Vancouver CoastalHealth
Promoting wellness. Ensuring care.

PARIS
PRIMARY ACCESS
Regional Information System

CD ASSESSMENT

Name:		**Team:**
DOB:	**Age:**	**PARIS ID:**
Gender:		**PHN:**

Header Details

Date Started:
Carried Out By:
Recorded By:
End Date:
Assessment ID:
Assoc. Referral ID:

Lab Reports

Date Reported	Specimen Date	Disease	Subtype	Report Source

Follow Up

Interview Date:
Case History Provided By:
First Name:
Last Name:
Phone Number:
Alternate Number:
Outbreak: ☐ Yes ☐ No
Outbreak setting:
Specify:
Premises #:
Outbreak #:
Infectious Agent or Toxin:
Clinical Case?: ☐
Total Number in Household?:
Any others in the house ill?: ☐ Yes ☐ No ☐ N/A
Any visitors to home?: ☐ Yes ☐ No ☐ Unknown

Do any household or known contacts attend/work at a Preschool/School, Child Care, Health Care, Other Facility or in Food Services?

☐ Yes ☐ No ☐ Unknown

Comments (Provide details if others in the house are ill, or attend/work in a sensitive environment):

Case Currently Resides in or Attends

☐ School - Primary
☐ School - Secondary
☐ School - Post Secondary
☐ Child Care
☐ Other If OTHER, Specify:
☐ Correctional Facility
☐ Health Care Facility
☐ Treatment Facility
☐ Group Home

Comments (Provide details regarding any facilities that the case resides in or attends)

Is the case currently breast feeding? ☐ Yes ☐ No ☐ Unknown
Has the case ever donated blood, organs, or semen? ☐ Yes ☐ No ☐ Unknown

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Comments (Provide details of where and when the case donated blood/organs/semen)

Other Follow Up Comments

Contact With Case

Contact with Case ☐ Confirmed ☐ Clinical ☐ Suspect ☐ Unknown

First Name: Last Name:

City (BC): City (Other):

Phone Number: Alternate Number:

Place of Exposure: If OTHER, Specify:

Exposure Risk: If OTHER, Specify:

Comments

Travel

Travel: ☐ Yes ☐ No Travelled With:

Destination 1

From: To Mode of Transportation:

City/Location: City (BC):

Country:

Province:

Destination 2

From: To Mode of Transportation:

City/Location: City (BC):

Country:

Province:

Destination 3

From: To Mode of Transportation:

City/Location: City (BC):

Country:

Province:

Received pre-travel advice? ☐ Yes ☐ No ☐ Unknown

Specify

Received pre-travel antimicrobial prophylaxis? ☐ Yes ☐ No ☐ Unknown

Specify

Received pre-travel vaccination? ☐ Yes ☐ No ☐ Unknown

Specify

Refugee? ☐ Yes ☐ No ☐ Unknown

Date arrived in Canada Country

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Any food items brought back? ☐ Yes ☐ No

Specify

Comments

Signs and Symptoms

Date of Onset: Unknown? ☐ Asymptomatic ☐

Communicable From: To:

General	Date of Onset	Time of Onset	Date of Onset	Time of Onset
☐ Altered Mental Status				
☐ Arthalgia/Arthritis				
☐ Chest Pain				
☐ Chills				
☐ Conjunctivitus				
☐ Disorientation				
☐ Dizziness				
☐ Epiglottitis				
Fatigue ☐ Yes ☐ No				
☐ Fever				
Temp C Puerpural ☐				
☐ Headache				
☐ Lethargy				
Loss of Appetite ☐ Yes ☐ No				
Malaise ☐ Yes ☐ No				

☐ Muscle Weakness				
☐ Myalgia				
☐ Neck Stiffness				
☐ Night Sweats				
☐ Numbness				
☐ Photophobia				
☐ Tenderness of one or more Salivary Glands				
If YES, Specify	☐ Parotid Glands			
	☐ Sublingual Glands			
	☐ Submaxillary Glands			
☐ Tremors				
☐ Weakness				
☐ Weight Loss				
☐ Vision Blurred				
☐ Vision Loss				

Enteric	Date of Onset	Time of Onset	Date of Onset	Time of Onset
Abdominal Pain ☐ Yes ☐ No				
☐ Diarrhea				
☐ Diarrhea - Bloody				
Nausea ☐ Yes ☐ No				

