

* CASE ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)
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HEPATITIS B AND C, HIV, AND SYPHILIS INVESTIGATION FORM

CASE FORM

I. NON-NOMINAL HIV TEST RESULTS**

subject > client details > personal information

1. CURRENT NON-NOMINAL HIV CODE (IF APPLICABLE) SPECIFY	2. PREVIOUS NON-NOMINAL CODE(S) OR NAME(S) USED FOR POSITIVE HIV TESTS SPECIFY COUNTRY/PROVINCE, CODE/NAME, AND DATES YYYY-MM-DD IF KNOWN
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**NOTE: FOR HIV, ONLY COMPLETE SECTION II PART A IF CURRENT HIV TEST IS NOMINAL, OR IF CLIENT PROVIDES CONSENT TO LINK CURRENT OR PREVIOUS NON-NOMINAL RESULTS WITH A NOMINAL RECORD. IF NON-NOMINAL, COMPLETE SECTION I AND II PART B ONLY.

II. *CASE IDENTIFICATION

subject > client details > personal information

PART A – CLIENT IDENTIFIERS (COMPLETE FOR NOMINAL CASES ONLY)

3. LAST NAME	4. FIRST NAME	5. DATE OF BIRTH YYYY - MM - DD
6. ALTERNATE LAST NAME	7. ALTERNATE FIRST NAME	
8. REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS	9. HEALTH NUMBER (PHIN) 9 DIGITS	10. ALTERNATE ID SPECIFY TYPE OF ID
11. ADDRESS AT TIME OF DIAGNOSIS → <input type="checkbox"/> ADDRESS IN FIRST NATION COMMUNITY	12. CITY/TOWN/VILLAGE	
13. PROVINCE/TERRITORY	14. POSTAL CODE A#A #A#	15. PHONE NUMBER ### - ### - ####
16. ALTERNATE LOCATION INFORMATION (IF ANY)		

PART B – CLIENT INFORMATION (COMPLETE FOR NOMINAL AND NON-NOMINAL CASES)

17. SEX <input type="radio"/> FEMALE <input type="radio"/> MALE <input type="radio"/> INTERSEX <input type="radio"/> UNKNOWN	18. GENDER IDENTITY (VOLUNTARY, SELF-REPORTED) <input type="radio"/> CISGENDER (SAME AS SEX AT BIRTH) <input type="radio"/> TRANSGENDER MAN <input type="radio"/> TRANSGENDER WOMAN <input type="radio"/> TRANSGENDER PERSON <input type="radio"/> DECLINED <input type="radio"/> OTHER (SPECIFY IN BOX 19)	19. IF OTHER GENDER IDENTITY, SPECIFY	20. AGE (YRS) (IF DOB NOT COMPLETED)
21. ETHNIC ORIGIN (VOLUNTARY, SELF-REPORTED – CHOOSE ONE ONLY) <input type="radio"/> AFRICAN <input type="radio"/> EUROPEAN (INCLUDES EASTERN EUROPE) <input type="radio"/> NORTH AMERICAN INDIGENOUS <input type="radio"/> DECLINED <input type="radio"/> ASIAN (INCLUDES MIDDLE EAST, PHILIPPINES) <input type="radio"/> LATIN, CENTRAL AND SOUTH AMERICAN (INCLUDES MEXICO) <input type="radio"/> OCEANIA (INCLUDES PACIFIC ISLANDS) <input type="radio"/> NOT ASKED <input type="radio"/> CARIBBEAN <input type="radio"/> NORTH AMERICAN (INCLUDES CANADA, USA) <input type="radio"/> UNKNOWN			
22. 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	23. FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED) <input type="radio"/> STATUS <input type="radio"/> NON-STATUS <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED	MHSU USE ONLY	
24. IMMIGRATION STATUS AT TIME OF ARRIVAL (VOLUNTARY - COMPLETE BOXES 25 AND 26 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	25. DATE ARRIVED IN CANADA YYYY	26. COUNTRY EMIGRATED FROM SPECIFY	

