RENFREW COUNTY AND DISTRICT HEALTH UNIT

COMMUNICABLE DISEASE REPORTING FORM

Please complete all applicable areas and fax to the **Infectious Disease Program**: **FAX: 613-735-3067**

PHONE: 613-735-8653 or 1-800-267-1097 (Office Hours) | 613-735-9926 (After Hours)

Please Note: Regular office hours are:

Monday-Friday 8:30-4:30 (Sept-June), 8:00-4:00 (July & Aug)

FOR HEALTH UNIT USE ONLY	
iPHIS Client ID:	iPHIS Case ID:

CLIENT INFORMATION		
Last Name:	First Name:	HIN#:
DOB (y/m/d):	Phone #:	Cell #:
Address:	City:	Postal Code:
Parent/Guardian (if applicable):		Gender: ◯ Male ◯ Female
Occupation:	Place of Employment:	
FAMILY PHYSICIAN:	Phone #:	Fax #:
DIAGNOSIS		
Diagnosis:		
Date (y/m/d):	Date of Onset (y/m/d):	
Symptoms:		
DIAGNOSING PHYSICIAN:	Phone #:	Fax #:
LAB INFORMATION AND TREATMENT		
Testing completed: ◯ Yes ◯ No	Specify Test(s):	
Collection Date (y/m/d):	Result(s):	
LAB REPORT TO FOLLOW: ◯ YES ◯ NO	Lab (Specify):	
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: ◯ Up-to-date ◯ N/A ◯ Unknown	Comments:	
Travel: ◯ Yes ◯ No ◯ Unknown	Location:	Date (y/m/d):
Complications:	Date of Death if applicable (y/m/d):	
Additional Comments:		
REPORTING SOURCE		
Name of Person Reporting:	Signature:	
Date (y/m/d):	Time:	
Agency:	Phone #:	Fax #:

Personal information on this form is collected under the authority of the Health Protection and Promotion Act, Sections 22 and 24, and will be used for Public Health follow-up. Any questions should be directed to Clinical Services Manager at 613-735-8653, ext. 515