Communicable Disease Control Investigation Form:



Date: ___/__/_d

A:	Notified by: Phone number: This is a: \[\subsetential \text{New report} \] or \[\subseteq \text{Update of previous report} \]					
3:	Diagnosis:					
	Patient name: Date of birth:/_ / _ Age:					
	Address: Sex: \square M \square					
	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:					
 ::	Disease: Symptomatic: U Y U N U					
	Disease: Symptomatic:YNU Date of onset of symptoms:// Duration of symptoms: (days) Clinical history:					
>:	Date of onset of symptoms:/ (days)					
	Date of onset of symptoms:// Duration of symptoms: (days) Clinical history:					
	Date of onset of symptoms:/ Duration of symptoms: (days) Clinical history: Clinical course: Treatment: U Y N U If yes, list: Drug					
łos	Date of onset of symptoms: (days) Clinical history: Clinical course: Treatment:					
los Seq	Date of onset of symptoms://					
los Seq	Date of onset of symptoms:/ Duration of symptoms: (days) Clinical history: Clinical course: Treatment:					
Hos Seq	Date of onset of symptoms: (days) Clinical history: Clinical course: Treatment:					
Seq I Jnd	Date of onset of symptoms:/ Duration of symptoms: (days) Clinical history: Clinical course: Treatment:					
los Seq Ind	Date of onset of symptoms:/ Duration of symptoms: (days) Clinical history: Clinical course: Treatment:Y N U If yes, list: Drug Dose Duration pitalized:Y N U If yes, days uelae:Y N U Died:Y N U erlying illness:Y N U U If yes, specify:					
los Seq Ind	Date of onset of symptoms:					
Hos Seq	Date of onset of symptoms:/_/					
los Seq Ind	Date of onset of symptoms:					
los Seq Ind	Date of onset of symptoms:/ Duration of symptoms: (days) Clinical history: Clinical course: Treatment:					
los Seq Ind	Date of onset of symptoms:/_/					
los Seq Ind	Date of onset of symptoms:/_/_ Duration of symptoms:					
los Seq Ind	Date of onset of symptoms:/ Duration of symptoms: (days)					

E:	Source of infection 1.	1. 2. 3. 4. 5. 6. 7. 8.		9. MD office 10. Workplace 11. Sexual contact 12. Wound 13. Camping 14. Restaurant		
116	Country/City/Area visited	Arrival date	Length of stay	Accomodation code**		
F:	** 1. Urban/Hotel/Business/Hoste	,	rek			
	1	ate Agent	☐ Religious ☐ Previous ☐ Not recor	contraindication /philosophical exemption disease documented mmended/not eligible pecify		
G: Outbreak associated						
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://					