Ontario

Appendix 1: Ontario's Severe Acute Respiratory Infection Case Report Form

<table>
<tr><td>

iPHIS Case ID: __________________

CLIENT RECORD

Last name: ____
First name: ____
Usual residential address: ____________________________
____
City: _________________ Province/Territory: ____________
Postal code: __________

Responsible Health Unit: ______________
Branch office: ______________

Diagnosing Health Unit: ______________

Phone number(s): (_____) ______ - _____________
(_____) ______ - _____________

Date of Birth ____/____/________ (dd/mm/yyyy)

</td><td>

PROXY Information

Is respondent a proxy? (e.g., for deceased patient, child)
☐No ☐ Yes (complete information below)

Last name:
____

First name:
____

Relationship to case:
____

Phone number(s): (_____) ______ -
____

____

</td></tr>
<tr><td colspan="2">

Contact information for health unit person reporting

Name: ____
Telephone #: (   ) ____-________
Email: ____

</td></tr>
</table>

Emerging Pathogens and Severe Acute Respiratory Infection (SARI) Case Report Form

<table>
<tr><th colspan="2">(2) ADMINISTRATIVE INFORMATION</th></tr>
<tr><td>☐ Initial Report ☐ Updated Report</td><td>Report Date: ____/____/________ (dd/mm/yyyy)</td></tr>
<tr><td>Outbreak or cluster related? ☐ Yes ☐ No
If yes, local Outbreak #:________

Number of ill persons associated with the outbreak: _____</td><td>For Provincial Use Only
Has the outbreak been declared and made public?
☐Yes ☐ No
If case is related to a provincial /territorial outbreak, P/T Outbreak ID:________</td></tr>
<tr><th colspan="2">(3) CASE DETAILS: DISEASE / AETIOLOGIC AGENT / SUBTYPE</th></tr>
<tr><td>☐ Severe Acute Respiratory Infection
☐ Middle East respiratory syndrome coronavirus (MERS-CoV)
☐ COVID-19, Wuhan,China

☐ Other Novel Respiratory Pathogen
Specify:________________________________</td><td>☐ Novel Influenza A
☐ H1__ ☐ H3__ ☐ H5__ ☐ H7__
☐ Other: ________________________
☐ Novel Influenza B
________________________________</td></tr>
<tr><th colspan="2">(4) CASE DETAILS: CASE CLASSIFICATION (please refer to Ontario case definitions)</th></tr>
<tr><td>☐ Confirmed ☐ Presumptive Confirmed</td><td>☐ Probable</td></tr>
<tr><th colspan="2">(5) CLIENT RECORD: DEMOGRAPHIC INFORMATION</th></tr>
<tr><td>Gender: ☐ Male ☐ Female ☐ Unk ☐ Other (sp): ______</td><td>Age:_____ years If under 2 years ______months ☐ Unk</td></tr>
<tr><td colspan="2">Does the case identify as Aboriginal? ☐ Yes ☐ No ☐ Refused to answer ☐ Unk
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 ☐ Unk</td></tr>
</table>

<table>
<tr><th colspan="4">(6) SYMPTOMS (check all that apply)</th></tr>
<tr><td colspan="4">Date of onset of first symptom(s): ____/____/________ (dd/mm/yyyy)</td></tr>
<tr><td>☐ Fever (≥38°C)
☐ Feverish (temp. not taken)
☐ Cough
☐ Sputum production
☐ Headache
☐ Rhinorrhea/nasal congestion
☐ Sore throat</td><td>☐ Swollen lymph nodes
☐ Sneezing
☐ Conjunctivitis
☐ Otitis
☐ Fatigue/prostration
☐ Malaise/chills
☐ Myalgia/muscle pain
☐ Arthralgia/joint pain</td><td>☐ Shortness of breath/difficulty breathing
☐ Chest pain
☐ Anorexia/decreased appetite
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Abdominal pain</td><td>☐ Nose bleed
☐ Rash
☐ Seizures
☐ Dizziness
☐ Other, specify:
____
____
☐ No Symptoms</td></tr>
<tr><th colspan="4">(7) SYMPTOMS, INTERVENTIONS, and OUTCOME</th></tr>
</table>

Date of first presentation to medical care: ____/____/________ (dd/mm/yyyy)

Clinical Evaluations *(check all that apply)*

☐ Altered mental status	☐ Encephalitis	☐ Renal Failure
☐ Arrhythmia	☐ Hypotension	☐ Sepsis
☐ Clinical or radiological evidence of pneumonia	☐ Meningismus/nuchal rigidity	☐ Tachypnea (accelerated respiratory rate)
☐ Diagnosed with Acute Respiratory Distress Syndrome	☐ O2 saturation ≤95%	☐ Other (specify): ________

