

Ebola Disease Case Report Form

Section 1: Case Protected Information – Local / Provincial / Territorial use only

Do not forward this section to PHAC

Instructions for Completion

- Please complete as much detail as possible on this form at the time of the initial report.
- It is not expected that all fields will be completed during the initial report, but that updates will be made when information becomes available.
- All fields indicated by an asterisk (*) are mandatory

Instructions to local public health authorities

- Reporting: Persons under investigation (PUIs) and confirmed cases of Ebola disease should be reported immediately as per jurisdictional protocols in the respective province or territory in Canada.

Instructions to provincial / territorial public health authorities

- Reporting: Persons under investigation (PUIs), and confirmed cases of Ebola disease should be reported immediately to the Agency's Health Portfolio Operations Centre (HPOC) at **1-800-545-7661**.
- Requests from provinces and territories for diagnostic or confirmatory laboratory services for Ebola disease should be directed to the Public Health Agency of Canada's National Microbiology Laboratory at **1-866-262-8433**.

Section 2: Ebola Disease Case Report Form

P/T Case ID*: Laboratory Case ID: Report Date (DD/MM/YYYY)*:

Administrative Information

Reporting Province / Territory*:

BC AB SK MB ON QC NB NS PE NL YK NT NU

Other Federal Government (OFG) Departments
Specify 'Other' Department and Details:

Contact information for person reporting*

Name:

Phone number:

Email:

Initial Report Updated Report

Surveillance Case Classification* (please refer to the [case definitions](#))

Person Under Investigation (PUI)

Confirmed

Non-case

Demographic Information

| | | |
|---------|--------|-----------------------------------------------------------------|
| Gender: | Other: | Age: years If under 2 years, months Unknown |
|---------|--------|-----------------------------------------------------------------|

Symptoms

Date of onset of first symptom(s) (dd/mm/yyyy):

Specify initial symptom(s) (see list below):

Fever ($\geq 38.0^{\circ}\text{C}$) Date of fever onset (dd/mm/yyyy):

Check all other symptoms that apply:

| | | | |
|-------------------|--------------------------------|-------------|------------------------------------|
| Subjective fever | Nausea | Arthralgia | Conjunctival redness |
| Headache | Abdominal pain | Myalgia | Haemorrhage |
| Haematemesis | Vomiting | Sore throat | Erythematous |
| Fatigue / Malaise | Diarrhea that can be bloody | Chest pain | maculopapular rash on the trunk |
| Loss of appetite | | | |

Name of the municipality (and country if outside Canada) where the case became ill:

Has the case been in any health care facilities since they became ill: Yes No Unknown

If the answer is "yes", complete the list indicating location of the health care facilities

City Health care facility:

City Health care facility:

City Health care facility:

How was the case transported to the health care facility? (check all that apply)

Medevac Private vehicle Commercial vehicle Public transportation Ambulance

Other, specify :

| Clinical Course, Hospitalizations, Complications And Outcome | | | | | |
|----------------------------------------------------------------------------------------------------------------|--------------------------------------|-----------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|---------|
| Case hospitalized? | Yes | No | Unknown | Admission Date (dd/mm/yyyy): | |
| Case admitted to Intensive Care Unit (ICU) | | | | Did case require a ventilator? Yes No Unknown | |
| Case isolated (single room, private bathroom) and placed on droplet and contact precautions while in hospital? | | | Were aerosol generating medical procedures (AGMP) performed while in hospital? | | |
| Yes | No | Unknown | Yes | No | Unknown |
| If yes, indicate date (dd/mm/yyyy) | | | If yes, please identify type(s) of AGMP, dates and other pertinent details: | | |
| Was there a break in IPC in the management of this case | | | Type: | | |
| Yes | No | Unknown | Type: | | |
| If yes, indicate date (dd/mm/yyyy) | | | Type: | | |
| Please provide other pertinent details | | | Were strategies to limit aerosol generation implemented? | | |
| | | | Yes | No | |
| Case discharged from hospital? | | | Yes | No | Unknown |
| | | | Discharge date (dd/mm/yyyy): | | |
| Laboratory Information | | | | | |
| Microbiology / Virology / Serology | | | | | |
| Lab ID and location of testing | Date Specimen Collected (dd/mm/yyyy) | Test Performed (Antigen detection, IgM, IgG, RT-PCR, viral culture, immunohistochemical staining, immunofluorescence) | Type of Specimen/Anatomic site (Blood sample using dry tube, saliva, biopsy please specify organ or tissue, blood using anticoagulants, stool/urine, swab, vaginal fluid, breast milk, other [specify]) | Test Result (positive, negative, titre and interpretation) | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Outcome (to be verified 4 weeks after symptom onset) | | | | | |
| Alive | Deceased | If deceased, date of death (dd/mm/yyyy): | | | |