III. INVESTIGATION INFORMATION

27. *INVESTIGATION DISPOSITION	<input type="radio"/> FOLLOW-UP COMPLETE <input type="radio"/> UNABLE TO COMPLETE INTERVIEW <input type="radio"/> PENDING
28. *RESPONSIBLE ORGANIZATION	<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
29. OTHER ORGANIZATIONS INVOLVED	<input type="checkbox"/> WRHA <input type="checkbox"/> NRHA <input type="checkbox"/> PMH <input type="checkbox"/> SH-SS <input type="checkbox"/> IERHA <input type="checkbox"/> FNIHB <input type="checkbox"/> CSC <input type="checkbox"/> DND

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MHSU-6780 (2019-07-24) – HEPATITIS B, C, HIV, AND SYPHILIS INVESTIGATION - CASE FORM

MHSAL- SURVEILLANCE UNIT: 4073H – 300 CARLTON ST. WINNIPEG, MB

CONFIDENTIAL FAX 204-948-3044



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IV. *INFECTION INFORMATION/STAGING

investigation > investigation details > disease summary > update > disease event history

30. <input type="checkbox"/> HEPATITIS B		Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html	
<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	31. HEPATITIS B STAGING	<input type="radio"/> ACUTE <input type="radio"/> CHRONIC <input type="radio"/> UNKNOWN OR UNDETERMINED	<input type="radio"/> OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB <input type="radio"/> PREVIOUS DIAGNOSIS- NEW TO MANITOBA
		32. SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION YYYY - MM - DD	
33. <input type="checkbox"/> HEPATITIS C		Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html	
<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	34. HEPATITIS C STAGING	<input type="radio"/> ACUTE <input type="radio"/> CHRONIC <input type="radio"/> UNKNOWN OR UNDETERMINED	<input type="radio"/> OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB <input type="radio"/> PREVIOUS DIAGNOSIS- NEW TO MANITOBA
		35. SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION YYYY - MM - DD	
36. <input type="checkbox"/> HIV		Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html	
<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	37. HIV STAGING	<input type="radio"/> NEW DIAGNOSIS <input type="radio"/> OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB <input type="radio"/> PREVIOUS DIAGNOSIS- NEW TO MANITOBA	38. SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION YYYY - MM - DD
39. <input type="checkbox"/> SYPHILIS		Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html	
<input type="checkbox"/> LAB CONFIRMED <input type="checkbox"/> NOT A CASE	40. SYPHILIS STAGING INFORMATION		<input type="radio"/> STAGING PENDING <input type="radio"/> STAGING COMPLETED (SPECIFY IN BOXES 41 OR 42) <input type="radio"/> OLD CASE- PREVIOUSLY DIAGNOSED/KNOWN IN MB <input type="radio"/> UNKNOWN/UNDETERMINED
41. INFECTIOUS STAGES	<input type="radio"/> PRIMARY <input type="radio"/> SECONDARY <input type="radio"/> EARLY LATENT (< 1 YEAR AFTER INFECTION)	42. NON-INFECTIOUS STAGES	<input type="radio"/> LATE LATENT (≥ 1 YEAR AFTER INFECTION) <input type="radio"/> TERTIARY
43. ADDITIONAL PRESENTATIONS <input type="checkbox"/> CARDIOVASCULAR SYPHILIS <input type="checkbox"/> NEUROSYPHILIS <input type="checkbox"/> GUMMATOUS SYPHILIS			
44. SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION YYYY - MM - DD	45. DATE OF FIRST DIAGNOSIS IF PREVIOUSLY DIAGNOSED YYYY - MM	46. 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 XIII, "REPORTER INFORMATION".

