**Ontario Cholera Investigation Tool**

|  |  |
| --- | --- |
| **Legend** | **for interview with case ♦ System-Mandatory ❖ Required Personal Health Information** |

|  |  |  |
| --- | --- | --- |
| **Cover Sheet***Note that this page can be autogenerated in iPHIS* | | |
| Date Printed: YYYY-MM-DD  Bring Forward Date: YYYY-MM-DD  iPHIS Client ID #:  Enter number **♦** Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **♦** Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **♦** Investigator:  **Enter name \_ \_** **♦** DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **♦** Branch Office:  Enter office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **♦** Reported Date: YYYY-MM-DD  **❖**Diagnosing Health Unit:  Enter health unit Tel. 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **♦** Disease: CHOLERA Type: Home Mobile Work  **♦** Is this an outbreak associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes, *OB #* ####-####-###  No, *link to OB # 0000-2005-008 in iPHIS*  Is the client in a high-risk occupation/ environment?  Yes, specify: Specify  No | **♦** Client Name:  **Enter name \_ \_**  Alias:  **Enter alias \_ \_** | |
| **♦** Gender: Select an option | **♦** Age: **Age** |
| **♦** DOB:YYYY-MM-DD  Address:  **Enter address \_**  **Enter address \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**  Tel. 1:  **###-###-####**  Type:  Home  Mobile  Work  **Other, specify**  Tel. 2:  **###-###-####**  Type:  Home  Mobile  Work  **Other, specify**  Email 1: **Enter email address \_ \_**  Email 2:  **Enter email address \_ \_** | |
| Is the client homeless?  Yes  No  New Address:  **Enter address \_**  **♦** Language:  **Specify \_ \_**  Translation required*?*  Yes  No  **Proxy respondent**  Name:  **Enter name \_ \_**  Parent/Guardian  Spouse/Partner  Other  **Specify \_ \_** | **♦** Physician’s Name: **Enter name \_ \_**  **♦** Role**:**  Attending Physician  Family Physician  Specialist  Walk-In Physician  Other  Unknown  **OPTIONAL**  Additional Physician’s Name: **Enter name \_**  Address:  **Enter address \_**  Tel:  **###-###-####**  Fax:  **###-###-####**  Role:  **Enter role \_ \_** | |

|  |
| --- |
| **Verification of Client’s Identity & Notice of Collection** |
| Client’s identity verified?  Yes, *specify*:  DOB  Postal Code  Physician  No |
| **Notice of Collection**  *Please consult with local privacy and legal counsel about PHU-specific Notice of Collection requirements under*  *PHIPA s. 16*. *Insert Notice of Collection, as necessary.* |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Record of File** | | | | | |
| **♦ Responsible Health Unit** | **Date** | **♦ Investigator’s Name** | **Investigator’s Signature** | **Investigator’s Initials** | **Designation** |
| Specify | **❖**Investigation Start Date  YYYY-MM-DD | Specify | Specify | Specify | PHI  PHN  Other \_\_\_\_\_\_\_ |
| Specify | Assignment Date  YYYY-MM-DD | Specify | Specify | Specify | PHI  PHN  Other \_\_\_\_\_\_\_ |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Call Log Details** | | | | | | | |
