REPORTABLE DISEASE NOTIFICATION FORM

EMAILS WILL NOT BE ACCEPTED FAX: 613-345-5777

After hours, weekends & statutory holidays, please call and the answering service will notify the person on-call.

	FOR HEALTH UNIT USE ONLY	
	IPHIS CASE ID:	**IPHIS CLIENT ID:**

REPORTING SOURCE		
Name:	Report Date (y/m/d):	Time:
Agency:	Phone #:	
Fax #:	Cell #:	

CLIENT INFORMATION			
Last Name:	First Name:		Gender:
DOB (y/m/d):	Phone #:	Cell #:	
Address:	City:	Postal Code:	
Name of Parent/Guardian (if applicable):			
Occupation:	Place of Employment:		
FAMILY PHYSICIAN:	Phone #:	Fax #:	

DIAGNOSIS	
Diagnosis:	Date of Diagnosis (y/m/d):
Symptoms:	Onset Date (y/m/d):
DIAGNOSING PHYSICIAN:	
Phone #:	Fax #:

LAB INFORMATION AND TREATMENT		
Testing completed: YES ☐ NO ☐	Specify test(s):	
Collection Date (y/m/d):	Result(s):	
Treatment: YES ☐ NO ☐	Start Date (y/m/d):	End Date (y/m/d):
Description of Treatment:		
Hospitalized: YES ☐ NO ☐	Admitted Date (y/m/d):	Discharged Date (y/m/d):
Name of Hospital:		
Risk Factors:		
Immunization Status:		
Complications:	Date of Death if applicable (y/m/d):	
LAB REPORT TO FOLLOW: YES ☐ NO ☐		