

ACCESSION NUMBER

ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)



HEPATITIS B AND C, HIV, AND SYPHILIS INVESTIGATION FORM

CASE FORM

I. *CASE IDENTIFICATION

subject > client details > client demographics

1. *LAST NAME		2. *FIRST NAME		3. *DATE OF BIRTH <small>YYYY - MM - DD</small>	
4. ALTERNATE LAST NAME			5. ALTERNATE FIRST NAME		
6. *SEX <input type="radio"/> FEMALE <input type="radio"/> MALE <input type="radio"/> INTERSEX <input type="radio"/> UNKNOWN		7. *GENDER IDENTITY (VOLUNTARY, SELF-REPORTED) <input type="radio"/> CISGENDER (SAME AS SEX AT BIRTH) <input type="radio"/> TRANSGENDER MAN <input type="radio"/> DECLINED <input type="radio"/> TRANSGENDER WOMAN <input type="radio"/> TRANSGENDER PERSON <input type="radio"/> OTHER (SPECIFY IN BOX 8)			8. *IF OTHER GENDER IDENTITY, SPECIFY
9. *REGISTRATION NUMBER (FORMER MHSC) <small>6 DIGITS (UPPERCASE ALPHANUMERIC)</small>		10. *HEALTH NUMBER (PHIN) <small>9 DIGITS</small>		11. ALTERNATE ID <small>SPECIFY TYPE OF ID</small>	
12. *ADDRESS AT TIME OF DIAGNOSIS ➔ <input type="checkbox"/> ADDRESS IN FIRST NATION COMMUNITY				13. *CITY/TOWN/VILLAGE	
14. *PROVINCE/TERRITORY		15. *POSTAL CODE <small>A#A #A#</small>		16. *PHONE NUMBER <small>### - ### - ####</small>	
17. *RACIAL/ETHNIC IDENTITY (VOLUNTARY, SELF-REPORTED) <input type="radio"/> AFRICAN <input type="radio"/> BLACK <input type="radio"/> CHINESE <input type="radio"/> DECLINED <input type="radio"/> FILIPINO <input type="radio"/> LATIN AMERICAN <input type="radio"/> NORTH AMERICAN INDIGENOUS <input type="radio"/> OTHER (SPECIFY) <input type="radio"/> SOUTH ASIAN <input type="radio"/> SOUTHEAST ASIAN <input type="radio"/> WHITE					
18. *INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED) <input type="radio"/> FIRST NATIONS <input type="radio"/> MÉTIS <input type="radio"/> INUIT <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED		19. *FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED) <input type="radio"/> STATUS NON-STATUS <input type="radio"/> NOT ASKED DECLINED		20. ALTERNATE LOCATION INFORMATION (IF ANY)	
21. IMMIGRATION STATUS AT TIME OF ARRIVAL (VOLUNTARY - COMPLETE BOXES 22 AND 23 IF BORN OUTSIDE CANADA) <input type="radio"/> CANADIAN BORN CITIZEN <input type="radio"/> DECLINED <input type="radio"/> LANDED IMMIGRANT <input type="radio"/> NOT ASKED <input type="radio"/> REFUGEE <input type="radio"/> OTHER (SPECIFY BELOW) <input type="radio"/> STUDENT <input type="radio"/> VISITOR <input type="radio"/> WORK PERMIT		22. DATE ARRIVED IN CANADA <small>YYYY</small>	23. COUNTRY EMIGRATED FROM <small>SPECIFY</small>		

II. INVESTIGATION INFORMATION DETAILS > INVESTIGATION CLASSIFICATION

investigation > investigation

24. *INVESTIGATION DISPOSITION		<input type="radio"/> FOLLOW-UP COMPLETE <input type="radio"/> UNABLE TO COMPLETE INTERVIEW <input type="radio"/> PENDING			
25. *PRIMARY INVESTIGATOR ORGANIZATION		<input type="radio"/> WRHA <input type="radio"/> NRHA <input type="radio"/> OPMH <input type="radio"/> SH-SS <input type="radio"/> IERHA <input type="radio"/> FNIHB <input type="radio"/> CSC			
26. OTHER ORGANIZATIONS INVOLVED		<input type="radio"/> WRHA <input type="radio"/> NRHA <input type="radio"/> OPMH <input type="radio"/> SH-SS <input type="radio"/> IERHA <input type="radio"/> FNIHB <input type="radio"/> CSC <input type="radio"/> DND			

III. INFECTION INFORMATION

investigation > disease summary > investigation

27. *DISEASE	28. *CASE CLASSIFICATION	29. *SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION <small>YYYY - MM - DD</small>
30. <input type="checkbox"/> HEPATITIS B	<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	
31. <input type="checkbox"/> HEPATITIS C	<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	
32. <input type="checkbox"/> HIV	<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	
33. <input type="checkbox"/> SYPHILIS	<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	

ACCESSION NUMBER

ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)



IV. *DISEASE-SPECIFIC INFORMATION

investigation > investigation details > disease summary > add > disease event history

Refer to disease protocol at <https://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html>

34. <input type="checkbox"/> HEPATITIS B	35. STAGING	<input type="radio"/> ACUTE <input type="radio"/> CHRONIC <input type="radio"/> PERINATAL <input type="radio"/> PREVIOUS DIAGNOSIS- CHRONIC <input type="radio"/> UNKNOWN OR UNDETERMINED
36. <input type="checkbox"/> HEPATITIS C	37. STAGING	<input type="radio"/> ACUTE <input type="radio"/> CHRONIC <input type="radio"/> PERINATAL <input type="radio"/> PREVIOUS DIAGNOSIS – CHRONIC <input type="radio"/> PREVIOUS DIAGNOSIS – RESOLVED <input type="radio"/> RESOLVED <input type="radio"/> UNKNOWN OR UNDETERMINED
38. <input type="checkbox"/> HIV	39. STAGING	<input type="radio"/> NEW DIAGNOSIS <input type="radio"/> OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB <input type="radio"/> PERINATAL <input type="radio"/> PREVIOUS DIAGNOSIS- NEW TO MANITOBA <input type="radio"/> UNKNOWN OR UNDETERMINED
40. <input type="checkbox"/> SYPHILIS	41. STAGING	INFECTIOUS: <input type="radio"/> PRIMARY <input type="radio"/> SECONDARY <input type="radio"/> EARLY LATENT NON-INFECTIOUS: <input type="radio"/> LATE LATENT (≥ 1 YEAR AFTER INFECTION) <input type="radio"/> TERTIARY OTHER: <input type="radio"/> PREVIOUS DIAGNOSIS <input type="radio"/> UNKNOWN OR UNDETERMINED
	42. ADDITIONAL PRESENTATIONS	<input type="radio"/> CARDIOVASCULAR SYPHILIS <input type="radio"/> NEUROSYPHILIS <input type="radio"/> GUMMATOUS SYPHILIS
	43. DATE OF FIRST DIAGNOSIS IF PREVIOUSLY DIAGNOSED	44. LOCATION OF FIRST DIAGNOSIS IF NOT IN MANITOBA
		YYYY – MM SPECIFY COUNTRY OR PROVINCE IN CANADA

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

V. SIGNS AND SYMPTOMS

investigation > signs and symptoms

45. SYMPTOMS <input type="radio"/> ASYMPTOMATIC <input type="radio"/> SYMPTOMATIC (COMPLETE BOX 47 FOR HEPATITIS B/C, BOX 48 FOR SYPHILIS, OR BOX 49 FOR HIV)	46. EARLIEST SYMPTOM ONSET DATE YYYY-MM-DD
47. HEPATITIS B/C (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)	48. SYPHILIS (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)
<input type="checkbox"/> ABDOMINAL PAIN/CRAMPING (RUQ) <input type="checkbox"/> JAUNDICE <input type="checkbox"/> ANOREXIA <input type="checkbox"/> NAUSEA <input type="checkbox"/> DARK URINE <input type="checkbox"/> STOOL, PALE <input type="checkbox"/> FATIGUE <input type="checkbox"/> VOMITING <input type="checkbox"/> FEVER <input type="checkbox"/> OTHER SPECIFY	<input type="checkbox"/> ANAL ULCERATIVE LESIONS <input type="checkbox"/> LYMPH NODES ENLARGED - REGIONAL <input type="checkbox"/> CHANCRE (OTHER SITE) <input type="checkbox"/> MENINGITIS <input type="checkbox"/> CONDYLOMATA LATA <input type="checkbox"/> OCULAR INVOLVEMENT <input type="checkbox"/> GENITAL ULCER <input type="checkbox"/> ORAL ULCERATIVE LESIONS <input type="checkbox"/> HAIR LOSS (ALOPECIA) <input type="checkbox"/> OTHER MUCOSAL LESIONS <input type="checkbox"/> HEADACHE <input type="checkbox"/> RASH - UNSPECIFIED <input type="checkbox"/> LYMPH NODES ENLARGED – GENERALIZED <input type="checkbox"/> OTHER SPECIFY
49. HIV SIGNS/ SYMPTOMS <input type="checkbox"/> CD4 COUNT, FIRST DATE: YYYY-MM-DD ABSOLUTE VALUE: (SEE FORM INSTRUCTIONS)	

