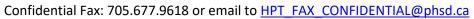
Fax to: Public Health Sudbury & Districts

Medical Officer of Health





COMMUNICABLE DISEASE NOTIFICATION FORM							
Disease:							
Reporting agency:				Site location:			
Physician (involved with direct care):							
Physician address:							
Lab/point of care test(s) ordered:				Collection date:			
Positive TST/IGRA							
Date administered/drawn:	Date read	d:	Result (mm of induration/interpretation):				
Client Information							
Legal name (last, first):						Pronouns:	
Chosen name:						DOB:	
Sex assigned at birth: □ F □ M □ Intersex □ Do not wish to disclose							
Gender identity (Ask "Please share your gender identity, if you feel comfortable disclosing?"):  Male Female Transgender Two-spirit Genderqueer Genderfluid Agender  Non-binary Unsure Prefer not to answer Other (specify):  (For entry into iPHIS/CCM, please enter as 'other (specify)' if gender not in list, and 'unknown' if client wishes not to disclose)							
Phone #1: Phone #2:							
Address:			•				
Parent/Legal guardian:							
Occupation/School/Workplace:							
Other Physician (family, physician, or specialist):							
Clinical Information							
Outpatient/ER/Clinic visit: Hospitalized:			□No □Yes Hospitalization discharge date:				
Date of visit: Date of admission			sion: Date of			f isolation:	
Arrived by EMS: □No □Yes			EMS arrival date:				
Patient transfer to:	Transfer date:						
Isolation type: ☐ Airborne ☐	Droplet	□Contac	t [	☐Droplet-Con	tact	□None	
Immunization (depending on infectious ag	gent): $\square$ Nc	) □Ye	es	Date:			
Symptoms:				On	set date	:	
Risk factors: □Alcohol abuse □Immunocompromised	☐Immunocompromised ☐Not immu			☐ Pregnant ☐ Under housed/homeless			
Follow-up/referrals:  ☐ Education to case and contacts about il	lness and p	revention of tr	ansmission.				

Notes (travel hx, possible exposures & contacts):							
(, , , , , , , , , , , , , , , , , ,							
Medications Prescribed Related to Communicable	: Disease						
RX:	Duration:		Date started:				
RX:	Duration:		Date started:				
RX:	Duration:		Date started:				
eported by:		Date:_					
DR PUBLIC HEALTH USE ONLY							
otified by: $\square$ T.C. $\square$ Fax							
HIS/CCM Classification:  Person under investig	gation $\square$ Probable	□Suspect □C	onfirmed	□ Does Not Meet			
tification received by (PHSD Staff):		Date:_					
ceived by lead PHSD investigator:		Investigation start date:					

To meet public health requirements, any personal information contained on this form is collected under the authority of one or more of the following (as amended) and related regulations: Health Protection and Promotion Act, R.S.O. 1990; Drug and Pharmacies Regulation Act, R.S.O. 1990, (formerly The Health Disciplines Act); Immunization of School Pupils Act, R.S.O.1990; Regulated Health Professions Act, 1991, S.O. 1991; Child Care and Early Years Act, 2014, S.O. 2014 and is in compliance with the Municipal Freedom of Information and Privacy Protection Act,, R.S.O. 1990; and the Personal Health Information Protection Act, 2004, S.O. 2004. This information is used to ensure that all appropriate personal care and public health services are provided, and that necessary statistics are kept. Questions about this collection should be directed to the Program Manager at Public Health Sudbury & Districts, 1300 Paris Street, Sudbury, ON P3E 3A3, 705.522.9200, ext. 398.