PNEUMOCOCCAL DISEASE, 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:
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):	
Pneumococcal immunization? Yes ☐ No ☐		**Date (y/m/d):**
Symptoms:		
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
☐ Chronic illness (specify)
☐ Not immunized for Pneumococcal ☐ Pregnant ☐ Unknown ☐ Other (specify)

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:		
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