V. METHOD OF DETECTION

investigation > investigation details > investigation information

47. METHOD OF DETECTION FOR CURRENT INVESTIGATION (REASON FOR TESTING)	48. OTHER METHOD OF DETECTION
<input type="radio"/> CONTACT INVESTIGATION <input type="radio"/> IMMIGRATION MEDICAL SURVEILLANCE <input type="radio"/> PRENATAL SCREENING	<input type="radio"/> ROUTINE TESTING (INCIDENTAL FINDING) <input type="radio"/> SYMPTOMS
SPECIFY	

VI. SIGNS AND SYMPTOMS

investigation > signs and symptoms

49. SYMPTOMS		50. EARLIEST SYMPTOM ONSET DATE	
<input type="radio"/> ASYMPTOMATIC <input type="radio"/> SYMPTOMATIC (COMPLETE BOX 51 FOR HEPATITIS B/C, BOX 52 FOR SYPHILIS, OR BOX 53 FOR HIV)		YYYY-MM-DD	
51. HEPATITIS B/C (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)	52. SYPHILIS (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)	53. HIV SIGNS/ SYMPTOMS	
<input type="checkbox"/> ABDOMINAL PAIN/CRAMPING (RUQ) <input type="checkbox"/> ANOREXIA <input type="checkbox"/> DARK URINE <input type="checkbox"/> FATIGUE <input type="checkbox"/> FEVER <input type="checkbox"/> OTHER	<input type="checkbox"/> JAUNDICE <input type="checkbox"/> NAUSEA <input type="checkbox"/> STOOL, PALE <input type="checkbox"/> VOMITING <input type="checkbox"/> ANAL ULCERATIVE LESIONS <input type="checkbox"/> CHANCRE (OTHER SITE) <input type="checkbox"/> CONDYLOMATA LATA <input type="checkbox"/> GENITAL ULCER <input type="checkbox"/> HAIR LOSS (ALOPECIA) <input type="checkbox"/> HEADACHE <input type="checkbox"/> LYMPH NODES ENLARGED - GENERALIZED <input type="checkbox"/> OTHER	<input type="checkbox"/> LYMPH NODES ENLARGED - REGIONAL <input type="checkbox"/> MENINGITIS <input type="checkbox"/> OCULAR INVOLVEMENT <input type="checkbox"/> ORAL ULCERATIVE LESIONS <input type="checkbox"/> OTHER MUCOSAL LESIONS <input type="checkbox"/> RASH	
SPECIFY		SPECIFY IF NEEDED FOR CASE MANAGEMENT	

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VII. RISK FACTOR INFORMATION

subject > risk factors

A. BLOOD AND PERCUTANEOUS EXPOSURES (COMPLETE FOR HEP B, HEP C, AND HIV CASES ONLY)					
COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
ACUPUNCTURE <small>SPECIFY LOCATION AND DATE YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BLOOD/TISSUE DONATION (E.G. BLOOD, PLASMA, ORGANS, BREAST MILK) <small>SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BLOOD/TISSUE RECIPIENT (E.G. BLOOD, PLASMA, TISSUE, ORGANS) <small>SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BODY PIERCING, SCARIFICATION, TATTOO APPLICATION <small>SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
DIALYSIS (HEMODIALYSIS OR PERITONEAL) <small>SPECIFY START DATE YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MEDICAL OR SURGICAL PROCEDURE <small>SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OCCUPATIONAL EXPOSURE (E.G. NEEDLE STICK, SHARPS) <small>SPECIFY TYPE AND DATE YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
RECIPIENT OF POOLED CONCENTRATES OF FACTOR VIII OR IX FOR TREATMENT OF HEMOPHILIA/COAGULATION DISORDER <small>SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY-MM-DD</small>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