| Source Identification and Exposures (add additional details in the comments section as necessary) | | | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------|--------------------|--------|----------------|--------------------|-----------------|
| Travel | | | | | | |
| In the 21 days prior to symptom onset, did the case travel outside of their province/territory of residence or outside of Canada? | | | | | | |
| Yes No Unknown | | | | | | |
| If yes, please specify the following (submit additional information on a separate page if required) | | | | | | |
| - | Country / City Visited and Dates of Travel for each country / city visited (including stopovers) | | | | Hotel or Residence | |
| Trip 1 | | | | | | |
| Trip 2 | | | | | | |
| Trip 3 | | | | | | |
| In the 21 days prior to symptom onset, did the case travel on a plane or other public carrier(s)? | | | | | | |
| Yes No Unknown | | | | | | |
| If yes, please specify the following | | | | | | |
| Travel Type | Carrier Name | Flight / Carrier # | Seat # | City of Origin | Destination city | Dates of Travel |
| | | | | | | To |
| | | | | | | To |
| Human Exposure(s) | | | | | | |
| In the 21 days prior to symptom onset, was the case exposed to: | | | | | | |
| A confirmed case of Ebola disease? Yes No Unknown | | | | | | |
| If yes, specify the Epi Case ID: | | | | | | |
| When (dd/mm/yyyy): | | | | | | |
| Did the exposure occur in Canada? Yes No Unknown | | | | | | |
| If no, specify the country where the exposure occurred: | | | | | | |
| At the time of exposure, was the source case (confirmed or PUI) alive deceased? | | | | | | |
| Date of last contact with source case (dd/mm/yyyy): | | | | | | |
| Was the case in contact with the source case as a (check all that apply): | | | | | | |
| household contact caregiver to a family member sexual contact Health Care Worker(HCW) ¹ | | | | | | |
| Other: | | | | | | |
| In the 21 days preceding symptom onset, was the case hospitalized or have they spent time in a healthcare facility where cases of Ebola disease are being treated in a country/region with widespread and intense Ebola disease transmission? | | | | | | |
| Yes No Unknown | | | | | | |
| If yes, where: | | | | | | |
| If yes, when (dd/mm/yyyy): | | | | | | |

In the 21 days preceding symptom onset, was the case in contact with human remains in a country/region with widespread and intense Ebola disease transmission (e.g. funerals or burial rites)?

Yes No Unknown If yes, specify when (dd/mm/yyyy):

Did the contact with the human remains take place in Canada? Yes No

If no, then indicate the country in which the contact with the human remains took place:

Was personal protective equipment (PPE) used during contact with human remains? Yes No Unknown

If yes, was there a safety breach? Yes No Unknown

Occupational and Recreational Exposure(s)

The case is a (check all that apply):

Medevac staff

Consular employee

NGO/Aid worker

Expatriate worker

Mortician

Veterinary/animal worker/or game hunter

Laboratory worker – handling ebolavirus or processing body fluids from a case of Ebola disease

Mineworker

Prospector, specify:

Other, specify:

HCW¹, specify:

Animal exposure(s)

In the 21 days prior to symptom onset, did the case have contact with wild animals in a country/region with widespread and intense Ebola disease transmission

Yes No Unknown If yes, specify date of last direct contact (dd/mm/yyyy):

Country/City/Village:

In the 21 days prior to symptom onset, did the case consume bush meat Yes No Unknown

If yes, specify date(dd/mm/yyyy):

Country/City/Village:

What type of animals did the case have direct contact with? (check all that apply)

Primates Bats Other: Specify 'other' details

Did the animal display any symptoms of illness or was the animal dead? Yes No Unknown

Where did the direct contact occur? (check all that apply)

Home Work (fill in occupational section) Outdoor work / recreation (camping, hiking, hunting, etc)

Other Specify 'other' details

Mines/Cave exposure(s)

In the 21 days prior to symptom onset, did the case work or spend time in a mine/cave inhabited by bat colonies in a country/region with widespread and intense Ebola disease transmission?

Yes No Unknown

If yes, specify date of last contact (dd/mm/yyyy):

¹ Healthcare workers: defined as individuals who provide health care or support services, such as nurses, physicians, dentists, nurse practitioners, paramedics, some emergency first responders, allied health professionals, unregulated healthcare providers, clinical instructors and students, volunteers and housekeeping staff; have varying degrees of responsibility related to the health care they provide, depending on their level of education and their specific job/responsibilities.

Additional Details/Comments (add as necessary)**To be completed by the Public Health Agency of Canada**

| | |
|--------------------------------|-----------------------------------------------------------------------------------|
| Date received (dd /mm/yyyy) | PHAC Case ID: If case is related to a national outbreak, national outbreak ID: |
|--------------------------------|-----------------------------------------------------------------------------------|