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| **FAX completed form to Alberta Health, CD: 780-415-9609** | | | | | | | | | | | | | | | | | | | **INITIAL REPORT**  **AMENDMENT** | |
| **SECTION 1: CASE DEFINITION** | | | | | | | | | | | | | | | | | | | | |
| **Confirmed Case:**  Enterovirus D68 | | | | | | | | | | | | | | | | | | | | |
| **SECTION 2: REPORTING INFORMATION** | | | | | | | | | | | | | | | | | | | | |
| **Date case investigation opened:** *Choose a date* | | | | | | | **Date reported to Alberta Health:**  *Choose a date* | | | | | | | | | | | | | |
| **Submitter:** Submitter Name | | | | | | | **FNIHB location Reporting:**  *Choose one* | | | | | | | | | | | | | |
| **Telephone number:** Enter telephone # | | | | | | | **Outbreak Associated?** No Yes **If Yes: EI#:** Enter EI# | | | | | | | | | | | | | |
| **SECTION 3: PERSONAL IDENTIFIERS** | | | | | | | | | | | | | | | | | | | | |
| **PHN:** Enter PHN | | | **Gender:** Male  Female  Other  Unknown | | | | | | | | | | | | **Birth Date:**  mm/dd/yyyy | | | | | |
| **Name:** *Last*  Enter Last Name | | | | | | | | *First* Enter First Name | | | | | | | | | | | | |
| **Address:**  Enter Address | | | | | **Municipality:**  Enter Municipality | | | | | | | | | **Postal Code:**  Enter Postal Code | | | | | | |
| **Province:**  Enter Province | | | | | **Country:**  Enter Country | | | | | | **Lives on Reserve** No Yes | | | | | | | | | |
| **Ethnicity:** | Caucasian  Black | First Nations  Inuit | | | | Métis  Latin American | | | Asian  Other Asian | | | Middle Eastern  Unknown | | | | | | | | Other,Specify: Enter Other |
| **SECTION 4: CLINICAL FINDINGS** | | | | | | | | | | | | | | | | | | | | |
| **Onset Date:**  *Choose a date* | | | | | | | | | | **Unable to contact**  **Lost to follow-up** | | | | | | | | | | |
| **Hospitalized?** | | | | | | | | | | Yes | | | No | | | | | Unknown | | |
| **Admitted to ICU?** | | | | | | | | | | Yes | | | No | | | | | Unknown | | |
| **Acute flaccid paralysis?** | | | | | | | | | | Yes | | | No | | | | | Unknown | | |
| **Severe respiratory illness?** | | | | | | | | | | Yes | | | No | | | | | Unknown | | |
| **Other: specify**  Enter Other | | | | | | | | | | | | | | | | | | | | |
| **Fatal** 🡪 Death Date:  *Choose a date* | | | | Died From disease  EV-D68 contributed to death (secondary cause) | | | | | | | | | | | | Died – other causes  Died – unknown cause | | | | |
| **SECTION 5: RISK FACTORS** | | | | | | | | | | | | | | | | | | | | |
| **History of asthma or other chronic respiratory illness?** | | | | | | | | | | Yes | | | No | | | | Unknown | | | |
| **Immunocompromised?** | | | | | | | | | | Yes | | | No | | | | Unknown | | | |
| **Comments:**  Enter Comments | | | | | | | | | | | | | | | | | | | | |