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| **Clinicians: submit completed form to Zone MOH/designate or FNIHB MOH/designate**  |

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| **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* |