Case Hospitalized? ☐ Yes ☐ No ☐ Unk Diagnosis at time of admission: ________________	Admission Date: ____/____/________ (dd/mm/yyyy) Re Admission Date: ____/____/________ (dd/mm/yyyy)
Case admitted to Intensive Care Unit (ICU) ☐ Yes ☐ No ☐ Unk	ICU Admission Date: ____/____/________ (dd/mm/yyyy) ICU Discharge Date: ____/____/________ (dd/mm/yyyy)
Patient isolated in hospital? ☐ Yes ☐ No ☐ Unk	If yes, specify type of isolation (e.g., respiratory droplet precaution, negative pressure):________________________
Supplemental oxygen therapy ☐ Yes ☐ No ☐ Unk	Mechanical ventilation ☐ Yes ☐ No ☐ Unk If yes, number of days on ventilation ________
Case Discharged from Hospital ☐ Yes ☐ No ☐ Unk Case Transferred to another hospital ☐ Yes ☐ No ☐ Unk	Discharge Date 1: ____/____/________ (dd/mm/yyyy) Discharge Date 2: ____/____/________ (dd/mm/yyyy) Transfer Date: ____/____/________ (dd/mm/yyyy)

Current Disposition ☐ Recovered ☐ Stable ☐ Deteriorating ☐ Deceased ____/____/________ (dd/mm/yyyy)

If deceased, is post-mortem: ☐ Performed ☐ Pending ☐ None ☐ Unk

Respiratory illness contributed to the cause of death? ☐ Yes ☐ No ☐ Unk

Respiratory illness was the underlying cause of death? ☐ Yes ☐ No ☐ Unk

Cause of death *(as listed on death certificate)*: ________________________

(8) RISK FACTORS (check all that apply)

☐None identified

Cardiac Disease *If yes, please specify:*	☐ Yes ☐ No ☐ Unk	Hemoglobinopathy/Anemia *If yes, please specify:*	☐ Yes ☐ No ☐ Unk
Hepatic Disease *If yes, please specify:*	☐ Yes ☐ No ☐ Unk	Receiving immunosuppressing medications *If yes, please specify:*	☐ Yes ☐ No ☐ Unk
Metabolic Disease *If yes, please specify:* ☐ Diabetes	☐ Yes ☐ No ☐ Unk	Substance use *If yes, please specify:* ☐ Smoker (current)	☐ Yes ☐ No ☐ Unk

☐ Obese (BMI > 30) ☐ Other:________________	☐ Alcohol abuse ☐ Injection drug use ☐ Other:________________
Renal Disease ☐ Yes ☐ No ☐ Unk *If yes, please specify:*	Malignancy ☐ Yes ☐ No ☐ Unk *If yes, please specify:*
Respiratory Disease ☐ Yes ☐ No ☐ Unk *If yes, please specify:* ☐Asthma ☐Tuberculosis ☐Other:________________	Other Chronic Conditions ☐ Yes ☐ No ☐ Unk *If yes, please specify:*
Neurologic Disorder ☐ Yes ☐ No ☐ Unk *If yes, please specify:* ☐Neuromuscular Disorder ☐Epilepsy ☐Other:________________	Pregnancy ☐ Yes ☐ No ☐ Unk *If yes, week of gestation:*_______
Immunodeficiency disease / condition ☐ Yes ☐ No ☐ Unk *If yes, please specify:*	Post-Partum (≤6 weeks) ☐ Yes ☐ No ☐ Unk

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

Did the case receive prescribed prophylaxis prior to symptom onset? ☐ Yes ☐ No ☐ Unk	Specify name:______________________ date of first dose*:* ____/____/_________ (dd/mm/yyyy) date of last dose*:* ____/____/_________ (dd/mm/yyyy)
In the treatment of this infection, is the case taking: ☐ Antiviral medication ☐ Antibiotic/antifungal medication ☐ Immunosuppressant/immunomodulating medication ☐ Unknown ☐ None ☐ Other	Specify name (1):______________________ date of first dose (1)*:* ____/____/_________ (dd/mm/yyyy) date of last dose (1)*:* ____/____/_________ (dd/mm/yyyy) Specify name (2):______________________ date of first dose (2)*:* ____/____/_________ (dd/mm/yyyy) date of last dose (2)*:* ____/____/_________ (dd/mm/yyyy)

