**Ontario Giardiasis** **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: GIARDIASIS Type: Home Mobile Work  **♦** Is this an outbreak associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes, *OB #* ####-####-###  No, *link to OB # 0000-2005-014 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** | | Giardia lamblia/ intestinalis/ duodenalis | | | | | | | | | | | | | | | | |
| **Subtype** | | Specify | | | | | | | | | **Further Differentiation** | | | Specify | | | | |
| **♦ Classification** | | Confirmed  Probable  Does Not Meet Definition | | | | | | | | | | | | **♦ Classification Date** | | | YYYY-MM-DD | |
| **♦ Outbreak Case Classification** | | Confirmed  Probable  Does Not Meet Definition | | | | | | | | | | | | **♦ 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 3-25 days or longer, usually about 7-10 days.*  ***Communicability:*** *Duration of cyst excretion is variable but can range from weeks to months. Giardiasis is communicable for as long as the infected person excretes cysts.* | | | | | | | | | | | | | | | | | |
| ***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 |  | |  | Note: Asymptomatic cases do not meet the case definition.  *Enter zero (0) for the duration days. DO NOT enter an Onset Date and DO NOT check the ‘Use as Onset’ box* | | | | | | | | | | | | | | | |
| Abdominal bloating or flatulence |  | |  |  |  | | |  |  | | | YYYY-MM-DD | | | HH:MM | YYYY-MM-DD | | | |
| Abdominal Pain |  | |  |  |  | | |  |  | | | YYYY-MM-DD | | | HH:MM | YYYY-MM-DD | | | |
| **Diarrhea** |  | |  |  | |  | |  |  | | | YYYY-MM-DD | | | HH:MM | YYYY-MM-DD | | | |
| Stool, Greasy |  | |  |  | |  | |  |  | | | 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  Unknown |

