯ DK		◯ Healthcare setting ◯ Family Setting ◯ Work place ◯ Unknown ◯ Other, specify:	
	Sustained contact: ◯ Y ◯ N ◯ DK		◯ Healthcare setting ◯ Family Setting ◯ Work place ◯ Unknown ◯ Other, specify:	

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

Was the case in close contact* with a person with fever and/or cough who has been to an affected area in the 14 days prior to their illness onset?** ◯ Yes ◯ No ◯ Unknown	Date of last contact (mm/dd/yyyy):	**If yes, specify contact setting:** ◯ Healthcare setting ◯ Family Setting ◯ Work place ◯ Unknown ◯ Other, specify:	**Exposure occurred in Canada:** ◯ Yes ◯ No , specify:_____ ◯ Unknown

In the 14 days prior to symptom onset, did the case have contact with live animals (not considered household pets) or animal products in any of the affected areas?** *This includes direct contact with animals, or contact with their feces or urine, soiled bedding/litter, or contact with other animal products (e.g. organs, exotic meats)*	◯ Yes ◯ No ◯ Unknown **If yes, specify what animals or animal products that you had contact with:**	**If yes, where:** ◯ Home ◯ Work ◯ During travel ◯ Live animal market **Specify City:**
In the 14 days prior to symptom onset, did the case visit any health care facility?	◯ Yes ◯ No ◯ Unknown	

* close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact OR who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill.

** Affected areas are subject to change; refer to the national COVID-19 surveillance case definition for the most up-to-date information.

Total number of contacts identified for this case: ☐ Unknown

LABORATORY INFORMATION *(microbiology / virology / serology) (complete if applicable)*

Lab ID	Specimen		Test Method	Test Result (positive, negative, inconclusive, pending)	Test Date (mm/dd/yyyy)
	Collection Date (mm/dd/yyyy)	Type & Source			

Results of National Microbiology Laboratory confirmatory testing:

◯ Not submitted ◯ Positive ◯ Negative ◯ Inconclusive ◯ Pending

Date of NML confirmation: (mm/dd/yyyy)

ADDITIONAL DETAILS/COMMENTS *(add as necessary)*

TO BE COMPLETED BY: ***The Public Health Agency of Canada***

Date Received: (mm/dd/yyyy)	**PHAC Case ID:**
	If applicable, national outbreak ID: