ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

Manitoba
Health, Seniors and Long-Term Care

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 (YYYY - MM - DD)
4. ALTERNATE LAST NAME	5. ALTERNATE FIRST NAME	

6. *SEX	7. *GENDER IDENTITY (VOLUNTARY, SELF-REPORTED)	8. *IF OTHER GENDER IDENTITY, SPECIFY
○ FEMALE ○ MALE ○ INTERSEX ○ UNKNOWN	○ CISGENDER (SAME AS SEX AT BIRTH) ○ TRANSGENDER MAN ○ DECLINED ○ TRANSGENDER WOMAN ○ TRANSGENDER PERSON ○ OTHER (SPECIFY IN BOX 8)	

9. *REGISTRATION NUMBER (FORMER MHSC) (6 DIGITS (UPPERCASE ALPHANUMERIC))	10. *HEALTH NUMBER (PHIN) (9 DIGITS)	11. ALTERNATE ID (SPECIFY TYPE OF ID)
12. *ADDRESS AT TIME OF DIAGNOSIS ➔ ☐ ADDRESS IN FIRST NATION COMMUNITY		13. *CITY/TOWN/VILLAGE
14. *PROVINCE/TERRITORY	15. *POSTAL CODE (A#A #A#)	16. *PHONE NUMBER (### - ### - ####)

17. *RACIAL/ETHNIC IDENTITY (VOLUNTARY, SELF-REPORTED)

○ AFRICAN ○ BLACK ○ CHINESE ○ DECLINED
○ FILIPINO ○ LATIN AMERICAN ○ NORTH AMERICAN INDIGENOUS ○ OTHER (SPECIFY)
○ SOUTH ASIAN ○ SOUTHEAST ASIAN ○ WHITE

18. *INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED)	19. *FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED)	20. ALTERNATE LOCATION INFORMATION (IF ANY)
○ FIRST NATIONS ○ MÉTIS ○ INUIT ○ NOT ASKED ○ DECLINED	○ STATUS ○ NON-STATUS ○ NOT ASKED ○ DECLINED	

21. IMMIGRATION STATUS AT TIME OF ARRIVAL (VOLUNTARY - COMPLETE BOXES 22 AND 23 IF BORN OUTSIDE CANADA)	22. DATE ARRIVED IN CANADA (YYYY)	23. COUNTRY EMIGRATED FROM (SPECIFY)
○ CANADIAN BORN CITIZEN ○ DECLINED ○ LANDED IMMIGRANT ○ NOT ASKED ○ REFUGEE ○ OTHER (SPECIFY BELOW) ○ STUDENT ○ VISITOR ○ WORK PERMIT		

II. INVESTIGATION INFORMATION

INVESTIGATION > INVESTIGATION DETAILS > INVESTIGATION CLASSIFICATION

24. *INVESTIGATION DISPOSITION	○ FOLLOW-UP COMPLETE ○ UNABLE TO COMPLETE INTERVIEW ○ PENDING
25. * PRIMARY INVESTIGATOR ORGANIZATION	○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC
26. OTHER ORGANIZATIONS INVOLVED	☐ WRHA ☐ NRHA ☐ PMH ☐ SH-SS ☐ IERHA ☐ FNIHB ☐ CSC ☐ DND

III. INFECTION INFORMATION

INVESTIGATION > DISEASE SUMMARY > INVESTIGATION INFORMATION

27. *DISEASE	28. *CASE CLASSIFICATION	29. *SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION (YYYY – MM - DD)
30. ☐ HEPATITIS B	☐ LAB CONFIRMED ☐ NOT A CASE	
31. ☐ HEPATITIS C	☐ LAB CONFIRMED ☐ NOT A CASE	
32. ☐ HIV	☐ LAB CONFIRMED ☐ NOT A CASE	
33. ☐ SYPHILIS	☐ LAB CONFIRMED ☐ NOT A CASE	

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Manitoba
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IV. *DISEASE-SPECIFIC INFORMATION

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

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

34. ☐ **HEPATITIS B**	35. **STAGING**	○ ACUTE ○ CHRONIC ○ PERINATAL ○ PREVIOUS DIAGNOSIS- CHRONIC ○ UNKNOWN OR UNDETERMINED
36. ☐ **HEPATITIS C**	37. **STAGING**	○ ACUTE ○ CHRONIC ○ PERINATAL ○ PREVIOUS DIAGNOSIS – CHRONIC ○ PREVIOUS DIAGNOSIS – RESOLVED ○ RESOLVED ○ UNKNOWN OR UNDETERMINED
38. ☐ **HIV**	39. **STAGING**	○ NEW DIAGNOSIS ○ OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB ○ PERINATAL ○ PREVIOUS DIAGNOSIS- NEW TO MANITOBA ○ UNKNOWN OR UNDETERMINED
40. ☐ **SYPHILIS**	41. **STAGING**	**INFECTIOUS:** ○ PRIMARY ○ SECONDARY ○ EARLY LATENT **NON-INFECTIOUS:** ○ LATE LATENT (≥ 1 YEAR AFTER INFECTION) ○ TERTIARY **OTHER:** ○ PREVIOUS DIAGNOSIS ○ UNKNOWN OR UNDETERMINED
	42. **ADDITIONAL PRESENTATIONS**	☐ CARDIOVASCULAR SYPHILIS ☐ NEUROSYPHILIS ☐ GUMMATOUS SYPHILIS
	43. **DATE OF FIRST DIAGNOSIS IF PREVIOUSLY DIAGNOSED** YYYY – MM	44. **LOCATION OF FIRST DIAGNOSIS IF NOT IN MANITOBA** 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**
○ ASYMPTOMATIC ○ 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)**	49. **HIV SIGNS/ SYMPTOMS**
☐ ABDOMINAL PAIN/CRAMPING (RUQ) ☐ ANOREXIA ☐ DARK URINE ☐ FATIGUE ☐ FEVER ☐ JAUNDICE ☐ NAUSEA ☐ STOOL, PALE ☐ VOMITING	☐ ANAL ULCERATIVE LESIONS ☐ CHANCRE (OTHER SITE) ☐ CONDYLOMATA LATA ☐ GENITAL ULCER ☐ HAIR LOSS (ALOPECIA) ☐ HEADACHE ☐ LYMPH NODES ENLARGED – GENERALIZED ☐ LYMPH NODES ENLARGED - REGIONAL ☐ MENINGITIS ☐ OCULAR INVOLVEMENT ☐ ORAL ULCERATIVE LESIONS ☐ OTHER MUCOSAL LESIONS ☐ RASH - UNSPECIFIED	☐ CD4 COUNT, FIRST DATE: YYYY-MM-DD ABSOLUTE VALUE: (SEE FORM INSTRUCTIONS)
☐ OTHER SPECIFY	☐ OTHER SPECIFY	

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	○	○	○	○	○
*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	○	○	○	○	○
BODY PIERCING/TATTOOING/SCARIFICATION/ACUPUNCTURE (INDICATE IF NON-LICENSED) (NOT REQUIRED FOR SYPHILIS) SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD	○	○	○	○	○
BORN TO INFECTED MOTHER/ BIRTH PARENT (NOT REQUIRED FOR SYPHILIS, USE CONGENITAL SYPHILIS CASE FORM) SPECIFY INFECTION(S)	○	○	○	○	○
CONTACT TO A NEW OR PREVIOUSLY DIAGNOSED CASE OF: (INCLUDES CLIENT REPORT) SPECIFY INFECTION(S) AND DATE OF INITIAL CONTACT	○	○	○	○	○
*HAS GIVEN GOODS IN EXCHANGE FOR SEX (NOT REQUIRED FOR HEPATITIS C)	○	○	○	○	○

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Manitoba
Health, Seniors and Long-Term Care

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

VII. OUTCOMES

investigation > outcomes

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

ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

Manitoba
Health, Seniors and Long-Term Care

VIII. TREATMENT INFORMATION (COMPLETE FOR SYPHILIS ONLY)

investigation > medications> medication summary

53. **PRESCRIBER NAME**	54. **TREATMENT FACILITY**	
☐ BENZATHINE PENICILLIN G 2.4 million units IM as single dose SPECIFY START DATE: YYYY-MM-DD	☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 2 doses SPECIFY START DATE: YYYY-MM-DD	☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 3 doses SPECIFY START DATE: YYYY-MM-DD
☐ CEFTRIAXONE 1 g OD for 10 days ○ IV ○ IM SPECIFY IM OR IV AND START DATE: YYYY-MM-DD	☐ CEFTRIAXONE 2 G OD FOR 10 DAYS ○ IV ○ IM SPECIFY IM OR IV AND START DATE: YYYY-MM-DD	☐ DOXYCYCLINE 100 mg PO BID X 14 days SPECIFY START DATE: YYYY-MM-DD
☐ DOXYCYCLINE 100 mg PO BID X 28 days SPECIFY START DATE: YYYY-MM-DD	☐ PENICILLIN G 3-4 MILLION UNITS IV Q4H X 10-14 days SPECIFY START DATE: YYYY-MM-DD	☐ OTHER (SPECIFY TREATMENT AND START DATE): SPECIFY START DATE: YYYY-MM-DD
55. **ALLERGIES** SPECIFY		

IX. EVIDENCE-BASED INTERVENTIONS

investigation > treatment and interventions >interventions summary

56. **INTERVENTIONS**	57. **DATE (YYYY-MM-DD)**
☐ PREVENTION EDUCATION/COUNSELLING PER DISEASE PROTOCOL	
☐ INTERVIEW FOR CONTACTS	
☐ IMMUNIZATION RECOMMENDED (SPECIFY) ☐ HBV ☐ HAV ☐ HPV ☐ MPOX	
☐ PUBLIC HEALTH SUPPORT TO ENGAGE WITH CARE (HIV/HCV) **START DATE** (DATE REFERRAL RECEIVED) **OUTCOME** (PENDING OR COMPLETE) COMMENT (REFERRAL SOURCE, ENGAGEMENT STATUS - PLAN)	
☐ REFERRAL/ NOTIFICATION OF CANADIAN BLOOD SERVICES (IF APPLICABLE)	
☐ REFERRAL TO HEPATITIS CARE PROVIDER **START DATE** (DATE OF REFERRAL) **END DATE** (DATE INTAKE APPOINTMENT ATTENDED	
☐ REFERRAL TO MANITOBA HIV PROGRAM **START DATE** (DATE OF REFERRAL) **END DATE** (DATE INTAKE APPOINTMENT ATTENDED) **COMMENT** (HIV CARE OR PATHS SITE) **OUTCOME** (PENDING OR ATTENDED)	
☐ REFERRAL TO INFECTIOUS DISEASE SPECIALIST (SPECIFY DATE)	
☐ REFERRAL FOR TREATMENT (SPECIFY - INCLUDING REFERRAL FOR HIV PREP OR PEP)	
☐ NEWBORN PROPHYLAXIS FOR HEPATITIS B	
☐ STBBI TESTING RECOMMENDED ☐ CT/GC ☐ SYPHILIS ☐ HBV ☐ HCV ☐ HIV	
☐ SYPHILIS SEROLOGY RECOMMENDED AS PER PROTOCOL	
☐ ADDITIONAL TREATMENT RECOMMENDED	
☐ TREATMENT RECOMMENDED FOR HIV: **START DATE** (DATE CLIENT BEGAN TREATMENT) **OUTCOME** (COMPLETED)	
☐ TREATMENT NOT RECOMMENDED	
☐ OTHER (SPECIFY)	

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

Subject > imms history interpretation

58. **INTERPRETATION OF HEPATITIS B IMMUNITY PRIOR TO INVESTIGATION**	○ IMMUNITY- LAB EVIDENCE ○ SUSCEPTIBLE – LAB EVIDENCE ○ INDETERMINATE- LAB EVIDENCE ○ FULLY IMMUNIZED ○ PARTIALLY IMMUNIZED ○ UNIMMUNIZED ○ UNKNOWN/NOT DETERMINED	59. **REASON FOR IMMUNITY/ IMMUNIZATION INTERPRETATION**	SOURCE OF SEROLOGY/ IMMUNIZATION RECORD: ○ CLIENT/PARENT/GUARDIAN ○ CLIENT/PARENT/GUARDIAN – OFFICIAL RECORD ○ HEALTH RECORD/ HEALTHCARE PROVIDER **REASON IF NOT FULLY IMMUNIZED OR UNKNOWN:** ○ GENERAL OBJECTION (NON-PHILOSOPHICAL) ○ IMMUNOCOMPROMISED ○ MEDICAL CONTRAINDICATION ○ NOT ELIGIBLE FOR ROUTINE IMMUNIZATION ○ NOT UP TO DATE WITH IMMUNIZATIONS ○ PHILOSOPHICAL OBJECTION ○ UNKNOWN/ NOT DETERMINED

XI. CONTACTS

investigation > exposure summary > transmission event summary

60. **NUMBER OF CONTACTS IDENTIFIED BY NAME** ➔	SPECIFY NUMBER	61. **NUMBER OF ANONYMOUS CONTACTS** ➔	SPECIFY NUMBER	62. **EARLIEST ANONYMOUS EXPOSURE START DATE** ☐ ESTIMATED YYYY-MM-DD
☐ CASE DECLINED TO IDENTIFY CONTACTS				

XII. * REPORTER INFORMATION

63. **FORM COMPLETED BY (PRINT NAME)**		64. **FACILITY NAME/ADDRESS/PHONE#**	**REPORTER USE ONLY**
65. **FORM COMPLETION DATE** YYYY-MM-DD	66. **INVESTIGATION STATUS** ☐ ONGOING ☐ CLOSED TO THE REGION	67. **ORGANIZATION** (IF APPLICABLE) ○ WRHA ○ NRHA ○ PMH ○ SH-SS ○ IERHA ○ FNIHB ○ CSC	STAMP HERE

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