(10) INTERVENTIONS: IMMUNIZATIONS

Did the case receive the *current* year's seasonal influenza vaccine? ☐ Yes ☐ No ☐ Unk ☐ Vaccine not yet available	*If yes,* date of vaccination: ____/____/_________ (dd/mm/yyyy)
Did the case receive the *previous* year's seasonal influenza vaccine?	☐ Yes ☐ No ☐ Unk
Did the case receive pneumococcal vaccine in the past? ☐ Yes ☐ No ☐ Unk *If yes,* year of most recent dose: ____/____/_________ (dd/mm/yyyy)	

If yes, type ☐ polysaccharide or ☐ conjugate: 7 or 13

(11) 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) *(complete if applicable)*

Lab ID	Name of Antimicrobial	Specimen Type & Source	Test Method	Test Result	Test Date

(12) 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 ☐ Unk

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 ☐ Unk

If yes, please specify the following

Travel Type	Carrier Name	Flight / Carrier #	Seat #	City of Origin	Dates 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 enclosed quarters (e.g., co-worker) or had direct contact with respiratory secretions)* with:

A confirmed case of the same disease? ☐ Yes ☐ No ☐ Unk
If yes, specify the Case ID:_________
A probable case of the same disease? ☐ Yes ☐ No ☐ Unk
If yes, specify disease:___________ and specify the Case ID:__________

A person who had fever, respiratory symptoms like cough or sore throat, or respiratory illness like pneumonia? ☐ Yes ☐ No ☐ Unk

If yes, specify the type of contact:

- ☐ Household member
- ☐ Person who works in a healthcare setting
- ☐ Works with Patients
- ☐ Person who works with animals
- ☐ Person who travelled outside of Canada
- ☐ Person who works in a laboratory
- ☐ Other (specify):____________________

Where did exposure occur?

- ☐ In a household setting
- ☐ School/daycare
- ☐ Farm
- ☐ Other (please specify)
- ☐ In a health care setting (e.g., hospital, long-term care home, community provider's office)
- ☐ Other institutional setting (dormitory, shelter/group home, prison, etc.)
- ☐ In means of travel (place, train, etc.)

Occupational / Residential

The case is a:

- ☐ Health care worker or health care volunteer
  - *If yes,* with direct patient contact? ☐ Yes ☐ No ☐ Unk
- ☐ Laboratory worker handling biological specimens
- ☐ School or daycare worker/ attendee
- ☐ Resident of a retirement residence or long-term care facility
- ☐ Resident in an institutional facility *(dormitory, shelter/group home, prison, etc.)*
- ☐ Veterinary worker
- ☐ Farm worker
- ☐ Other:

Animal

A. Direct Contact ***(touch or handle)***

In the 14 days prior to symptom onset, did the case have *direct contact* with any animals or animal products *(faeces, bedding/nests, carcass/fresh meat, fur/skins, camel milk, etc.)*? ☐ Yes ☐ No ☐ Unk

If yes, specify date of last direct contact: ____/____/________ (dd/mm/yyyy)

What type of animals did the case have direct contact with? *(check all that apply)*

☐ Cat(s) ☐ Dogs ☐ Horses ☐ Cows ☐ Poultry ☐ Sheep / Goat ☐ Wild Birds ☐ Rodents ☐ Swine ☐ Camel ☐ Snakes/ reptiles

☐Wild game (eg. Deer) ☐ Bats ☐ Other:________________________

Did the animal display any symptoms of illness or was the animal dead? ☐ Yes ☐ No ☐ Unk

Where did the direct contact occur? *(check all that apply)*

☐ Home ☐ Work *(fill in occupational section)*☐ Agricultural fair or event/petting zoo

☐ Outdoor work/recreation (camping, hiking, hunting etc.) ☐ Other:________________________________

B. Indirect Contact ***(e.g., visit or walk through or work in an area where animals are present, etc.)***

In the 14 days prior to symptom onset, did the case have *indirect contact* with animals? ☐ Yes ☐ No ☐ Unk

If yes, specify date of last indirect contact: ____/____/________ (dd/mm/yyyy)

Where did the *indirect contact* occur? *(check all that apply)*

□ Home □ Work *(fill in occupational section)* □ Agricultural fair or event/petting zoo

□ Outdoor work / recreation (camping, hiking, hunting, etc.)

□ Market where animals, meats and/or animal products are sold

□ Other:______________________________

(13) ADDITIONAL DETAILS/COMMENTS *(add as necessary)*