Vaccine Preventable Disease (VPD) Surveillance Form

Public Health Ontario | Santé publique Ontario

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iPHIS Case ID:

Electronic completion of this form is recommended. iPHIS aligned drop down options will not be visible in print form.

- ☐ *Haemophilus Influenzae* (Hi)
- ☐ Invasive Meningococcal Disease (IMD)
- ☐ Mumps
- ☐ Measles
- ☐ Pertussis (Whooping Cough)
- ☐ Invasive Pneumococcal Disease (IPD)
- ☐ Varicella (Chickenpox)
- ☐ Rubella
- ☐ Diphtheria
- ☐ Tetanus
- ☐ Polio

1 - CLIENT INFORMATION

Last name:

First name:

Parent / Guardian (if applicable)

Last name:

First name:

Date of birth (yyyy-mm-dd):

Ontario Health Card:

Gender: ☐ Female ☐ Male ☐ Transgender ☐ Other ☐ Unknown

Contact Information:

Address:

City / Town:

Postal Code:

Province:

☐ No Fixed Address:

Primary phone #: ☐ Home ☐ Mobile ☐ Work ☐ Other

Alternate phone #: ☐ Home ☐ Mobile ☐ Work ☐ Other

Email:

Client Language / Proxy Info:

Preferred language: ☐ English ☐ French ☐ Other:

If Other, specify:

Translation required? ☐ Yes ☐ No

Proxy respondent (if applicable)? ☐ Yes ☐ No

Proxy Name:

Relationship to client:

Proxy Phone #:

Clinician / Healthcare provider info:

Name:

Tel.

Clinic / Hospital name:

Role:

- ☐ Attending Physician
- ☐ Family Physician
- ☐ Specialist
- ☐ Walk-in Physician
- ☐ Nurse Practitioner
- ☐ Unknown
- ☐ Other Specify:

2 - REPORTING INFORMATION

Reported to PHU date (yyyy-mm-dd):

Reporting Source:

☐ Hospital ☐ Physician/Nurse Practitioner ☐ Lab ☐ School ☐ Self ☐ Parent ☐ PHU

☐ Other (If Other, specify):

Initial Case Classification:

☐ Person Under Investigation ☐ Probable ☐ Confirmed ☐ Does Not Meet

Initial Case Classification date (yyyy-mm-dd):

Final Case Classification:

☐ Probable ☐ Confirmed ☐ Does Not Meet

Final Case Classification date (yyyy-mm-dd):

3 - LABORATORY INFORMATION

Laboratory testing completed: ☐ Yes (Complete fields below) ☐ No ☐ N/A

Specimen forwarded for typing if applicable: ☐ Yes ☐ No

Specimen 1:	**Specimen 2:**	**Specimen 3:**	**Specimen 4:**
Type and site:	Type and site:	Type and site:	Type and site:
Test:	Test:	Test:	Test:
Result:	Result:	Result:	Result:
Specify / Lab comments:	Specify / Lab comments:	Specify / Lab comments:	Specify / Lab comments:
Date collected: / Date of Result:	Date collected: / Date of Result:	Date collected: / Date of Result:	Date collected: / Date of Result:

Hi Serotype:

IMD Serogroup:

IPD Serotype:

Diptheria:

PCR Toxin Gene: ☐ Detected ☐ Not Detected

Elek Test - Toxin Production: ☐ Toxin Positive ☐ Toxin Negative

Measles / Mumps / Rubella Genotype
Note: If vaccine strain, report as Adverse Events Following Immunization (AEFIs), Appendix 1

Other, specify:

4 - CLINICAL INFORMATION / SYMPTOMS

Symptom entry is limited. Prioritize entry of symptoms to those that are necessary to meet case definition/clinical compatibility as per Appendix 1

Diphtheria	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Haemophilus Influenzae (HI)	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Invasive Meningococcal Disease (IMD)	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Invasive Pneumococcal Disease (IPD) / Streptococcus Pneumoniae	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Mumps	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Pertussis	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Polio	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Tetanus	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Varicella (Primary Chickenpox)	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Rubella	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Measles	**Onset date**
1.	1.
2.	2.
3.	3.
4.	4.

Other symptoms	**Onset date**
1. ☐ Fever Temp (°C):	1.
2. ☐ Other Specify:	2.
3. ☐ Other Specify:	3.

5 - RISK FACTORS

Medical Risk Factors:

Unimmunized ☐ Yes ☐ No (If No enter details in Immunization History Section 7) ☐ Unknown

Pregnant: ☐ Yes (If Yes, enter # of weeks gestation): ☐ No ☐ N/A

Chronic Illness / Underlying Medical condition: ☐ Yes ☐ No Specify:

Immunocompromised: ☐ Yes ☐ No Specify:

☐ Other Specify:

Behavioural Risk Factors:

Travel Outside of Ontario within the past month: ☐ Yes (If Yes, enter travel details in Acquisition Exposure Section 8) ☐ No

Close Contact with a Case: ☐ Yes (If Yes, enter details in Acquisition Exposure Section 8) ☐ No

Close Contact with a Travel History: ☐ Yes Specify: ☐ No

Other Risk Factors:

Specify #1: Specify #2:

6 - INTERVENTIONS

Hospitalization: ☐ Yes (If Yes, complete the following fields) ☐ No

Admission date: Hospital Name:

Discharge date: Admission details:

7 - IMMUNIZATION HISTORY

Client is unimmunized: ☐ Yes (If Yes, specify reason):

☐ No (If No, complete fields below)

Entry 1:

Exact Administration ☐ **Or** Estimated ☐ Date: Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 2:

Exact Administration ☐ **Or** Estimated ☐ Date: Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 3:

Exact Administration ☐ **Or** Estimated ☐ Date: Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 4:

Exact Administration ☐ **Or** Estimated ☐ Date: Site: Dose Number:

Agent: Lot Number: Source of info:

Entry 5:

Exact Administration ☐ **Or** Estimated ☐ Date: Site: Dose Number:

Agent: Lot Number: Source of info:

8 - ACQUISITION EXPOSURE

Client Travelled outside of Ontario within the past month? ☐ Yes (Complete these fields below): ☐ No

Travel start date: End date:

Travel Details: (Include each province/country & dates visited; flight details as required; out-of-province visitors suspected of transmitting VPD)

Epi-linked to a confirmed case? ☐ Yes (If Yes, provide iPHIS case ID below): ☐ No

iPHIS case ID (7 digit): ☐ Unknown

Other acquisition exposure(s): ☐ Yes (If Yes, provide details below): ☐ No

1. Start date: End date:
2. Start date: End date:
3. Start date: End date:

9 - TRANSMISSION EXPOSURE

Using the Infectious Disease Protocol VPD specific Appendices, establish the first and final day when case would be communicable (i.e. at risk for transmission of the disease to others) in the community. Use this time period (period of communicability) to identify susceptible contacts based on the specific VPD under investigation.

Onset date for disease defining symptom (measles use rash onset):

First Day Communicable:

Last Day Communicable:

Transmission details: (Places where case attended during period of communicability)

1.		Start date:	
		End date:	
2.		Start date:	
		End date:	
3.		Start date:	
		End date:	
4.		Start date:	
		End date:	
5.		Start date:	
		End date:	
6.		Start date:	
		End date:	

10 - COMPLICATIONS

Complications: Yes (If Yes, specify):

No Unknown

11 - OUTCOMES

Outcomes: Fatal Ill Pending Recovered Residual Effects Unknown

If Fatal: Date of death: Cause of death:

12 - CONTACT FOLLOW-UP SHEET (OPTIONAL)

VPD:

1. **Initials** (Last, First): **Age:** Years: Months:

Susceptible: Yes No Unknown

Education Provided: Yes No Pending Unknown N/A

Exclusion Recommended: Yes No Unknown N/A

Prophylaxis / Treatment: **Comments:** **Date:**

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2. **Initials** (Last, First): **Age:** Years: Months:

Susceptible: Yes No Unknown

Education Provided: Yes No Pending Unknown N/A

Exclusion Recommended: Yes No Unknown N/A

Prophylaxis / Treatment: **Comments:** **Date:**

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3. **Initials** (Last, First): **Age:** Years: Months:

Susceptible: Yes No Unknown

Education Provided: Yes No Pending Unknown N/A

Exclusion Recommended: Yes No Unknown N/A

Prophylaxis / Treatment: **Comments:** **Date:**

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4. **Initials** (Last, First): **Age:** Years: Months:

Susceptible: Yes No Unknown

Education Provided: Yes No Pending Unknown N/A

Exclusion Recommended: Yes No Unknown N/A

Prophylaxis / Treatment: **Comments:** **Date:**

5. **Initials** (Last, First): ☐ **Age:** Years: ☐ Months: ☐

Susceptible: ☐ Yes ☐ No ☐ Unknown

Education Provided: ☐ Yes ☐ No ☐ Pending ☐ Unknown ☐ N/A

Exclusion Recommended: ☐ Yes ☐ No ☐ Unknown ☐ N/A

Prophylaxis / Treatment: ☐ **Comments:** ☐ **Date:** ☐

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6. **Initials** (Last, First): ☐ **Age:** Years: ☐ Months: ☐

Susceptible: ☐ Yes ☐ No ☐ Unknown

Education Provided: ☐ Yes ☐ No ☐ Pending ☐ Unknown ☐ N/A

Exclusion Recommended: ☐ Yes ☐ No ☐ Unknown ☐ N/A

Prophylaxis / Treatment: ☐ **Comments:** ☐ **Date:** ☐

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7. **Initials** (Last, First): ☐ **Age:** Years: ☐ Months: ☐

Susceptible: ☐ Yes ☐ No ☐ Unknown

Education Provided: ☐ Yes ☐ No ☐ Pending ☐ Unknown ☐ N/A

Exclusion Recommended: ☐ Yes ☐ No ☐ Unknown ☐ N/A

Prophylaxis / Treatment: ☐ **Comments:** ☐ **Date:** ☐

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8. **Initials** (Last, First): ☐ **Age:** Years: ☐ Months: ☐

Susceptible: ☐ Yes ☐ No ☐ Unknown

Education Provided: ☐ Yes ☐ No ☐ Pending ☐ Unknown ☐ N/A

Exclusion Recommended: ☐ Yes ☐ No ☐ Unknown ☐ N/A

Prophylaxis / Treatment: ☐ **Comments:** ☐ **Date:** ☐

Number of contacts identified: ☐ **Number of contacts traced:** ☐ **Number of contacts tested & treated:** ☐

13 - PUBLIC HEALTH ACTION

Enter Notes: (e.g. letter to daycare / school / workplace, immunization clinic, media release, Public Health Alert / CNPHI / CIOSC)

14 - PROGRESS / CLINICAL NOTES

Enter progress or clinical notes:

15 - CASE INVESTIGATORS

Case manager #1: Signature: Date: Time:

Case manager #2: Signature: Date: Time:

Ontario