**Ontario Paralytic Shellfish Poisoning Investigation Tool**

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

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| **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: PARALYTIC SHELLFISH POISONING Type: Home Mobile Work  **♦** Is this an outbreak associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes, *OB #* ####-####-###  No, *link to OB # 0000-2013-011 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 \_ \_** | |

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| **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.* |

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| **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 \_\_\_\_\_\_\_ |

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| **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 | | | | | | | |

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| **Case Details** | | | | | |
| **♦ Aetiologic Agent** | Gonyautoxins  Paralytic Shellfish Poisoning Toxins  Saxitoxin Producing Dinoflagellates | | | | |
| **Subtype** | Specify | | **Further Differentiation** | Specify | |
| **♦ 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)* | | | | |
| **Lab specimens**  *Contact your local CFIA office and/or the Ontario Area Recall Coordinator to discuss submission of shellfish or other seafood for possible analysis.* | Is the client willing to submit food sample?  Yes  No  Enter notes here | | | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Specimen Type  e.g., shellfish/ seafood | Collection Date | Result Date | Result | Comments | | Specify | YYYY-MM-DD | YYYY-MM-DD | Specify | Comments | | Specify | YYYY-MM-DD | YYYY-MM-DD | Specify | Comments | | Specify | YYYY-MM-DD | YYYY-MM-DD | Specify | Comments | | Specify | YYYY-MM-DD | YYYY-MM-DD | Specify | Comments | | | | | |

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| **Symptoms** | | | | | | | | | | |
| ***Incubation period*** *can range from less than a minute to 12 hours, usually 30 minutes to 12 hours.* | | | | | | | | | | |
| ***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** |
| **Ataxia [loss of coordination/ balance]** |  |  |  |  | |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Diarrhea |  |  |  |  | |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Dizziness** |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| Swallowing difficulity [dysphagia] |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| **Paresthesia [tingling, numbness or burning]** |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| Slurred speech |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| Nausea |  |  |  | |  |  |  | YYYY-MM-DD | HH:MM | YYYY-MM-DD | |
| Respiratory paralysis |  |  |  | |  |  |  | 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.*** | | | | | | | | | | | |

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| ♦ **Complications** |
| Other  Respiratory failure |

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| **Incubation Period** |
| *Enter onset date and time, using this as day 0, then count back to determine the incubation period.* |
| - 12 hours onset  Select a date & time Select a date & time |

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| **❖ Medical Risk Factors** | **❖ Response** | | | | **Details**  *iPHIS character limit: 50.* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| Other (specify) |  |  |  |  | If yes, specify |
| Unknown |  |  | *→ For iPHIS data entry – check Yes for Unknown if all other Medical Risk Factors are No or Unknown.* | | |

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| **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 any 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* | | |

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| **Date of Onset, Age and Gender**  *Complete this section if submission of pages 6-7 and 10-11 to Public Health Ontario is required* | | | | | |
| Date of Onset: | YYYY-MM-DD | Age: | **Age** | Gender: | Select an option |

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| **Preliminary Questions** | **Response** | | | **Details** |
| **Yes** | **No** | **Unsure** |
| Do you have any idea how you became sick? |  |  |  | If yes, specify |
| Did you attend any special functions such as weddings, parties, family gatherings or group meals where shellfish or seafood were served in the 12 hours prior to the onset of your illness? |  |  |  | If yes, specify *(e.g., location, number attended, any ill)* |

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| **Behavioural Social Risk Factors in the 24 hours prior to onset of illness**  **Travel** | | **❖ Response** | | | | **Details**  *Shellfish/seafood are not grown in Ontario as they are marine-water inhabitants. Canadian federal authorities conduct a monitoring and prevention program for toxins found in shellfish/seafood. It is important to be able to identify the location from where the shellfish/seafood were obtained in order to be able to report this to the CFIA.*  *iPHIS character limit: 50.* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖** Travel outside province in the 24 hours 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* ***Symptomatic/Asymptomatic Contact Information*** *section on page 8. If the case travelled for part of their incubation period, please collect information for the food items consumed in Canada.* | | | | | |

