

### REPORTABLE DISEASE- Notification Form

**FAX to Infectious Disease Team at 519-663-8241**

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| 1. **Please indicate the disease you are reporting-** check all that apply

Note: **Bolded font** indicate diseases that need to be reported immediately to the Middlesex-London Health Unit for confirmed and suspected cases, and outbreaks. Report all other diseases (confirmed or suspected) as soon as possible or by the next working day.  |
|  | Acute Flaccid Paralysis (AFP) in children < 15 years of age |  |  | **Influenza (Novel, not seasonal)** |
|  | Acquired Immunodeficiency Syndrome (AIDS) |  | **Legionellosis** |
|  | Amebiasis |  | Leprosy |
|  | **Anthrax** |  | Listeriosis |
|  | Blastomycosis |  | Lyme Disease |
|  | **Botulism** |  | **Measles** |
|  | **Brucellosis** |  | **Meningitis, acute: bacterial, viral and other causes** |
|  | Campylobacter Enteritis |  | **Meningococcal disease, invasive** |
|  | Carbapenamase-producing Enterobacteriacease (CPE), colonization or infection |  | **Mumps** |
|  | Chancroid |  | Ophthalmia neonatorum |
|  | Chickenpox, varicella |  | Other |
|  | **Cholera** |  | **Paralytic Shellfish Poisoning (PSP)** |
|  | Chlamydia trachomatis infections |  | **Paratyphoid Fever** |
|  | **Clostridium difficile associated disease (CDAD) outbreaks in public hospitals** |  | **Pertussis** |
|  | **COVID-19** |  | **Plague** |
|  | **Creutzfeldt-Jakob Diseases, all types** |  | Pneumococcal disease (Streptococcus pneumoniae), invasive |
|  | Cryptosporidiosis |  | **Poliomyelitis, acute** |
|  | Cyclosporiasis |  | **Psittacosis/Ornithosis** |
|  | **Diphtheria** |  | Q fever |
|  | Echinoccoccus multilocularis infection |  | **Rabies** |
|  | Encephalitis, primary, viral |  | **Respiratory infection, outbreaks in institutions and public hospitals** |
|  | Encephalitis, post-infectious, vaccine-related, subacute sclerosing panencephalitis and unspecified |  | **Rubella and Congenital Rubella Syndrome** |
|  | **Food poisoning all causes** |  | Salmonellosis |
|  | **Gastroenteritis, outbreaks in institutions and public hospitals** |  | **SARS (Severe Acute Respiratory Syndrome)** |
|  | Giardiasis (except asymptomatic cases) |  | **Shigellosis** |
|  | Gonorrhoea |  | **Smallpox and other Orthopoxviruses including Monkeypox** |
|  | **Group A Streptococcal Disease, invasive** |  | Syphilis |
|  | Group B Streptococcal disease, neonatal |  | Tetanus |
|  | **Haemophilus influenzae disease, all types, invasive** |  | Transmissible Spongiform Encephalopathy (e.g. CJD) |
|  | **Hantavirus pulmonary syndrome** |  | Trichinosis |
|  | **Hemorrhagic fevers, including Ebola Virus Disease and Marburg Virus Disease, Lassa Fever & other viral causes** |  | **Tuberculosis \*Please complete** [**TB Reporting form**](https://www.healthunit.com/tb-healthcare-providers#reporting) |
|  | **Hepatitis A** |  | **Tularemia** |
|  | Hepatitis B |  | **Typhoid Fever** |
|  | Hepatitis C |  |  | **Verotoxigenic-producing E. coli infection indicator conditions, including hemolytic uremic syndrome (HUS)** |
|  | Influenza (Community cases) |  |  | West Nile Virus |
|  | **Influenza (institutions and public hospitals)** |  |  | Yersiniosis |

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| 1. **Please indicate if the disease is – □ Confirmed or □ Suspect**
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| **Comments:** |
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| Reporting Information | Date Reported to Health Unit: YYYY-MM-DD  | Time: |
| Type of reporting source:(Name of clinic, hospital, school, laboratory, etc.) |
| Name: | Phone Number: |
|  |
| Client Demographics |
| Last Name: | First Name: |
| Date of birth:  | Age: |  |  |  |  |  |  |  |  |  |
| Gender: | Male |  | Female |  | Other |  | Specify: |  |
|  YYYY-MM-DD |  |  |
| Address: |
| City: | Postal Code: | Phone:  |
| Next of Kin: | Relationship: | Phone:  |
| Family Physician: | Phone Number: |

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| Laboratory Results – please attach if available □ N/A |
| Specimen Type: | Collection Date: YYYY-MM-DD | Result: | Date of Laboratory Result: YYYY-MM-DD |
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| 1. **Hospitalization**
 | □ **N/A** |
| Name of Hospital : |  |
| Date Admitted / Seen in emergency: |  | Date Discharged: |  |
| Attending Physician: |  | Phone Number: |  |
|  |
| 1. **Treatment □ N/A**
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| Treatment Started: □ Yes □ No |
| Treatment Start date:  | Medication |
| Comments: |
| 1. **Comments**
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| See attached:  progress notes  laboratory results  |

*The Personal Information on this form is collected under the authority of the Health Protection and Promotion Act and applicable privacy legislation. This information will be used for delivery of public health programs and services and may be used for evaluation or statistical/research purposes. Any questions about the collection of this information should be directed to the MLHU Privacy Officer, Middlesex-London Health Unit, 355 Wellington St, London, ON N6A 3N7, (519) 663-5317 x2251 Fax: (519)663-9413 or e-mail:* *privacy@mlhu.on.ca*