B. SEXUAL EXPOSURE (COMPLETE ROUTINELY FOR HEP B, HIV, AND SYPHILIS CASES ONLY)					
<input type="checkbox"/> PREGNANT AT TIME OF DIAGNOSIS <small>SPECIFY EDC: YYYY-MM-DD</small>			<input type="checkbox"/> DATE OF LAST SEXUAL EXPOSURE <small>SPECIFY DATE YYYY-MM-DD</small>		
COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
HAS GIVEN GOODS IN EXCHANGE FOR SEX	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HAS RECEIVED GOODS IN EXCHANGE FOR SEX	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MALE WHO HAS SEX WITH MEN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
NEW SEX PARTNER IN PERIOD OF COMMUNICABILITY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL ASSAULT (NON-CONSENSUAL SEX)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL EXPOSURE TYPE: ANAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL EXPOSURE TYPE: ORAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEXUAL EXPOSURE TYPE: VAGINAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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C. HISTORY OF STBBI AND EXPOSURE RISKS (COMPLETE FOR ALL CASES EXCEPT WHERE INDICATED)					
<input type="checkbox"/> BORN TO INFECTED MOTHER	CONTACT TO A CASE OF: <input type="radio"/> HEPATITIS B <input type="radio"/> HEPATITIS C <input type="radio"/> HIV <input type="radio"/> SYPHILIS				
SPECIFY INFECTION(S)	SPECIFY DATE OF INITIAL CONTACT:	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD
COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
HISTORY OF INCARCERATION SPECIFY LOCATION AND DATE RANGE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HISTORY OF RESIDENCE IN AN ENDEMIC COUNTRY (FOR CASES OF HEP B/C AND HIV) SPECIFY COUNTRY AND DATES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HISTORY OF STI SPECIFY INFECTION(S) AND DATE(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HOUSEHOLD CONTACT WITH CONFIRMED OR SUSPECTED CASE (HEP B CASES ONLY)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INJECTION DRUG USE SPECIFY SUBSTANCE(S) AND DATE OF LAST IDU EXPOSURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INJECTION DRUG USE OUTSIDE CANADA SPECIFY SUBSTANCE(S), DATES, AND COUNTRY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PREVIOUS ANTI-RETROVIRAL THERAPY (HIV CASES ONLY) SPECIFY PROVINCE/COUNTRY AND DATE(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PREVIOUSLY DIAGNOSED HEPATITIS B CASE SPECIFY PROVINCE/COUNTRY AND DATE OF DIAGNOSIS YYYY-MM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PREVIOUSLY DIAGNOSED HEPATITIS C CASE SPECIFY PROVINCE/COUNTRY AND DATE OF DIAGNOSIS YYYY-MM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PREVIOUSLY DIAGNOSED HIV CASE SPECIFY PROVINCE/COUNTRY AND DATE OF FIRST POSITIVE TEST YYYY-MM	<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"/>
SAFER INJECTION PROGRAM USE (COMPLETE ONLY IF INJECTION DRUG USE REPORTED) <input type="checkbox"/> ALWAYS <input type="checkbox"/> NEVER <input type="checkbox"/> SOMETIMES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SHARED NEEDLES SPECIFY LOCATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SHARED OTHER DRUG PARAPHERNALIA SPECIFY TYPE	<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"/>
NO IDENTIFIABLE RISK FACTORS IN SECTIONS A, B, OR C	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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VIII. TREATMENT INFORMATION (COMPLETE FOR SYPHILIS ONLY)

investigation > prescriptions > prescription summary

54. PRESCRIBER NAME		55. TREATMENT FACILITY	
<input type="checkbox"/> BENZATHINE PENICILLIN G 2.4 million units IM as single dose SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> BENZATHINE PENICILLIN G 2.4 million units IM weekly for 2 doses SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> BENZATHINE PENICILLIN G 2.4 million units IM weekly for 3 doses SPECIFY START DATE: YYYY-MM-DD	
<input type="checkbox"/> CEFTRIAXONE 1 g OD for 10 days <input type="radio"/> IV <input type="radio"/> IM SPECIFY IM OR IV AND START DATE: YYYY-MM-DD	<input type="checkbox"/> CEFTRIAXONE 2 G OD FOR 10 DAYS <input type="radio"/> IV <input type="radio"/> IM SPECIFY IM OR IV AND START DATE: YYYY-MM-DD	<input type="checkbox"/> DOXYCYCLINE 100 mg PO BID X 14 days SPECIFY START DATE: YYYY-MM-DD	
<input type="checkbox"/> DOXYCYCLINE 100 mg PO BID X 28 days SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> PENICILLIN G 3-4 MILLION UNITS IV Q4H X 10-14 days SPECIFY START DATE: YYYY-MM-DD	<input type="checkbox"/> OTHER (SPECIFY TREATMENT AND START DATE); SPECIFY START DATE: YYYY-MM-DD	
56. ALLERGIES			
SPECIFY			

