

* CASE ACCESSION NUMBER	INVESTIGATION ID	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)
-------------------------	------------------	--



WEST NILE VIRUS INFECTION INVESTIGATION FORM

CASE FORM

*I. CASE IDENTIFICATION

subject > client details > personal information

1. *LAST NAME		2. *FIRST NAME		3. *DATE OF BIRTH YYYY - MM - DD		
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"/> TRANSGENDER WOMAN <input type="radio"/> TRANSGENDER PERSON <input type="radio"/> DECLINED <input type="radio"/> OTHER (SPECIFY IN BOX 8)			8. IF OTHER GENDER IDENTITY, SPECIFY	
9. *REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS		10. *HEALTH NUMBER (PHIN) 9 DIGITS		11. ALTERNATE ID SPECIFY TYPE OF ID		
12. *ADDRESS AT TIME OF DIAGNOSIS → <input type="checkbox"/> ADDRESS IN FIRST NATION COMMUNITY				13. *CITY/TOWN/VILLAGE		
14. *PROVINCE/TERRITORY		15. *POSTAL CODE A#A #A#		16. *PHONE NUMBER ### - ### - ####		
17. 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						
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 <input type="radio"/> NON-STATUS <input type="radio"/> NOT ASKED <input type="radio"/> DECLINED		MHSU USE ONLY		
20. 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		21. DATE ARRIVED IN CANADA YYYY				22. COUNTRY EMIGRATED FROM SPECIFY
23. ALTERNATE LOCATION INFORMATION (IF ANY)						

II. INVESTIGATION INFORMATION

investigation > investigation details > investigation information
investigation > investigation details > resp. org/investigator

24. *INVESTIGATION DISPOSITION	<input type="radio"/> FOLLOW-UP COMPLETE <input type="radio"/> UNABLE TO COMPLETE INTERVIEW <input type="radio"/> PENDING
25. *RESPONSIBLE ORGANIZATION (PRIMARY)	<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
26. 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

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN
-------------------------	-----------------------	-----------



III. *INFECTION INFORMATION (TO BE COMPLETED BY REGIONAL MOH)

Refer to disease protocol: <https://www.gov.mb.ca/health/publichealth/cdc/protocol/wnvhumancaseprotocol2006.pdf>

investigation > investigation details > disease summary

27. WNV SITE (PRESENTATION)	28. CASE CLASSIFICATION	29. LAB CRITERIA	30. CLINICAL CRITERIA
<input type="checkbox"/> ASYMPTOMATIC	<input type="checkbox"/> LAB CONFIRMED	CONFIRMED DIAGNOSTIC TEST	N/A
	<input type="checkbox"/> PROBABLE	PROBABLE DIAGNOSTIC TEST	N/A
<input type="checkbox"/> NEUROLOGICAL SYNDROME	<input type="checkbox"/> LAB CONFIRMED	CONFIRMED DIAGNOSTIC TEST	EXPOSURE AND RECENT ONSET OF NEUROLOGIC CONDITION
	<input type="checkbox"/> PROBABLE	PROBABLE DIAGNOSTIC TEST	EXPOSURE AND RECENT ONSET OF NEUROLOGIC CONDITION)
	<input type="checkbox"/> SUSPECT	ABSENCE OF OR PENDING	EXPOSURE AND RECENT ONSET OF NEUROLOGIC CONDITION AND NO OTHER CAUSE
<input type="checkbox"/> NON- NEUROLOGICAL SYNDROME	<input type="checkbox"/> LAB CONFIRMED	CONFIRMED DIAGNOSTIC TEST	EXPOSURE AND CLINICAL CRITERIA
	<input type="checkbox"/> PROBABLE	PROBABLE DIAGNOSTIC TEST	EXPOSURE AND CLINICAL CRITERIA
	<input type="checkbox"/> SUSPECT	ABSENCE OF OR PENDING	EXPOSURE AND CLINICAL CRITERIA AND NO OTHER CAUSE
<input type="checkbox"/> NOT A CASE			