|  | **Date** | **Start Time** | **Type of Call** | **Call To/From** | | **Outcome**  **(contact made, v/m, text, email, no answer, etc.)** | **Investigator’s initials** |
| Call 1 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 2 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 3 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 4 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 5 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Call 6 | YYYY-MM-DD |  | Outgoing  Incoming |  |  |  |  |
| Date letter sent: YYYY-MM-DD | | | | | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Case Details** | | | | | | | | |
| **♦ Aetiologic Agent** | *Vibrio Cholerae* | | | | | | | |
| **Subtype** | Select an option | | |  | | |  | |
| **♦ Classification** | Confirmed  Person Under Investigation  Probable  Does Not Meet Definition  *Do not close case as PUI* | | | | | **♦ Classification Date** | | YYYY-MM-DD |
| **♦ Outbreak Case Classification** | Confirmed  Person Under Investigation  Probable  Does Not Meet Definition  *Do not close case as PUI* | | | | | **♦ Outbreak Classification Date** | | YYYY-MM-DD |
| **♦ Disposition** | Complete  Closed- Duplicate-Do Not Use  Entered In Error  Lost to Follow Up  Does Not Meet Definition  Untraceable | | | | | **♦ Disposition Date** | | YYYY-MM-DD |
| **♦ Status** | Closed | | Initial here | | | **♦ Status Date** | | YYYY-MM-DD |
| Open (re-opened) | | Initial here | | | **♦ Status Date** | | YYYY-MM-DD |
| Closed | | Initial here | | | **♦ Status Date** | | YYYY-MM-DD |
| **♦ Priority** | High | Medium  Low | | | *(At health unit’s discretion)* | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptoms** | | | | | | | | | | |
| ***Incubation period*** *can range from a few hours to 5 days, usually 2-3 days.*  ***Communicability*** *can occur for the duration of the stool-positive stage, usually until 2-3 days after recovery, however, a carrier state may persist for months.* | | | | | | | | | | |
| ***Specimen collection date:*** YYYY-MM-DD | | | | | | | | | | |
| **♦ Symptom**  *Ensure that symptoms in* ***bold font*** *are asked* | **♦ Response** | | | | | | **❖ Use as Onset**  *(choose one)* | **❖ Onset Date**  YYYY-MM-DD | **Onset Time**  24-HR Clock  HH:MM  *(discretionary)* | **❖ Recovery Date**  YYYY-MM-DD  *(one date is sufficient)* |
| **Yes** | **No** | **Don’t Know** | **Not Asked** | | **Refused** |
| Asymptomatic |  |  | *Enter zero (0) for the duration days. DO NOT enter an Onset Date and DO NOT check the ‘Use as Onset’ box* | | | | | | | |
| Dehydration |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| **Profuse watery diarrhea with flecks of mucous (rice water diarrhea)**  *Enter as ‘Diarrhea, watery’* |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| Vomiting |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| Other (*specify)* |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| ***Note: This list is not comprehensive. There are additional symptoms listed in iPHIS.*** | | | | | | | | | | | |

