Fax to: Public Health Sudbury & Districts
Medical Officer of Health
Confidential Fax: 705.677.9618 or email to HPT_FAX_CONFIDENTIAL@phsd.ca

Public Health
Santé publique
SUDBURY & DISTRICTS

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: | 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: | Date of isolation:

Arrived by EMS: ☐No ☐Yes | EMS arrival date:

Patient transfer to: | Transfer date:

Isolation type: ☐Airborne ☐ Droplet ☐Contact ☐Droplet-Contact ☐None

Immunization (depending on infectious agent): ☐No ☐Yes Date:

Symptoms: Onset date:

Risk factors: ☐Alcohol abuse ☐Drug use ☐Pregnant
☐Immunocompromised ☐Not immunized ☐Under housed/homeless

Follow-up/referrals:
☐Education to case and contacts about illness and prevention of transmission.

Notes (*travel hx, possible exposures & contacts*):		
Medications Prescribed Related to Communicable Disease		
RX:	Duration:	Date started:
RX:	Duration:	Date started:
RX:	Duration:	Date started:

Reported by: ____ Date: ______________________

FOR PUBLIC HEALTH USE ONLY

Notified by: ☐T.C. ☐Fax

IPHIS/CCM Classification: ☐Person under investigation ☐Probable ☐Suspect ☐Confirmed ☐Does Not Meet

Notification received by (PHSD Staff): __________________________________ Date: ______________________

Received 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.