Services de santé du TIMISKAMING Health Unit

Fax to: Timiskaming Health Unit
Medical Officer of Health
Confidential Fax: **705-647-5779**
(Attach lab result if available)

REPORTABLE COMMUNICABLE DISEASE NOTIFICATION FORM

Disease (*see list on back*):	Reporting Agency:
Test & Source type:	Collection Date:

Result: ☐ Positive ☐ Negative ☐ Pending ☐ **Attach lab result**

TB Skin Test Reporting

Date/Time Administered:	Date/Time Read:	Result: (mm of induration)
Location planted: ☐ Lt ☐ Rt ☐ Forearm ☐ Other (specify):	Lot #: Expiry:	Interpretation: ☐ Positive ☐ Negative ☐ Indeterminant

Client Information *(as reflected on Health Card)*

Last name	First name	DOB: YYYY | MM | DD Gender: ☐M ☐F ☐Other:_____
Address		Postal Code:
Health Card Number:		Employer/School/Daycare:
Telephone Home:	Cell:	
Physician (involved with direct care):		Phone:
Other Physician (family, physician, or specialist)		Phone:

Clinical Information

☐ **Arrived by EMS** **Date:**_____	☐ Outpatient visit: _____ Date: _____ ☐ ER Visit: _____ Date: _____ ☐ Clinic Visit: _____ Date: _____

☐ **Hospitalized** **Date of Admission:** _____ **Date of Discharge:** _____

☐ **Patient Transferred to another facility (name):** _____ **Date of Transfer:** _____

☐ **Airborne Isolation** ☐ **Droplet Isolation** ☐ **Contact Isolation** ☐ **Droplet-Contact Isolation** ☐ **None**

Start Date: _____ **End date:** _____

Clinical Signs and Symptoms *(include onset date and end date if known)*:

Risk Factors: ☐ Alcohol misuse ☐ Drug Misuse ☐ Immunocompromised ☐ Pregnant
☐ Underhoused/Homeless ☐ Travel *(dates & location)* _____
☐ Other:_____

Notes *(possible community exposures, other high-risk contacts, etc.)*:

Medications Prescribed *Related to Reportable Disease*

Medication Name	Dosage & Route	Frequency	Start Date	End date

Reported by: _____ Contact phone #:_____ Date: _____
(Please Print)