VI. RISK FACTOR INFORMATION

subject > risk factors

50. COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED: REQUIRED RISK FACTORS INDICATED WITH * MUST HAVE A RESPONSE DOCUMENTED IN PHIMS. FOR PERINATAL HIV CASES, SEE CASE FORM INSTRUCTIONS FOR REQUIRED RISK FACTORS	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
* BLOOD/TISSUE DONATION (INCLUDES TISSUE, BLOOD PRODUCTS, PLASMA, ORGANS, BREAST MILK) (NOT REQUIRED FOR SYPHILIS) SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* BLOOD /TISSUE RECIPIENT (INCLUDES BLOOD PRODUCTS, PLASMA, TISSUE, ORGANS, POOLED CONCENTRATES) (NOT REQUIRED FOR SYPHILIS) SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BODY PIERCING/TATTOOING/SCARIFICATION/ACUPUNCTURE (INDICATE IF NON-LICENSED) (NOT REQUIRED FOR SYPHILIS) SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BORN TO INFECTED MOTHER/ BIRTH PARENT (NOT REQUIRED FOR SYPHILIS, USE CONGENITAL SYPHILIS CASE FORM) SPECIFY INFECTION(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CONTACT TO A NEW OR PREVIOUSLY DIAGNOSED CASE OF: (INCLUDES CLIENT REPORT) SPECIFY INFECTION(S) AND DATE OF INITIAL CONTACT	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
*HAS GIVEN GOODS IN EXCHANGE FOR SEX (NOT REQUIRED FOR HEPATITIS C)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

ACCESSION NUMBER

ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED: REQUIRED RISK FACTORS INDICATED WITH * MUST HAVE A RESPONSE DOCUMENTED IN PHIMS	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
* HAS RECEIVED GOODS IN EXCHANGE FOR SEX (NOT REQUIRED FOR HEPATITIS C)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* HISTORY OF INCARCERATION SPECIFY LOCATION AND DATE RANGE OF LAST INCARCERATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HISTORY OF STBBI (HISTORY OF HIV, SYPHILIS, HEPATITIS B OR C, OR OTHERS RELEVANT TO INVESTIGATION) SPECIFY INFECTION(S) AND DATE(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* HOUSING UNSTABLE (IN THE PAST 12 MONTHS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* INJECTION DRUG USE (SINCE LAST NEGATIVE TEST OR EVER IF NEVER TESTED BEFORE) SPECIFY SUBSTANCE(S) AND DATE OF LAST IDU	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INVASIVE MEDICAL/SURGICAL/DENTAL PROCEDURE (E.G. HEMODIALYSIS, EXTRACTION) (NOT REQUIRED FOR SYPHILIS) SPECIFY TYPE, LOCATION, AND DATE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* MEN WHO HAVE SEX WITH MEN (NOT REQUIRED FOR HEPATITIS C)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MENTAL HEALTH ISSUE (UNDERLYING) INCLUDES UNDIAGNOSED SYMPTOMS OR INTELLECTUAL DISABILITY IMPACTING CARE SPECIFY IN ADDITIONAL INFORMATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NO IDENTIFIABLE RISK FACTORS (EXPLORE NON-REQUIRED RISK FACTORS)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OCCUPATIONAL EXPOSURE (E.G. NEEDLE STICK, SHARPS) (NOT REQUIRED FOR SYPHILIS) SPECIFY TYPE AND DATE YYYY-MM-DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER RISK FACTOR SPECIFY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* PREGNANT AT TIME OF DIAGNOSIS SPECIFY EDC: YYYY-MM-DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PREVIOUS TREATMENT FOR SYPHILIS (SYPHILIS CASES ONLY) SPECIFY PROVINCE/COUNTRY AND DATE(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* PROBABLE ACQUISITION IN ANOTHER COUNTRY SPECIFY COUNTRY AND DATES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL ASSAULT (NON-CONSENSUAL SEX; SPECIFIC TO ACQUISITION/INTERVIEW PERIOD OR REASON FOR TESTING)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* SEXUAL PARTNER AT RISK (PERSON WHO INJECTS DRUGS, MSM, SEX WORKER, ANONYMOUS) (NOT REQUIRED FOR HEPATITIS C) SPECIFY RISK GROUP AND LAST EXPOSURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* SHARED NEEDLES OR OTHER INJECTION EQUIPMENT (ONLY REQUIRED IF "YES" FOR INJECTION DRUG USE) SPECIFY DATES AND LOCATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
* SUBSTANCE USE- NON-INJECTION DRUG USE DURING SEXUAL EXPOSURE (SEE FORM INSTRUCTIONS) NOT REQUIRED FOR HEPATITIS C SPECIFY SUBSTANCE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