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| **Behavioural Social Risk Factors in the 24 hours prior to onset of illness**  **Foodborne** | | **❖ Response** | | | | **Details**  (e.g., Brand name, purchase/consumption location, product details, date of exposure)  *iPHIS character limit: 50.* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖** Consumption of shellfish  *(i.e., bivalve mollusks - shellfish with two shells, hinged together along one side)* | |  |  |  |  | Specify |
| Clams, oysters, mussels, scallops and cockles (specify) |  |  |  |  | Specify |
| **❖** Consumption of tomalley or hepatopancreas of crustaceans  *(i.e., the soft green substance inside the body cavity)* | |  |  |  |  | Specify |
| **❖** Consumption of other seafood (specify) | |  |  |  |  | Specify |
| Crabs, lobsters, whelks, moon snails and dogwinkles (specify) |  |  |  |  | Specify |
| **❖** Other (specify) | |  |  |  |  | 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.* | | | |  | | |

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| **Premises Referral** | | |
| Has a food premises been identified as a possible source? | Yes    No | *If yes, refer premises to the Food Safety Program and create an exposure as appropriate.* |

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| **Symptomatic/Asymptomatic Contact Information** | | | | | |
| **Are you aware of anyone who experienced similiar symptoms before, during, or after you became ill? This includes those in your family, household, child care or kindergarten class, 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 | | | |

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| **Education/Counselling** *Discuss the relevant sections with case* | | |
| **Food Safety** |  | Purchase shellfish from reputable suppliers - all shellfish should have a tag verifying federal inspection. |
|  | Health Canada recommends that children not eat lobster tomalley or hepatopancreas (the soft green substance inside the body cavity), and that adults restrict their consumption of lobster tomalley to no more than the amount from one cooked lobster per day. |
|  | Eat only food that has been fully cooked and is still hot. |
|  | Proper cooking temperatures for all food.   * Although it won’t prevent Paralytic Shellfish Poisoning, shellfish should be boiled or steamed for at least 10 minutes before consumption to prevent other diseases. |
| **Travel-related Illness** |  | PSP occurs worldwide. It is common in shellfish harvested from waters above 30oN (north of Florida) and below 30oS, but may also be found in shellfish from tropical waters. PSP is uncommon in North America. Small clusters have been reported mainly in coastal locations. |
| **Recovery** |  | If you continue to feel unwell, or new symptoms appear, or symptoms change – seek medical attention. |

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| **Outcome** *Mandatory in iPHIS only if Outcome is Fatal* |
| Unknown  ♦ Fatal  Ill  Pending  Residual effects  Recovered  *If fatal, please complete additional required fields in iPHIS* |

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| **Thank you** |
| Thank you for your time. This information will be used to help prevent future illnesses caused by Paralytic Shellfish Poisoning. 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. |

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| **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) |  |  | 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.*** | | | | |

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

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| **Shopping Venues** *Optional for sporadic cases* | | | | |
| **Where do you usually purchase food for home consumption (include grocery stores, farmers markets, specialty stores, ethnic markets, food banks, etc.)?** | | | | |
| **Types of food premises** | **Response** | | | **Name(s), Address(es) and Date(s) of purchase** |
| **Yes** | **No** | **Don’t know** |
| Grocery store/supermarkets/food warehouse (e.g., Costco)  If yes, do you use any loyalty cards at the grocery stores identified (e.g., Costco membership, PC points, etc.)?  Yes  No  Don’t know |  |  |  | Specify |
| Ethnic specialty markets |  |  |  | Specify |
| Fish shop |  |  |  | Specify |
| Farmer’s market |  |  |  | Specify |
| Other |  |  |  | Specify |

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