IV. SIGNS AND SYMPTOMS

investigation > signs and symptoms

31. SYMPTOMS <input type="radio"/> ASYMPTOMATIC <input type="radio"/> SYMPTOMATIC	32. EARLIEST SYMPTOM ONSET DATE YYYY-MM-DD
33. CHECK ALL SIGNS AND SYMPTOMS THAT APPLY IF SYMPTOMATIC	
<input type="checkbox"/> ALTERED LEVEL OF CONSCIOUSNESS <input type="checkbox"/> CEREBROSPINAL FLUID (CSF) ABNORMALITIES <input type="checkbox"/> CONFUSION, ALTERED MENTAL STATE <input type="checkbox"/> DIFFICULTY BREATHING <input type="checkbox"/> ENCEPHALITIS/ ENCEPHALOMYELITIS <input type="checkbox"/> FEVER <input type="checkbox"/> GUILLAIN-BARRE SYNDROME <input type="checkbox"/> HEADACHE <input type="checkbox"/> JOINT PAIN (ARTHRALGIA) <input type="checkbox"/> OTHER	<input type="checkbox"/> LACK OF VOUNTARY MUSCLE COORDINATION (ATAXIA) <input type="checkbox"/> LYMPH NODES ENLARGED – GENERALIZED <input type="checkbox"/> MENINGITIS <input type="checkbox"/> MUSCLE JERKS (MYOCLONUS) <input type="checkbox"/> MUSCLE PAIN (MYALGIA) <input type="checkbox"/> NAUSEA <input type="checkbox"/> PARALYSIS, ACUTE FLACCID <input type="checkbox"/> PERIPHERAL NERVE PALSY/ NEUROPATHY
	<input type="checkbox"/> PHOTOPHOBIA <input type="checkbox"/> RASH <input type="checkbox"/> SEIZURES <input type="checkbox"/> STIFF NECK (NUCHAL RIGIDITY) <input type="checkbox"/> TREMOR <input type="checkbox"/> VISION, BLURRED <input type="checkbox"/> VOMITING <input type="checkbox"/> WEAKNESS (ASTHENIA)
SPECIFY SIGNS AND SYMPTOMS	

V. *OUTCOMES

investigation > outcomes

<input type="checkbox"/> ER VISIT YYYY-MM-DD	<input type="checkbox"/> HOSPITAL ADMISSION YYYY-MM-DD	<input type="checkbox"/> HOSPITAL DISCHARGE YYYY-MM-DD	<input type="checkbox"/> ICU ADMISSION YYYY-MM-DD	<input type="checkbox"/> ICU DISCHARGE YYYY-MM-DD
34. OUTCOME OF ILLNESS <input type="checkbox"/> DECEASED (SPECIFY DATE OF DEATH) YYYY-MM-DD <input type="checkbox"/> PENDING <input type="checkbox"/> RECOVERED <input type="checkbox"/> UNKNOWN <input type="checkbox"/> SEQUELAE (SPECIFY)			35. SPECIFY SEQUELAE	

VI. *IMMUNIZATION HISTORY (ENSURE ALL DOSES DOCUMENTED IN PHIMS)

Investigation > view client imms profile
Immunization > record & update imms

36. JAPANESE ENCEPHALITIS VACCINE RECORD AGENT AND DATE IMMUNIZED	<input type="radio"/> NO PREVIOUS IMMUNIZATION	YYYY – MM – DD	YYYY – MM – DD	YYYY – MM – DD
37. YELLOW FEVER VACCINE RECORD AGENT AND DATE IMMUNIZED	<input type="radio"/> NO PREVIOUS IMMUNIZATION	YYYY – MM – DD	YYYY – MM – DD	YYYY – MM – DD

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN
--------------------------------	------------------------------	------------------



VII. RISK FACTOR INFORMATION

subject > risk factors

COMPLETE THE FOLLOWING AS APPLICABLE AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
ANIMAL CONTACT (BIRDS) BEFORE ONSET SPECIFY DETAILS					
BLOOD/TISSUE DONATION (E.G. BLOOD, PLASMA, ORGANS, BREAST MILK) IN 12 WEEKS PRIOR TO ONSET SPECIFY IF HISTORY OF FEVER AND/OR HEADACHE IN WEEK PRIOR TO DONATION SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BLOOD/TISSUE RECIPIENT (E.G. BLOOD, PLASMA, TISSUE, ORGANS) IN 12 WEEKS PRIOR TO ONSET 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"/>
BORN TO INFECTED MOTHER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BREASTFEEDING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EXPOSURE SETTING/LOCATION: OUTDOORS - SPECIFY RECREATIONAL ACTIVITIES (I.E. GARDENING, GOLFING, HIKING, HUNTING, MOUNTAIN BIKING, ETC.) SPECIFY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EXPOSURE SETTING/LOCATION: OTHER COMMUNITY IN MANITOBA WITHIN 15 DAYS PRIOR TO ONSET SPECIFY LOCATION AND DATES YYYY – MM – DD TO YYYY – MM – DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EXPOSURE SETTING/LOCATION: OTHER PROVINCE IN CANADA WITHIN 15 DAYS PRIOR TO ONSET SPECIFY PROVINCE AND DATES YYYY – MM – DD TO YYYY – MM – DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EXPOSURE SETTING/LOCATION: OUTSIDE CANADA IN PAST 12 MONTHS SPECIFY COUNTRY AND DATES YYYY – MM – DD TO YYYY – MM – DD	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
HISTORY OF INFECTION (WNV OR OTHER ARBOVIRUS INFECTIONS -E.G. DENGUE, YF, JE, CHIKUNGUNYA, POWASSEN, ZIKA, RIFT VALLEY FEVER) SPECIFY DIAGNOSIS AND DATE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
INSECT REPELLANT USE <input type="checkbox"/> ALL OF THE TIME <input type="checkbox"/> NEVER <input type="checkbox"/> SOME OF THE TIME SPECIFY TYPE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OCCUPATIONAL EXPOSURE (E.G. OUTDOOR, LABORATORY, ANIMAL HANDLER) SPECIFY TYPE AND DATE	<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"/>
UNDERLYING ILLNESS SPECIFY	<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"/>