VII. OUTCOMES

investigation > outcomes

51. <input type="radio"/> FATAL (INCLUDE UNKNOWN OR NON COMMUNICABLE DISEASE CAUSES) SPECIFY DATE OF DEATH YYYY-MM-DD	52. <input type="radio"/> OTHER SIGNIFICANT OUTCOME/SEQUELAE (SPECIFY) <input type="radio"/> RECOVERED (FOR HEPATITIS C CASES WITH SUBSEQUENT RESOLVED INFECTION AFTER INITIAL STAGING)
---	---

ACCESSION NUMBER

ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)



X. HEPATITIS B IMMUNIZATION HISTORY INTERPRETATION (FOR HEPATITIS B CASES ONLY – ENTER IMMS RECORDS IF MISSING DOSES IN PHIMS)

Subject > imms history interpretation

<p>58. INTERPRETATION OF HEPATITIS B IMMUNITY PRIOR TO INVESTIGATION</p> <ul style="list-style-type: none"> <input type="radio"/> IMMUNITY- LAB EVIDENCE <input type="radio"/> SUSCEPTIBLE – LAB EVIDENCE <input type="radio"/> INDETERMINATE- LAB EVIDENCE <input type="radio"/> FULLY IMMUNIZED <input type="radio"/> PARTIALLY IMMUNIZED <input type="radio"/> UNIMMUNIZED <input type="radio"/> UNKNOWN/NOT DETERMINED 	<p>59. REASON FOR IMMUNITY/ IMMUNIZATION INTERPRETATION</p> <p>SOURCE OF SEROLOGY/ IMMUNIZATION RECORD:</p> <ul style="list-style-type: none"> <input type="radio"/> CLIENT/PARENT/GUARDIAN <input type="radio"/> CLIENT/PARENT/GUARDIAN – OFFICIAL RECORD <input type="radio"/> HEALTH RECORD/ HEALTHCARE PROVIDER <p>REASON IF NOT FULLY IMMUNIZED OR UNKNOWN:</p> <ul style="list-style-type: none"> <input type="radio"/> GENERAL OBJECTION (NON-PHILOSOPHICAL) <input type="radio"/> IMMUNOCOMPROMISED <input type="radio"/> MEDICAL CONTRAINDICATION <input type="radio"/> NOT ELIGIBLE FOR ROUTINE IMMUNIZATION <input type="radio"/> NOT UP TO DATE WITH IMMUNIZATIONS <input type="radio"/> PHILOSOPHICAL OBJECTION <input type="radio"/> UNKNOWN/ NOT DETERMINED
--	--

XI. CONTACTS

investigation > exposure summary > transmission event summary

<p>60. NUMBER OF CONTACTS IDENTIFIED BY NAME →</p>	<p>SPECIFY NUMBER</p>	<p>61. NUMBER OF ANONYMOUS CONTACTS →</p>	<p>SPECIFY NUMBER</p>	<p>62. EARLIEST ANONYMOUS EXPOSURE START DATE</p> <p><input type="checkbox"/> ESTIMATED</p> <p style="text-align: right;">YYYY-MM-DD</p>
<p><input type="checkbox"/> CASE DECLINED TO IDENTIFY CONTACTS</p>				

XII. * REPORTER INFORMATION

<p>63. FORM COMPLETED BY (PRINT NAME)</p>	<p>64. FACILITY NAME/ADDRESS/PHONE#</p>	<p>REPORTER USE ONLY</p>
<p>65. FORM COMPLETION DATE</p> <p>YYYY-MM-DD</p>	<p>66. INVESTIGATION STATUS</p> <ul style="list-style-type: none"> <input type="checkbox"/> ONGOING <input type="checkbox"/> CLOSED TO THE REGION 	<p>67. ORGANIZATION (IF APPLICABLE)</p> <ul style="list-style-type: none"> <input type="radio"/> WRHA <input type="radio"/> NRHA <input type="radio"/> PMH <input type="radio"/> SH-SS <input type="radio"/> IERHA <input type="radio"/> FNIHB <input type="radio"/> CSC
		<p>STAMP HERE</p>

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 https://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 <https://www.gov.mb.ca/health/publichealth/surveillance/forms.html>