☐ Stomach - Pain				
☐ Stools - Black/Tarry				
☐ Vomiting				

Respiratory	Date of Onset	Time of Onset	Date of Onset	Time of Onset
☐ Coryza				
☐ Cough				
☐ Coughing Paroxysmal				
☐ Coughing with Apnea				
☐ Coughing with Blood				

☐ Cyanosis				
☐ Pneumonia				
☐ Short of Breath				
☐ Wheezing				

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Invasive — Date of Onset — Time of Onset — Date of Onset — Time of Onset

- ☐ Cellulitis
  - Specify site
- ☐ Lymphadenopathy
- ☐ Mastitis
- ☐ Necrotizing Fascitis/Myositis
  - Specify
- ☐ Orchitis
- ☐ Septic Arthritis Bursitis
  - Affected joint
- ☐ Septicemia
- ☐ Toxic Shock Syndrome
  - Specify

CNS — Date of Onset — Time of Onset — Date of Onset — Time of Onset

- ☐ Bulging Fontanel
- ☐ Coma
- ☐ Convulsions
- ☐ Meningeal Irritation
- ☐ Meningitis
- ☐ Paralysis

Hepatic — Date of Onset — Time of Onset — Date of Onset — Time of Onset

- Dark Urine ☐ Yes ☐ No
- Jaundice ☐ Yes ☐ No
- Pale Stools ☐ Yes ☐ No

Rash — Date of Onset — Time of Onset

- ☐ Rash
  - If YES, Specify Type
    - ☐ Erythematous Maculopapular Rash
    - ☐ Koplik's Spots
    - ☐ Petechial
    - ☐ Vesicular
  - If YES, Specify Location
    - ☐ Head
    - ☐ Extremities
    - ☐ Trunk

Other — Date of Onset — Time of Onset

- ☐ Other
  - If OTHER, Specify
  - Comments

Risk Factors

☐ No Risk Identified

Mother - Fetal Risk Factors

- ☐ Mother is known to be infected
- ☐ Mother is from an endemic country — Country:
- ☐ Mother is an injection drug user
- ☐ Mother is at other risk — Specify:

Ethnicity

- ☐ Born in/from an endemic country — Country:
- ☐ First nations
- ☐ Other risk related to ethnicity — Specify:

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Household Contacts

- ☐ With person from an endemic country — Country: / Relationship:
- ☐ With person who is an injection drug user — Relationship:
- ☐ Other risk related to household contacts — Specify:

Environmental Risk Factors

- ☐ Attendance at special event — Specify:
- ☐ Attendance at recreational facility — Specify:
- ☐ Swimming or wading — Specify:
- ☐ Camping or hiking — Specify:
- ☐ Other environmental risk — Specify:

Contact with Vectors — Date

- ☐ Mosquitos — Specify:
- ☐ Ticks — Specify:
- ☐ Rodents — Specify:
- ☐ Lab Animals — Specify:
- ☐ Pets — Specify:
- ☐ Contact with Pet Treats — Specify:
- ☐ Petting Zoo — Specify:
- ☐ Farm — Specify:
- ☐ Wild Animals — Specify:
- ☐ Other Contact with Vectors — Specify:

Occupational Exposure

☐ Occupational Exposure ☐ Last 6 Months ☐ Ever

Specify:

If OTHER, Specify:

Risk Factors - Medical

Risk Factors Related to Medical Treatment or Admission to Hospital

- ☐ Surgical Procedure — Date — ☐ Last 6 Months ☐ Ever
  - Specify:
  - Place:
- ☐ Hemodialysis — ☐ Last 6 Months ☐ Ever
- ☐ Endoscopy — ☐ Last 6 Months ☐ Ever
- ☐ Other Medical Procedure — ☐ Last 6 Months ☐ Ever
  - Specify:

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☐ Dental Procedure ☐ Last 6 Months ☐ Ever

Specify:

☐ Recent Antimicrobial Treatment

Reason:

Antimicrobial:

If OTHER, Specify:

☐ Contact with an Infected Care Provider

☐ Other Infection acquired after admission to hospital

Specify:

☐ Other

Specify:

Risks Related to Blood/Blood Products and Organ/Tissue

☐ Blood Transfusion Recipient ☐ Last 6 Months ☐ Ever

Year: Estimated ☐ Country: ☐ Multiple

Year: Estimated ☐ Country: ☐ Multiple

Year: Estimated ☐ Country: ☐ Multiple

☐ Blood Product Recipient ☐ Last 6 Months ☐ Ever

Year: Estimated ☐ Country: ☐ Multiple

Year: Estimated ☐ Country: ☐ Multiple

Year: Estimated ☐ Country: ☐ Multiple

☐ Solid Organ Transplant Recipient ☐ Last 6 Months ☐ Ever

Date: Place:

Organ: Type:

☐ Tissue Transplant Recipient ☐ Last 6 Months ☐ Ever

Date: Place:

Tissue: Type:

☐ Cell Transplant Recipient ☐ Last 6 Months ☐ Ever

Date: Place:

Cell: Type:

☐ Other Transplant Recipient ☐ Last 6 Months ☐ Ever

Date: Place:

Specify: Type:

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Gender:		**PHN:**

- ☐ Accidental Percutaneous
- ☐ Accidental Mucosal
- ☐ Other

  Specify:

Risk Factors Related to Medical History

☐ HIV		
☐ Cancer	Specify:	
☐ Diabetes	Specify:	
☐ Other Immunosupressive Condition	Specify:	
☐ Immunosupressive Medication	Specify:	
☐ Other Medication Use	Specify:	
☐ Wound	Date:	Type
Specify Wound Site		
☐ Chicken Pox or Shingles	Date:	
☐ Chronic Cardio Condition	Specify:	
☐ Chronic Respiratory Condition	Specify:	
☐ Other	Specify:	

Comments

Risk Factors - Sexual

Sexual Risk Factors	Last 6 Months	Ever
☐ Heterosexual	☐	☐
How many sexual partners? (Known)		
How many sexual partners? (Unknown)		
☐ Homosexual	☐	☐
How many sexual partners? (Known)		
How many sexual partners? (Unknown)		
☐ Bisexual partner(s)	☐	☐
☐ Multiple sex partners	☐	☐
☐ Anonymous sex	☐	☐
☐ Sex trade worker	☐	☐
☐ Patron of sex trade worker	☐	☐
☐ Victim of sexual assault	☐	☐
☐ Sexual partner of person known to be infected	☐	☐
☐ Sexual partner of an injection drug user	☐	☐
☐ Sexual partner of person from an endemic country	☐	☐
Country:		

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Gender:		**PHN:**	

☐ Sexual partner of person at other risk ☐ ☐

Specify:

☐ Other sexual risk ☐ ☐

Specify:

Condom Use

Anal	☐ Sometimes	☐ Always	☐ Never
Vaginal	☐ Sometimes	☐ Always	☐ Never
Oral	☐ Sometimes	☐ Always	☐ Never

Risk Factors - Behavioural/Social

Behavioural Risk Factors	Last 6 Months	Ever
☐ Injection Drug User	☐	☐
How long has the client been injecting?		
Shared needles used for (recreational) IDU with others?		
Shared other drug paraphernalia used for (recreational) IDU?		
# of partners case has shared with? (Known)		
# of partners case has shared with? (Unknown)		
☐ Non Injection Drug User	☐	☐
Shared straws/other devices used for snorting with others?		
Shared crack pipes/other devices with others?		
# of partners case has shared with? (Known)		
# of partners case has shared with? (Unknown)		
☐ Alcohol Abuser	☐	☐
☐ Smoker Specify: ☐ Current ☐ Former	☐	☐
☐ Tattoo(s)	☐	☐
How many times?		
☐ Body Piercings	☐	☐
How many times?		
☐ Acupuncture	☐	☐
☐ Other Personal Care Services	☐	☐
Specify:		
☐ Other	☐	☐
Specify:		

CD ASSESSMENT

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Gender:		**PHN:**	

Social Risk Factors	Last 6 Months	Ever
☐ Correctional Facility Role:		
Engaged in activities while in correctional facility?	☐	☐
Which activities:	☐ Tattooing	☐ Tattooing
	☐ Body Piercing	☐ Body Piercing
	☐ IDU	☐ IDU
	☐ Sexual	☐ Sexual
☐ Institution		
Role: Type:		
Shared personal hygiene products while at the institution?	☐	☐
Which products?		
☐ Homeless	☐	☐
☐ Resident of the Downtown Eastside (DTES)	☐	☐
☐ Resident of Single Room Occupancy Hotel (SRO)	☐	☐
☐ Resident of a First Nations Reserve	☐	☐
☐ Mental Illness	☐	☐
☐ Other	☐	☐
Specify:		

Food Source

Restaurant foods? ☐ Yes ☐ No

If YES, provide details - locations, when, foods eaten, eaten by others?