|  |
| --- |
| ♦ **Complications** |
| None  Other  Renal Failure  Unknown |

|  |
| --- |
| **Incubation Period** |
| *Enter onset date, using this as day 0, then count back to determine the incubation period.* |
| - 5 days onset  Select a date Select a date |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Risk Factors** | **❖ Response** | | | | **Details**  *iPHIS character limit: 50* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖** Gastric achlorhydria *(low or no stomach acid)* |  |  |  |  | If yes, specify |
| **❖** Immunocompromised (specify) |  |  |  |  | If yes, specify |
| **❖** Other (specify) |  |  |  |  | If yes, specify |
| **❖** Persons with blood type ‘O’ |  |  |  |  | If yes, specify |
| **❖** Unknown |  |  | *→ For iPHIS data entry – check Yes for Unknown if all other Medical Risk Factors are No or Unknown.* | | |

|  |  |  |
| --- | --- | --- |
| **Hospitalization & Treatment** *Mandatory in iPHIS only if admitted to hospital* | | |
| Did you go to an emergency room? | Yes  No | If yes, Name of hospital: Enter name  Date(s): YYYY-MM-DD |
| **♦** Were you admitted to hospital as a result of your illness (not including stay in the emergency room)? | Yes  No  Don’t recall | If yes, Name of hospital: Enter name  ♦ Date of admission: YYYY-MM-DD  ❖ Date of discharge: YYYY-MM-DD  Unknown discharge date |
| *→ For iPHIS data entry – if the case is hospitalized enter information under Interventions.* | | |
| Were you prescribed antibiotics or medication for your illness? | Yes  No  Don’t recall | If yes, Medication: Enter name  Start date: YYYY-MM-DDEnd date: YYYY-MM-DD  Route of administration: Enter route Dosage: Enter dosage |
| Did you take over-the-counter medication? | Yes  No  Don’t recall | If yes, specify |
| *Treatment information can be entered in iPHIS under* ***Cases > Case > Rx/Treatments>Treatment*** *as per current iPHIS User Guide* | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Onset, Age and Gender**  *Complete this section if submission of pages 6-7 and 10 to Public Health Ontario is required* | | | | | |
| Date of Onset: | YYYY-MM-DD | Age: | **Age** | Gender: | Select an option |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Preliminary Questions** | **Response** | | | **Details** |
| **Yes** | **No** | **Unsure** |
| Do you have any idea how you became sick? |  |  |  | If yes, specify |
| Chronic carriers can harbor the *V. cholerae* bacteria unknowingly for several months without being ill. Have you had contact with anyone who is a known cholera carrier? |  |  |  | If yes, specify |
| Did you attend any special functions such as weddings, parties, showers, family gatherings or group meals in the 5 days prior to the onset of your illness? |  |  |  | If yes, specify *(e.g,. location, number attended, any ill)* |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Behavioural Social Risk Factors in the 5 days prior to onset of illness**  **Travel** | | **❖ Response** | | | | **Details**  *iPHIS character limit: 50* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖** Travel outside province in the 5 days prior to illness (specify) | |  |  |  |  |  |
| Within Canada |  |  |  |  | From: YYYY-MM-DD To: YYYY-MM-DD  Where: Specify |
| Outside of Canada |  |  |  |  | From: YYYY-MM-DD To: YYYY-MM-DD  Where: Specify  Hotel/Resort: Specify |
| ***Attention!*** *If the case travelled during the entire incubation period, you can skip the remainder of the behavioural social risk factor section and go to the* **High Risk Occupation/High Risk Environment** *section on page7. If the case travelled for part of their incubation period, please collect information for the behavioural social risk factors acquired in Canada.* | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Behavioural Social Risk Factors in the 5 days prior to onset of illness** | **❖ Response** | | | | **Details**  (e.g., Brand name, purchase/consumption location, product details, date of exposure)  *iPHIS character limit: 50.* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖** Close contact with a case |  |  |  |  | Specify |
| **❖** Close contact with visitors from abroad  *Please see here for* [*WHO's cholera country profiles*](http://www.who.int/cholera/countries/en/) |  |  |  |  | Specify |
| **❖** Consumption of shellfish  (specify) |  |  |  |  | Specify |
| **❖** Consumption of other seafood (specify) |  |  |  |  | Specify |
| **❖** Other (specify) *for all modes of transmission* |  |  |  |  | Specify |
| **❖** Poor hand hygiene |  |  |  |  | Specify |
| **❖** Unknown |  |  | *→ For iPHIS data entry – check Yes for Unknown if all other Behavioural Risk Factors are No or Unknown.* | | |
| **♦** CreateExposures  *Identify Exposures to be entered in iPHIS.*  *→ For iPHIS data entry – record details of exposure(s) in iPHIS Case Exposure Form as required.* | | |  | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **High Risk Occupation/High Risk Environment** | | | |
| Are you/ your child in a high risk occupation or high risk environment (including paid and unpaid/volunteer position)? | Yes  No | Childcare/kindergarten staff or attendees  Food handler  Health care provider  Other (specify)  Occupation: Specify | |
| Name of Childcare/Kindergarten/Employer | Enter name | | |
| Childcare/Kindergarten/Employer Contact Information (name, phone number, etc.) | Enter contact information | | |
| Address | **Enter address** | | |
| Are you/ your child still experiencing diarrhea? | Yes  No | Last day case attended childcare/kindergarten/work | YYYY-MM-DD |

