



DISEASES OF PUBLIC HEALTH SIGNIFICANCE REPORTING FORM

(Previously Communicable Disease Reporting Form)

Please complete all applicable areas and **FAX** to the **Infectious Disease Program: FAX: 613-735-3067**
PHONE: 613-735-8653 or 1-800-267-1097 (Office Hours) | 613-735-9926 (After Hours)

Please Note: Regular office hours are:

Monday-Friday 8:30-4:30 (Sept-June), 8:00-4:00 (July & Aug)

FOR HEALTH UNIT USE ONLY

iPHIS Client ID:

iPHIS Case ID:

CLIENT INFORMATION

Last Name:		First Name:		HIN#:	
DOB (y/m/d):		Phone #:		Cell #:	
Address:			City:		Postal Code:
Parent/Guardian (if applicable):				Gender: <input type="radio"/> Male <input type="radio"/> Female	
Occupation:			Place of Employment:		
FAMILY PHYSICIAN:			Phone #:		Fax #:

DIAGNOSIS

Diagnosis:					
Date (y/m/d):			Date of Onset (y/m/d):		
Symptoms:					
DIAGNOSING PHYSICIAN:			Phone #:		Fax #:

LAB INFORMATION AND TREATMENT

Testing completed: <input type="radio"/> Yes <input type="radio"/> No		Specify Test(s):			
Collection Date (y/m/d):		Result(s):			
LAB REPORT TO FOLLOW: <input type="radio"/> YES <input type="radio"/> NO		Lab (Specify):			
Treatment: <input type="radio"/> Yes <input type="radio"/> No	Start Date (y/m/d):		End Date (y/m/d):		
Description of Treatment:					
Hospitalized: <input type="radio"/> Yes <input type="radio"/> No	Admitted Date (y/m/d):		Discharged Date (y/m/d):		
Name of Hospital:					
Underlying/Chronic Medical Conditions:					
Immunization Status: <input type="radio"/> Up-to-date <input type="radio"/> N/A <input type="radio"/> Unknown			Comments:		
Travel: <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unknown	Location:		Date (y/m/d):		
Complications:			Date of Death if applicable (y/m/d):		

Additional Comments:

REPORTING SOURCE

Name of Person Reporting:			Signature:		
Date (y/m/d):			Time:		
Agency:		Phone #:		Fax #:	