VIII. INTERVENTIONS

investigation > treatment and interventions > intervention summary

<input type="checkbox"/> EDUCATION – TRANSMISSION AND PREVENTIVE MEASURES	<input type="checkbox"/> PUBLIC HEALTH ADVISORY (CLIENT ADVISED OF ANNOUNCEMENT)
<input type="checkbox"/> NOTIFICATION OF CANADIAN BLOOD SERVICES	<input type="checkbox"/> REFERRAL TO INFECTIOUS DISEASES
<input type="checkbox"/> OTHER (SPECIFY)	

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.

* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN
--------------------------------	------------------------------	------------------



IX.*ACQUISITION EXPOSURE

(POTENTIAL EXPOSURE SETTINGS DURING INCUBATION PERIOD)

investigation > exposure summary > create acquisition event

SETTING TYPE	EXPOSURE SETTING		
1. AGRICULTURAL LOCATIONS	FARM	PETTING ZOO	OTHER
2. HOUSEHOLD EXPOSURE (RESIDENCE)			
3. LABORATORY			
4. RECREATIONAL FACILITIES	CAMPGROUND COMMUNITY CENTER/ARENA FORESTED AREA	PARK RIVER/LAKE/OCEAN	SPLASH PAD/WADING POOL SWIMMING POOL/WATER PARK OTHER
5. TRAVEL	TO OTHER COMMUNITIES IN MB	TO OTHER PROVINCE IN CANADA	OUTSIDE CANADA
6. OTHER SETTING			
7. UNKNOWN			

INDICATE ALL SETTINGS WHERE THE CASE MAY HAVE BEEN EXPOSED TO MOSQUITOS WITHIN 15 DAYS PRIOR TO ONSET OF SYMPTOMS, INCLUDING THEIR PLACE OF RESIDENCE. E.G. LOCATIONS WHERE TIME SPENT OUTDOORS, ESPECIALLY BETWEEN DUSK AND DAWN.

SETTING #	38. SETTING TYPE (FROM ABOVE TABLE)	39. EXPOSURE SETTING (FROM ABOVE TABLE)	40. EXPOSURE SETTING DETAILS (NAME/LOCATION)	41. POTENTIAL MODE OF ACQUISITION	42. *EXPOSURE START DATE/TIME (YYYY-MM-DD HH:MM)	43. EXPOSURE END DATE/TIME (YYYY-MM-DD HH:MM)	44. MOST LIKELY SETTING
				<input type="checkbox"/> MOSQUITO <input type="checkbox"/> OTHER (SPECIFY)			<input type="checkbox"/>
				<input type="checkbox"/> MOSQUITO <input type="checkbox"/> OTHER (SPECIFY)			<input type="checkbox"/>
				<input type="checkbox"/> MOSQUITO <input type="checkbox"/> OTHER (SPECIFY)			<input type="checkbox"/>
				<input type="checkbox"/> MOSQUITO <input type="checkbox"/> OTHER (SPECIFY)			<input type="checkbox"/>
				<input type="checkbox"/> MOSQUITO <input type="checkbox"/> OTHER (SPECIFY)			<input type="checkbox"/>

X. *RESPONSIBLE REGIONAL PUBLIC HEALTH AUTHORITY USE ONLY (PRIMARY INVESTIGATOR)

investigation > investigation details > close investigation

45. FORM COMPLETED BY (PRINT NAME)	46. SIGNATURE	47. FORM COMPLETION DATE YYYY-MM-DD
48. FORM REVIEWED BY (PRINT NAME)	49. FORM REVIEWED DATE YYYY-MM-DD	REPORTER USE ONLY
50. INVESTIGATION STATUS ○ ONGOING ○ CLOSED TO THE REGION	51. ORGANIZATION ○ 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 <http://www.gov.mb.ca/health/publichealth/surveillance/forms.html>

A USER GUIDE FOR COMPLETION OF SURVEILLANCE FORMS FOR REPORTABLE DISEASES AND INSTRUCTIONS FOR THIS FORM ARE AVAILABLE FOR DOWNLOAD AT <http://www.gov.mb.ca/health/publichealth/surveillance/forms.html>

* IDENTIFIES CRITICAL DATA ELEMENT OR SECTION TO BE COMPLETED. IF THIS DATA IS MISSING, THE FORM WILL BE RETURNED.