Takeout foods? ☐ Yes ☐ No

If YES, Specify:

Bakery or street vendor foods? ☐ Yes ☐ No

If YES, Specify:

Herbal supplements, vitamins, or traditional medicines? ☐ Yes ☐ No

If YES, Specify:

Source of groceries?

Shopping outside of neighbourhood? ☐ Yes ☐ No

If YES, Specify:

Food samples eaten while shopping? ☐ Yes ☐ No

Any food brought by visitors? ☐ Yes ☐ No

If YES, Specify:

Food

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Meats

	Yes	No	Comments
Beef	☐	☐	
Ground Beef	☐	☐	
Chicken	☐	☐	
Cold Cuts	☐	☐	
Duck	☐	☐	
Hams	☐	☐	
Lamb	☐	☐	
Pork	☐	☐	
Wieners	☐	☐	
Turkey	☐	☐	

Other Comments re: above Meats:

Seafood

	Yes	No	Comments
Fish	☐	☐	
Oysters	☐	☐	
Shrimp/Prawns	☐	☐	

Other Comments re: above Seafood:

Dairy/Eggs

	Yes	No	Comments
Cheese	☐	☐	
Cream Products	☐	☐	
Eggs	☐	☐	
Milk	☐	☐	

Other Comments re: above Eggs/Dairy:

Vegetables

	Yes	No	Comments
Alfalfa	☐	☐	
Bean Sprouts	☐	☐	
Broccoli	☐	☐	
Carrots	☐	☐	
Cauliflower	☐	☐	
Celery	☐	☐	
Cucumber	☐	☐	
Fresh Herbs	☐	☐	
Green Onion	☐	☐	
Lettuce	☐	☐	
	☐	☐	

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Pea Shoots	☐	☐
Radishes	☐	☐
Ready to Eat	☐	☐
Tomatoes	☐	☐

Other Comments re: above Vegetables:

Fruit

	Yes	No	Comments
Apples	☐	☐	
Bananas	☐	☐	
Cantaloupe	☐	☐	
Honey dew	☐	☐	
Grapes	☐	☐	
Mangoes	☐	☐	
Oranges	☐	☐	
Peaches	☐	☐	
Strawberries	☐	☐	
Watermelon	☐	☐	

Other Comments re: above Fruit:

Other

	Yes	No	Comments
(Baby) Formula	☐	☐	
Unpasteurized Juice	☐	☐	
Tofu	☐	☐	

Water

	Yes	No	Comments
Bottled	☐	☐	
Municipal - Surface Filtered	☐	☐	
Municipal - Surface Unfiltered	☐	☐	
Private	☐	☐	
Well Water	☐	☐	

Other Comments re: above Water:

Any meat dishes eaten raw?	☐ Yes	☐ No
Any eggs eaten raw?	☐ Yes	☐ No

Comments

Other Foods

Food Consumed?	Food Type	Food	Comments

CD ASSESSMENT

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Gender:		**PHN:**

Tests And Procedures

Date Entered	Date Ordered	Procedure	Comments

Biological Products

Date Entered:

Antimicrobial Prescribed: ☐ Yes ☐ No ☐ Recommended

Antimicrobial:

If OTHER, Specify:

Date Started: # of Days Completed:

Dose: Units

Immunnoprophylaxis Administered: ☐ Yes ☐ No ☐ Recommended

Imm. Product

If OTHER, Specify:

Date Administered: # in Series: Volume ml

Lot Number: Site:

Surgical Intervention: ☐ Yes ☐ No ☐ Recommended

If YES, Specify:

Other Treatment: ☐ Yes ☐ No ☐ Recommended

If YES, Specify:

Client Refused Treatment?: ☐ Date:

If YES, Specify:

Contraindications: ☐ Yes ☐ No Date:

If YES, Specify:

HIV

Case Number: Date Client Received Result:

From Whom:

Date of Most Recent Negative Result: None Found ☐

Is the case a previous positive? ☐ Yes ☐ No Province:

Date of Previous Positive Result: Country:

Does the client have concerns re: violence related to the HIV Reportability process? ☐ Yes ☐ No

Incedent Form Submitted? ☐ Yes ☐ No

Health at Time of Test

- ☐ Asymptomatic
- ☐ Seroconversion Illness
- ☐ Early Stage HIV
- ☐ Late Stage HIV
- ☐ AIDS
- ☐ Unknown

Current CD4 Count:

Current Viral Load:

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Reason for Testing

- ☐ Client Requested
- ☐ Client Born in/Resident of an Endemic Country
  - Country
- ☐ Presence of another STD
  - STD:
  - If OTHER, Specify:
- ☐ VISA Requirement
- ☐ Prenatal Work Up
- ☐ Organ or Blood Donor Program
- ☐ Partner of a HIV Positive Person
- ☐ Other
  - If OTHER, Specify
- ☐ Notified as a Contact
- ☐ Confirmatory Test
- ☐ Symptomatic
  - ☐ Seroconversion Illness
  - ☐ Early Stage HIV
  - ☐ Late Stage HIV
  - ☐ AIDS
- ☐ History of Known Risk Factor
  - Specify

Has an Index Case Evaluation Questionnaire been given to the client? ☐ Yes ☐ No

Has the client given consent for future BCCDC confidential contact for evaluation purposes? ☐ Yes ☐ No

HIV Index Case Summary

Demographics

Age: Ethnicity:

Gender:

Counseled By

☐ HCP ☐ PHN ☐ Clinic

Comments

Contact Elicitation Completed By

☐ HCP ☐ PHN ☐ Clinic

Comments

Number of Identified Contacts

Identified Known: Identified Unknown:

Number of Contacts Followed By

HCP: PHN: Clinic: Index Case:

Number of Contacts Unlocated: Number of Contacts Referred Out of HSDA:

Comments

Rabies

Date of Exposure:

Place of Exposure:

Province: Country:

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Gender:		**PHN:**

Exposure Location:

If OTHER, Specify:

Exposure Type:

If OTHER, Specify:

Any bleeding or breaks to the skin? ☐ Yes ☐ No ☐ Unknown

Client previously immunized for rabies? ☐ Yes ☐ No ☐ Unknown

Serology Done: ☐ Yes ☐ No ☐ Unknown Date

Animal: Type of Animal

If OTHER, Specify:

Animal immunized against rabies? ☐ Yes ☐ No ☐ Unknown Date

Animal behaviour at time of exposure:

Detention period following exposure? ☐ Yes ☐ No ☐ Unknown

Detention From: Detention To

Vet Name:

Phone Number: Alternate Number

Brain sent for testing? ☐ Yes ☐ No ☐ Unknown

Date Specimen Shipped: Date of Result

Result: ☐ Negative ☐ Positive ☐ Indeterminate

Comments

Case Summary

Based on the assesment and your clinical judgement:

Primary Mode Transmission

Factors Contributing to Illness/Outbreak

Food

- ☐ Improper Cooling
- ☐ Inadequate Cooking Processing
- ☐ Improper Storage Temperature
- ☐ Other

If OTHER, Specify:

- ☐ Cross Contamination
- ☐ Food Contaminated at Source
- ☐ Infected Food Handler
- ☐ Unknown

Environmental

- ☐ Inadequate Environmental Sanitation
- ☐ Crowded Inadequate Housing
- ☐ Animal Exposure
- ☐ Other

If OTHER, Specify:

- ☐ Drinking Water Treatment Failure
- ☐ Portable Water Treatment Failure
- ☐ Recreational Water Contamination
- ☐ Unknown

Personal

- ☐ Personal Hygiene
- ☐

- ☐ Chronic Infection
- ☐

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- ☐ Lack of Immunization
- ☐ Predisposing Condition
- ☐ Other
- ☐ Addiction
- ☐ Unknown

If OTHER, Specify:

Comments

Epidemiology

Incubation Period: min. hrs. days.

Likely Mode of Transmission:

Comments

Other People Involved with Assessment

Who	Association	Comments

Copies To Be Sent To

Casenote (may have been added after assessment authorized)

---------- End of Report ----------