

REPORTABLE COMMUNICABLE DISEASE NOTIFICATION FORM

Disease:		Reporting Agency:	
Test type:		Source type:	
Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Pending		Collection date:	
Positive TST/Mantoux Positive			
Date administered: _____		Date read: _____ Result: _____ (mm of induration)	
Location: <input type="checkbox"/> Lt <input type="checkbox"/> Rt <input type="checkbox"/> Forearm <input type="checkbox"/> Other (specify) _____		Lot# _____ Expiry: _____	
Client Information			
Last name:		First name:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____
Health card number (optional):			DOB:
Address:		City/Town:	Postal Code:
Telephone:	Home:	Cell:	Employer:
Physician (involved with direct care):			Phone:
Other Physician (Family/Physician/Specialist):			Phone:
Clinical Information (if known)			
<input type="checkbox"/> Arrived by EMS Date: _____		<input type="checkbox"/> Outpatient visit: _____ Date of visit: _____ <input type="checkbox"/> ER visit _____ Date of visit: _____ <input type="checkbox"/> Clinic visit: _____ Date of visit: _____	
<input type="checkbox"/> Hospitalized		Date of admission: _____ Date of discharge: _____	
<input type="checkbox"/> Airborne isolation <input type="checkbox"/> Droplet isolation <input type="checkbox"/> Contact isolation		Isolation start date: _____	
Clinical signs and symptoms:			Date of onset: _____
Risk factors: <input type="checkbox"/> Alcohol misuse <input type="checkbox"/> Drug misuse <input type="checkbox"/> Pregnant <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Under housed/homeless <input type="checkbox"/> Travel <input type="checkbox"/> Other: _____			
Notes:			
Treatment related to communicable disease (dosage, route, frequency, duration):			
1.	Date started: _____ Date d/c: _____		
2.	Date started: _____ Date d/c: _____		
3.	Date started: _____ Date d/c: _____		

REPORTED BY: _____ **Tel #:** _____ **DATE:** _____

Personal health information collected on this form is collected under the authority of the *Health Protection and Promotion Act*, R.S.O. 1990 c. H. 7. The information is used to investigate communicable disease events and to control and prevent the spread of communicable/infectious diseases. Questions about this collection can be directed to the NEPH Manager (169 Pine Street South, Timmins, Ontario, P4N8B7) or by phone at 1-877-442-1212. This facsimile transmission is intended for the addressee indicated above. It may contain information that is privileged, confidential, or otherwise protected from disclosure. Any review, dissemination or use of this information or contents by persons other than the addressee is strictly prohibited.

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