IX. OUTCOMES AT TIME OF INVESTIGATION

investigation > outcomes

<input type="radio"/> FATAL SPECIFY DATE OF DEATH YYYY-MM-DD	<input type="radio"/> OTHER SIGNIFICANT OUTCOME/SEQUELAE SPECIFY
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X. EVIDENCE-BASED INTERVENTIONS

investigation > treatment and interventions > interventions summary

57. RECOMMENDED IMMUNIZATIONS		
<input type="checkbox"/> HBV <input type="radio"/> RECOMMENDED <input type="radio"/> ADMINISTERED <input type="radio"/> IMMUNE <input type="radio"/> DECLINED	<input type="checkbox"/> HAV <input type="radio"/> RECOMMENDED <input type="radio"/> ADMINISTERED <input type="radio"/> IMMUNE <input type="radio"/> DECLINED	
58. STBBI TESTING RECOMMENDED/COMPLETED	59. LOCATION OF TESTING IF KNOWN	60. DATE (YYYY-MM-DD)
<input type="checkbox"/> CHLAMYDIA <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> GONORRHEA <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> HEPATITIS B <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> HEPATITIS C <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> HIV <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
<input type="checkbox"/> SYPHILIS <input type="radio"/> POSITIVE <input type="radio"/> NEGATIVE <input type="radio"/> UNKNOWN		
61. OTHER INTERVENTIONS	62. DATE (YYYY-MM-DD)	
<input type="checkbox"/> REFERRAL FOR TREATMENT (SPECIFY)		
<input type="checkbox"/> REFERRAL TO PEDIATRIC INFECTIOUS DISEASES (SPECIFY DATE)		
<input type="checkbox"/> FOLLOW-UP STBBI TESTING IN 6 MONTHS		
<input type="checkbox"/> NOTIFICATION OF CANADIAN BLOOD SERVICES (IF APPLICABLE)		
<input type="checkbox"/> IMMUNIZATION: NEWBORN PROPHYLAXIS FOR HEPATITIS B (IF APPLICABLE)		
<input type="checkbox"/> OTHER (SPECIFY)		

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XI. HEPATITIS B IMMUNIZATION HISTORY INTERPRETATION

Subject > imm history interpretation
Immunization

63. INTERPRETATION OF HEPATITIS B IMMUNITY PRIOR TO INVESTIGATION	<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			64. REASON FOR IMMUNITY/ IMMUNIZATION INTERPRETATION	SOURCE OF SEROLOGY/ IMMUNIZATION RECORD: <input type="radio"/> CLIENT/PARENT/GUARDIAN <input type="radio"/> CLIENT/PARENT/GUARDIAN – OFFICIAL RECORD <input type="radio"/> HEALTH RECORD/ HEALTHCARE PROVIDER REASON IF NOT FULLY IMMUNIZED OR UNKNOWN: <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
	65. HEPATITIS B VACCINES AND DATES (LIST AGENTS AND DATES ONLY IF NOT ALREADY ENTERED IN MB IMMUNIZATION REGISTRY)	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD		
	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD		

XII. CONTACTS

investigation > exposure summary > transmission event details

66. NUMBER OF CONTACTS IDENTIFIED BY NAME →	SPECIFY NUMBER	67. NUMBER OF ANONYMOUS CONTACTS →	SPECIFY NUMBER	68. EARLIEST ANONYMOUS EXPOSURE START DATE
				<input type="checkbox"/> ESTIMATED YYYY-MM-DD
<input type="checkbox"/> CASE DECLINED TO IDENTIFY CONTACTS				

XIII. * REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

69. FORM COMPLETED BY (PRINT NAME)	70. FACILITY NAME/ADDRESS/PHONE#	REPORTER USE ONLY
71. SIGNATURE		
72. FORM COMPLETION DATE YYYY-MM-DD	73. ORGANIZATION (IF APPLICABLE) <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	
		STAMP HERE

XIV. * RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE USE ONLY

74. FORM COMPLETED BY (PRINT NAME)	75. SIGNATURE	76. FORM COMPLETION DATE YYYY-MM-DD
77. FORM REVIEWED BY (PRINT NAME)	78. FORM REVIEWED DATE YYYY-MM-DD	RHA USE ONLY
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