MENINGOCOCCAL, INVASIVE 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:	
Name of Parent/Guardian (if applicable):			
Occupation:	Place of Employment:		
HEALTH CARE PROVIDER:	Phone #:	Fax #:	

LAB INFORMATION AND TREATMENT			
Specimen Site (normally sterile site)	**Result**	**Collection date (y/m/d)**	**Reported date (y/m/d)**
Antibiotic Treatment (dose, route, frequency, duration)		**Treatment start date (y/m/d)**	**Treatment end date (y/m/d)**

CASE DETAILS			
Doctor who made diagnosis:			Phone #:
Onset Date (y/m/d):	Date of Diagnosis (y/m/d):		
Symptoms (i.e. fever, headache, photophobia, n&v, stiff neck, impaired consciousness, rash, etc.):			
Possible source of infection:			
History of travel/location/dates:			
Immunization up-to-date: Yes ☐ No ☐	1st Dose (y/m/d):	2nd Dose (y/m/d):	
Hospitalized: Yes ☐ No ☐	Admitted (y/m/d):	Discharged (y/m/d):	
Name of Hospital:			
Complications:			Outcomes:

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RISK FACTORS	
For disease acquisition:	
☐ Communal residency	☐ Injection/inhalation drug use
☐ Immunocompromised (specify)	
☐ Complement, Properdin or Factor D deficiency	☐ Functional or anatomic asplenia
☐ Pregnant	☐ Receipt of cochlear implant
☐ Unknown	☐ Recent upper respiratory tract infection (<2 weeks)
☐ Other	
For disease transmission:	
☐ Work for vulnerable populations	☐ Daycare attendee or worker
☐ Health Care Provider	☐ Direct contact with immunocompromised patients and/or infants less than one year of age

TIMELINE PROPHYLAXIS		
ONSET DATE minus 7 DAYS (y/m/d)	**ONSET DATE (y/m/d)**	**24 HRS POST TREATMENT DAY (y/m/d)**

☐ **Consider anyone who had contact within 7 days prior to the case becoming ill & up to 24 hours following the start of appropriate treatment.**

CLOSE CONTACTS (*identified according to protocol*):

Ensure all close contacts are offered prophylactic antibiotics as soon as possible; preferably within 24 hours (see protocol for recommended chemoprophylaxis.) Provide counseling and education re: the risk of disease, the signs and symptoms to watch for and information on the prophylactic antibiotic.

NOTE: In addition to prophylaxis, close contacts should receive immunization with the serogroup-specific meningococcal vaccine where indicated.

NAME	AGE	RELATIONSHIP/HCW/DAYCARE	PHONE #

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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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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