|  |
| --- |
| **Incubation Period** |
| - 25 days - 3 days Onset  Select a date Select a date Select a date & time |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Medical Risk Factors** | **❖ Response** | | | | **Details**  *iPHIS character limit: 50* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖**Immunocompromised (specify)  (e.g., by medication or by disease such as cancer, diabetes, etc.) |  |  |  |  | If yes, specify |
| **❖**Other (specify)  (e.g., use of antacid, surgery, etc.) |  |  |  |  | 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 5-6 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 |
| Were you on any specific diet(s) in the 3-25 days prior to the onset of your illness (e.g., vegetarian, vegan, gluten-free, kosher, halal, etc.)? |  |  |  | If yes, specify |
| Did you attend any special functions such as weddings, parties, showers, family gatherings or group meals in the 3-25 days prior to the onset of your illness? |  |  |  | If yes, specify *(e.g., location, number attended, any ill)* |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Behavioural Social Risk Factors in the 3-25 days prior to onset of illness**  **Travel** | | **❖ Response** | | | | | | **Details**  *iPHIS character limit: 50.* | | |
| **Yes** | **No** | **Unknown** | | **Not asked** | |
| **❖** Travel outside province in the last 3-25 daysprior 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 page 7. 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 3-25 days prior to onset of illness**  **Residential drinking water source** | | | **❖ Response** | | | | | | | **Details**  (e.g., Brand name, purchase/consumption location, product details, date of exposure)  *iPHIS character limit: 50.* |
| **Yes** | | **No** | | **Unknown** | | **Not asked** |
| **❖** Private water system  (specify if treated, e.g., Brita, boiled, UV light, on tap filter, reverse osmosis, etc.) | | |  | |  | |  | |  | Specify |
| **❖** Municipal water system  (specify if treated, e.g., Brita, boiled, UV light, on tap filter, reverse osmosis, etc.) | | |  | |  | |  | |  | Specify |
| Waterborne | | | | | | | | | | |
| **❖** Swim or contact with water from lakes, rivers, streams in Ontario *(specify location)* | | |  | |  | |  | |  | Specify |
| **❖**Swim or contact with water from swimming pools, hot tubs, wading pools or water parks in Ontario *(specify location)* | | |  | |  | |  | |  |  |
| Foodborne | | | | | | | | | | |
| **❖** Consumption of raw vegetables (specify) (e.g., spinach, green leaf lettuce, romaine lettuce, green onion, broccoli, carrots) | | |  | |  | |  | |  | Specify |
| **❖** Consumption of raw fruits (specify) (e.g., strawberries, tomatoes) | | |  | |  | |  | |  | Specify |
| **❖** Consumption of fresh herbs (specify) (e.g., fresh basil, fresh parsley) | | |  | |  | |  | |  | Specify |
| **❖** Consumption of ready-to-eat, pre-washed, or pre-made salads  E.g., pre-washed leafy greens in bags or packages; lettuce or leafy greens salad kits with toppings and dressing; ready-to-eat salads sold at the grocery store deli counter or fast food restaurant | | |  | |  | |  | |  | Specify |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Behavioural Social Risk Factors in the 3-25 days prior to onset of illness**  Zoonotic | **❖ Response** | | | | **Details**  (e.g., Brand name, purchase/consumption location, product details, date of exposure)  *iPHIS character limit: 50.* |
| **Yes** | **No** | **Unknown** | **Not asked** |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **❖** Contact with animals, e.g., pets, farm animals or (petting) zoo |  | |  |  | |  | Specify |
| Other Modes of Transmission | | | | | | | |
| **❖** Anal-oral contact |  | |  |  | |  | Specify |
| **❖** Close contact with case |  | |  |  | |  | Specify |
| **❖** Poor hand hygiene |  | |  |  | |  | Specify |
| **❖** Other (specify) *for all modes of transmission* |  | |  |  | |  | 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.* | | | | | | | |
| **Premises Referral** | | | | | | | |
| Has a food premise(s) been identified as a possible source? | | Yes    No | | | *If yes, refer premises to the Food Safety Program and create an exposure as appropriate.* | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **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 | Child care/kindergarten staff or attendees  Food handler  Health care provider  Other (specify)  Occupation: Specify | |
| Name of Child care/Kindergarten/Employer | Enter name | | |
| Child care/Kindergarten/Employer Contact Information (name, phone number, etc.) | Enter contact information | | |
| Address | **Enter address** | | |
| **High Risk Occupation/High Risk Environment** | | | |
| Are you/ your child still experiencing diarrhea? | Yes  No | Last day case attended child care/kindergarten/work: | YYYY-MM-DD |
| Exclusion required from child care/kindergarten/work? | Yes  No | Case/Parent/Guardian advised that public health unit will contact child care/ kindergarten/work? | Yes  No |
| Could we have your permission to release your/ your child’s diagnosis to child care/kindergarten/work? | Yes Enter name of individual permission granted by  No | | |
| *Refer to the current Infectious Diseases Protocol, Giardiasis 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 child care/kindergarten enter information under Interventions.* | | | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Symptomatic 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, child care 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* | | | | | | | |
| **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. | | | | | |
|  | The duration of parasite excretion can range from weeks to months. | | | | | |
| **Recovery** |  | If you continue to feel unwell, or new symptoms appear, or symptoms change – seek medical attention. | | | | | |
| **Water** |  | Avoid using recreational water venues such as swimming pools, lakes and rivers for two weeks after symptoms resolve. | | | | | |
|  | If using well water, test water regularly as water quality can change frequently. If results are adverse, boil or treat water for consumption. | | | | | |
|  | If using surface water, boil or treat if testing is not readily available (e.g., while camping) or if test results indicate the water is unsafe for consumption. | | | | | |
|  | For more information on small drinking water systems and well disinfection, please visit  https://www.ontario.ca/page/drinking-water  and Public Health Ontario’s [Well Disinfection Tool](http://www.publichealthontario.ca/en/ServicesAndTools/Tools/Pages/Well-Disinfection-Tool.aspx) at <http://www.publichealthontario.ca/en/ServicesAndTools/Tools/Pages/Well-Disinfection-Tool.aspx>. | | | | | |
| **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 and uncooked vegetables. * 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, oceans, and inadequately treated swimming pools can cause many enteric illnesses. | | | | | |
| **Sexual Transmission** |  | Certain sexual activities increase the risk of transmission.   * Avoid anal-oral sexual contact. *Giardia* can be transmitted as long as the person is infected. | | | | | |
|  | Review importance of personal hygiene. | | | | | |
| **Animals** |  | Wash your hands after handling animals, especially cats and dogs, their feces, and the living environment such as cages, pens, etc. Cattle and beavers are also known to carry *Giardia*. | | | | | |

|  |  |  |
| --- | --- | --- |
| **Education/Counselling** *Discuss the relevant sections with case* | | |
| **Food Safety** |  | Avoid preparing or serving food while ill with diarrhea. Consider reassignment of duties. |
|  | Thoroughly cooking or baking fruits and vegetables will eliminate the risk of *Giardia* infection. |
|  | Freezing fruits and vegetables may kill parasites. |
|  | Prevent cross contamination when preparing/handling food:   * Clean raw vegetables and fruit including those used as garnishes |
|  | Produce should be washed thoroughly using potable water before it is eaten, although this practice does not eliminate the risk of *Giardia*. |

|  |
| --- |
| **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* |

|  |
| --- |
| **Thank you** |
| Thank you for your time. This information will be used to help prevent future illnesses caused by *Giardia*. 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).