|  |  |  |  |
| --- | --- | --- | --- |
| **High Risk Occupation/High Risk Environment** | | | |
| Exclusion required from childcare/kindergarten/work? | Yes  No | Case/Parent/Guardian advised that public health unit will contact childcare/ kindergarten/work? | Yes  No |
| Could we have your permission to release your/your child’s diagnosis to childcare/kindergarten/work? | Yes Enter name of individual permission granted by  No | | |
| *Refer to the current Infectious Diseases Protocol, Cholera chapter, Appendix A, Management of Cases section for exclusion pertaining to day care staff and attendees, food handlers, and health care providers.*  *→**For iPHIS data entry – if the case is excluded from work or childcare/kindergarten, enter information under Interventions.* | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Symptomatic/Asymptomatic Contact Information** | | | | | |
| **Are you aware of anyone who experienced similar symptoms before, during, or after you (or your child) became ill? This includes those in your family, household, childcare or kindergarten class, sexual partner(s), friends or coworkers.** | | | | Yes  No  N/A | |
| Contact 1 | | | | | |
| Name | Enter name | | Relation to case | | Specify |
| Contact information  (phone, address, email) | Enter contact information | | | | |
| Notes | Enter notes | | | | |
| Recommend contact seek medical attention/testing? | | Yes  No  N/A | | | |
| Contact 2 | | | | | |
| Name | Enter name | | Relation to case | | Specify |
| Contact information  (phone, address, email) | Enter contact information | | | | |
| Notes | Enter notes | | | | |
| Recommend contact seek medical attention/testing? | | Yes  No  N/A | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Education/Counselling** *Discuss the relevant sections with case* | | | |
| **Vaccination** |  | Oral vaccination should be considered for persons travelling to endemic high-risk areas. |
| **Travel-Related Illness** |  | Refer to the Government of Canada’s Travel Health and Safety Page: [www.phac-aspc.gc.ca/tmp-pmv/info/index-eng.php](http://www.phac-aspc.gc.ca/tmp-pmv/info/index-eng.php). |
|  | In areas where hygiene and sanitation are inadequate:   * Bottled water from a trusted source is recommended instead of tap water. Use bottled water for drinking, preparing food and beverages, making ice, cooking, and brushing teeth. Alternatively, water can be boiled, chemically disinfected or filtered. Instructions for each method should be consulted. * Avoid salads, already peeled or pre-cut fresh fruit, uncooked vegetables, and unpasteurized milk and milk products, such as cheese. * Eat only food that has been fully cooked and is still hot, and fruit that has been washed in clean water and then peeled by the traveler. Avoid buying ready to eat foods from a street vendor. |
|  | Accidental ingestion or contact with recreational water from lakes, rivers, and oceans can cause many enteric illnesses. |
| **Food Safety** | |  | Avoid preparing or serving food while ill with diarrhea. Thus, there is still the potential for transmission after diarrhea has resolved. Consider reassignment of duties. |
|  | Proper cooking temperatures for all food.   * Shellfish should be boiled or steamed for at least 10 minutes before consumption. * Cook raw foods according to instructions. |
|  | Prevent cross contamination when preparing/handling food. |
|  | Left-over shellfish and seafood should be thoroughly reheated to an internal temperature of 70° Celsius for at least 15 seconds. |
| **Hand Hygiene** | |  | Wash hands with soap and water after using the bathroom, after changing diapers, handling animals or pet food, and before preparing meals or eating meals is shown to be an effective measure to reduce transmission of diseases.  Duration of excretion of the pathogen can persist for a few days after recovery. Occasionally excretion can occur for several months. |
| **Recovery** | |  | If you continue to feel unwell, or new symptoms appear, or symptoms change – seek medical attention |
| **Water** | |  | Avoid swimming or using a pool/spa, hot tub or splash pad if ill with diarrhea. |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Outcome** *Mandatory in iPHIS only if Outcome is Fatal* | | | | | |
| **Outcome** | Unknown  ♦ Fatal  Ill  Pending  Residual effects  Recovered | | | ♦ **Cause(s) of** **Death?**  *If fatal, complete disposition type and facility name in iPHIS* | Specify |
| *If fatal, complete section below under Outcome* | | | | | |
| ♦ **Disposition type** | Crematorium  Other  Funeral Home  Unknown  Morgue | | | ♦**Facility Name** |  |
| ♦ **Type of Death** | Reportable Disease Contributed to but was Not the underlying cause of death  Reportable Disease was the Underlying cause of Death  Reportable Disease was Unrelated to the cause of Death  Unknown | | | | |
| **Outcome Date** | YYYY-MM-DD | **Date Accurate** | Yes Specify source (e.g., death certificate)  No | | |

|  |
| --- |
| **Thank you** |
| Thank you for your time. This information will be used to help prevent future illnesses caused by cholera. Please note that another investigator may contact you again to ask additional questions if it is identified that there is a possibility that you are included in an outbreak. |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Interventions** | | | | |
| **❖ Intervention Type** | **Intervention implemented (check all that apply)** | **Investigator’s initials** | ♦ **Start Date**  **YYYY-MM-DD** | **❖ End Date**  **YYYY-MM-DD** |
| Counselling |  |  | **YYYY-MM-DD** | **YYYY-MM-DD** |
| Education  (e.g., disease fact sheet, general food safety chart/cooking temperature chart, hand washing information) |  |  | YYYY-MM-DD | YYYY-MM-DD |
| ER visit |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Exclusion |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Food Recall |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Hospitalization |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Letter - Client |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Letter - Physician |  |  | YYYY-MM-DD | YYYY-MM-DD |
| Other (i.e., contacts assessed, PHI/PHN contact information) |  |  | YYYY-MM-DD | YYYY-MM-DD |
| *→**For iPHIS data entry – enter information under* ***Cases > Case > Interventions.*** | | | | |

|  |
| --- |
| **Progress Notes** |
| **Enter notes** |

If you have any comments or feedback regarding this Investigation Tool, please email us at [ezvbd@oahpp.ca](mailto:ezvbd@oahpp.ca).