|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | | --- | | **Clinicians: submit completed form to Zone MOH/designate or FNIHB MOH/designate** | | | | | | | | | |
| **SECTION 1: PERSONAL IDENTIFIERS** | | | | | | | | |
| **Name:** *Last*  *Enter text here* | | | *First* *Enter text here* | | | | **Gender:** Male Female  Other Unknown | |
| **PHN:** *Enter text here* | | | **Birth Date:**  *mm/dd/yyyy* | | | | **Age:** *Enter text here* | |
| **Address:**  *Enter text here* | | | **Municipality:**  *Enter text here* | | | | **Postal Code:**  *Enter text here* | |
| **Province:**  *Enter text here* | | | **Country:**  *Enter text here* | | | | **Lives on Reserve**  No  Yes | |
| **SECTION 2: CASE DEFINITION** | | | | | | | | |
| **Preliminary MIS-C Case (Fever + A + B + C ± D)**  Fever (38.1 oC or greater) for 3 days or longer  **A. AND TWO OR MORE**  Rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands or feet)  Features of myocardial dysfunction, or pericarditis, or valvulitis, or coronary abnormalities (ECHO findings or elevated Troponin/NT-proBNP)  Hypotension or shock  Evidence of coagulopathy (abnormal PT, PTT, elevated d-Dimers)  Acute gastrointestinal problems (diarrhea, vomiting or abdominal pain)  **B. AND**  Elevated markers of inflammation such as ESR, C-reactive protein or procalcitonin  **C. AND**  No other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes (e.g., respiratory panel, strep throat, monospot, CMV IgM/IgG, EBV IgM/IgG, blood culture).  **D. WITH OR WITHOUT**  Evidence of COVID-19 or close contact with a case(s) of COVID-19  Confirmed COVID-19 test result (e.g., NAT/PCR+) and specimen collected date: *Choose a date*  COVID-19 serology result (e.g., IgG pos) and specimen collected date: *Choose a date*  Close contact with COVID-19 case(s)? *Enter text here* | | | | | | | | |
| **SECTION 3: CLINICAL FINDINGS** | | | | | | | | |
| **Onset Date:**  *Choose a date* | | | **Diagnosis Date:**  *Choose a date* | | | | | |
| **Hospitalized?** | | Yes 🡪 Admit date: *Choose a date* | | | | No | | Unknown |
| **Admitted to ICU?** | | Yes 🡪 Admit date: *Choose a date* | | | | No | | Unknown |
| **Current Disposition** | Convalescing  Deceased  Deteriorating  Recovered  Unknown | | **If Deceased:**  Death Date: *Choose a date* | | Died From disease  MIS-C contributed to death (secondary cause)  Died – other causes  Died – unknown cause | | | |
| **SECTION 4: REPORTING INFORMATION** | | | | | | | | |
| **Name of Submitter to MOH:** *Enter text here* | | | | **Date reported to MOH:** *Choose a date* | | | | |
| **Telephone number of Submitter:** *Enter text here* | | | |  | | | | |
| **Comments:** *Enter text here* | | | | | | | | |