Leeds, Grenville & Lanark District HEALTH UNIT

MENINGITIS / ENCEPHALITIS REPORTING FORM
EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

REPORTING SOURCE		iPHIS CASE NUMBER:	
Name:	Agency:		
Phone #:	Date (y/m/d):	Time:	
CLIENT INFORMATION			
Last Name:	First Name:		Gender:
Phone #:	DOB (y/m/d):		
Address:	City:	Postal Code:	
Occupation:			
Residency/Attendance at a Facility or Institution:			
Name of Parent/Guardian (if applicable):		Cell/Work #:	
HEALTH CARE PROVIDER:	Phone #:	Fax #:	
LAB INFORMATION AND TREATMENT			
Testing from sterile site: Yes ☐ No ☐	Site:		
	Date (y/m/d):	Result:	
Treatment: Yes ☐ No ☐	Start Date (y/m/d):	End Date (y/m/d):	
Antibiotic (dose, route, frequency, duration):			
CASE DETAILS			
Doctor who made diagnosis:		Phone #:	
Onset Date (y/m/d):	Date of Diagnosis (y/m/d):		
Depending on infectious agent (bacterial)			
Earliest Exposure Date (y/m/d):	Latest Exposure Date (y/m/d):		
Immunization (depending on infectious agent): Yes ☐ No ☐ Date (y/m/d):			
Symptoms:			
Travel History:			
Hospitalized: Yes ☐ No ☐	Admitted (y/m/d):	Discharged (y/m/d):	
Name of Hospital:			
Complications:		Outcome:	
RISK FACTORS			
☐ Alcohol abuse ☐ Drug use ☐ Under housed/homeless ☐ Immunocompromised ☐ Not immunized ☐ Pregnant			
☐ Chronic illness (specify):			
FOLLOW-UP			
☐ Education to case and contacts about illness and prevention of transmission			

Personal information on this form is collected under the authority of the Health Protection and Promotion Act R.S.O. 1990, c. H.7.

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FOR HEALTH UNIT USE ONLY				
NOTES (Response/Assessment/Intervention/Plan)			**INVESTIGATOR:**	
			iPHIS Client #:	
DATE	**TIME**		**iPHIS Case/Incident #:**	
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
		Notes taken by: Notes:		
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