Health Canada Santé Canada

CONFIDENTIAL

First Nations and Inuit Health – Ontario Region
Reportable Disease Contact Tracing Form

(For STIs use STI Contact Tracing Form)

DISEASE:

FNIH-OR Case #:

CONTACT INFORMATION

Last Name:	First Name:	Initial(s):
DOB: D D M M M Y Y Y Y	If child, parent's name:	
Phone:	Age :	Gender: ❒ Male ❒ Female ❒ Unknown
Community:		Pregnant: ❒ Yes ❒ No ❒ Unknown
Address:		If yes, LNMP: D D M M M Y Y Y Y
Postal code: | | | | | | |		

EXPOSURE INFORMATION

Relationship to case: **Date of last contact:** D D M M M Y Y Y Y

Type of exposure: Household ❒ Close ❒ Casual ❒

Attends: School ❒ Day care ❒ Stay at home ❒ Private day care ❒ Works ❒ Other ❒

Name of establishment: _____	Name of establishment: _____
Address: _____	Address: _____
Phone: _____	Phone: _____
Grade/Occupation: _____	Grade/Occupation: _____
Last day attended school/work: _____	Last day attended school/work: _____

Outbreak associated: ❒ YES ❒ NO Province case # (if applicable): _____(if yes, notify CD nurse)

CLINICAL INFORMATION

SYMPTOMS	**ONSET DATE** (DD/MMM/YYYY)	**DATE RESOLVED** (DD/MMM/YYYY)

MEDICAL CONSULTATION / REFERRAL

Physician name: _____ Telephone: _____

Address: _____

Testing done: ❒ YES ❒ NO ❒ Not Known **Date Tested:** D D M M M Y Y Y Y

Result: _____ **Tested by:** _____

TREATMENT

Medication	Dose	Duration	Start Date (DD/MMM/YYYY)	Comments:

VACCINATION STATUS ❒ **Complete** ❒ **Up-to-date** ❒ **Incomplete**

Nursing Notes:

Name of reporting facility: _____ Date: D D M M M Y Y Y Y

CHN Name (printed): _____ CHN Signature: _____