*	CASE ACCESSION NUMBER	ADDITIONAL ACCESSION NUMBERS (COMMA SEPARATED)

HEPATITIS B AND C, HIV, AND SYPHILIS INVESTIGATION FORM

CASE FORM

I. NON-NOMINAL HIV TEST RESULTS**

subject > client details > personal information

1. CURRENT NON-NOMINAL HIV CODE (IF APPLICABLE) SPECIFY	2. PREVIOUS NON-NOMINAL CODE(S) OR NAME(S) USED FOR POSITIVE HIV TESTS SPECIFY COUNTRY/PROVINCE, CODE/NAME, AND DATES YYYY-MM-DD IF KNOWN

**NOTE: FOR HIV, ONLY COMPLETE SECTION II PART A IF CURRENT HIV TEST IS NOMINAL, OR IF CLIENT PROVIDES CONSENT TO LINK CURRENT OR PREVIOUS NON-NOMINAL RESULTS WITH A NOMINAL RECORD. IF NON-NOMINAL, COMPLETE SECTION I AND II PART B ONLY.

II. *CASE IDENTIFICATION

subject > client details > personal information

PART A – CLIENT IDENTIFIERS (COMPLETE FOR NOMINAL CASES ONLY)

3. LAST NAME	4. FIRST NAME	5. DATE OF BIRTH YYYY - MM - DD
6. ALTERNATE LAST NAME	7. ALTERNATE FIRST NAME	
8. REGISTRATION NUMBER (FORMER MHSC) 6 DIGITS	9. HEALTH NUMBER (PHIN) 9 DIGITS	10. ALTERNATE ID SPECIFY TYPE OF ID
11. ADDRESS AT TIME OF DIAGNOSIS ➔	☐ ADDRESS IN FIRST NATION COMMUNITY	12. CITY/TOWN/VILLAGE
13. PROVINCE/TERRITORY	14. POSTAL CODE A#A #A#	15. PHONE NUMBER ### - ### - ####
16. ALTERNATE LOCATION INFORMATION (IF ANY)		

PART B – CLIENT INFORMATION (COMPLETE FOR NOMINAL AND NON-NOMINAL CASES)

17. SEX	18. GENDER IDENTITY (VOLUNTARY, SELF-REPORTED)	19. IF OTHER GENDER IDENTITY, SPECIFY	20. AGE (YRS)
O FEMALE O MALE O INTERSEX O UNKNOWN	O CISGENDER (SAME AS SEX AT BIRTH) O TRANSGENDER MAN O TRANSGENDER WOMAN O TRANSGENDER PERSON O DECLINED O OTHER (SPECIFY IN BOX 19)		(IF DOB NOT COMPLETED)

21. ETHNIC ORIGIN (VOLUNTARY, SELF-REPORTED – CHOOSE ONE ONLY)

O AFRICAN
O ASIAN (INCLUDES MIDDLE EAST, PHILIPPINES)
O CARIBBEAN
O EUROPEAN (INCLUDES EASTERN EUROPE)
O LATIN, CENTRAL AND SOUTH AMERICAN (INCLUDES MEXICO)
O NORTH AMERICAN (INCLUDES CANADA, USA)
O NORTH AMERICAN INDIGENOUS
O OCEANIA (INCLUDES PACIFIC ISLANDS)
O DECLINED
O NOT ASKED
O UNKNOWN

22. INDIGENOUS IDENTITY DECLARATION (VOLUNTARY, SELF-REPORTED)	23. FIRST NATIONS STATUS (VOLUNTARY, SELF-REPORTED)	MHSU USE ONLY
O FIRST NATIONS O MÉTIS O INUIT O NOT ASKED O DECLINED	O STATUS O NON-STATUS O NOT ASKED O DECLINED	

24. IMMIGRATION STATUS AT TIME OF ARRIVAL (VOLUNTARY - COMPLETE BOXES 25 AND 26 IF BORN OUTSIDE CANADA)	25. DATE ARRIVED IN CANADA	26. COUNTRY EMIGRATED FROM
O CANADIAN BORN CITIZEN O DECLINED O LANDED IMMIGRANT O NOT ASKED O REFUGEE O OTHER (SPECIFY BELOW) O STUDENT O VISITOR O WORK PERMIT	YYYY	SPECIFY

III. INVESTIGATION INFORMATION

27. *INVESTIGATION DISPOSITION	O FOLLOW-UP COMPLETE	O UNABLE TO COMPLETE INTERVIEW			O PENDING			
28. *RESPONSIBLE ORGANIZATION	O WRHA	O NRHA	O PMH	O SH-SS	O IERHA	O FNIHB	O CSC	
29. OTHER ORGANIZATIONS INVOLVED	☐ WRHA	☐ NRHA	☐ PMH	☐ SH-SS	☐ IERHA	☐ FNIHB	☐ CSC	☐ DND

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CONFIDENTIAL WHEN COMPLETED

* CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN

IV. *INFECTION INFORMATION/STAGING

investigation > investigation details > disease summary > update > disease event history

30. ☐ **HEPATITIS B** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

- ☐ LAB CONFIRMED
- ☐ NOT A CASE

31. **HEPATITIS B STAGING**
- O ACUTE
- O CHRONIC
- O UNKNOWN OR UNDETERMINED

32. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** — YYYY – MM - DD

33. ☐ **HEPATITIS C** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

- ☐ LAB CONFIRMED
- ☐ NOT A CASE

34. **HEPATITIS C STAGING**
- O ACUTE
- O CHRONIC
- O UNKNOWN/UNDETERMINED

35. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** — YYYY – MM - DD

36. ☐ **HIV** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

- ☐ LAB CONFIRMED
- ☐ NOT A CASE

37. **HIV STAGING**
- O NEW DIAGNOSIS
- O PREVIOUS DIAGNOSIS- NEW TO MANITOBA

38. **SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION** — YYYY – MM - DD

39. ☐ **SYPHILIS** — Refer to disease protocol at http://www.gov.mb.ca/health/publichealth/cdc/protocol/index.html

- ☐ LAB CONFIRMED
- ☐ NOT A CASE

40. **SYPHILIS STAGING INFORMATION**
- O STAGING PENDING
- O STAGING COMPLETED (SPECIFY IN BOXES 41 OR 42)
- O UNKNOWN/UNDETERMINED

41. **INFECTIOUS STAGES**
- O PRIMARY
- O SECONDARY
- O EARLY LATENT (< 1 YEAR AFTER INFECTION)
- O EARLY CONGENITAL (ONSET < 2 YEARS AFTER BIRTH)

42. **NON-INFECTIOUS STAGES**
- O LATE LATENT (≥ 1 YEAR AFTER INFECTION)
- O LATE CONGENITAL (PERSISTENCE ≥ 2 YEARS AFTER BIRTH)
- O TERTIARY

43. **ADDITIONAL PRESENTATIONS** ☐ CARDIOVASCULAR SYPHILIS ☐ NEUROSYPHILIS ☐ GUMMATOUS SYPHILIS

44. SPECIMEN COLLECTION DATE FOR CURRENT INVESTIGATION	45. DATE OF FIRST DIAGNOSIS IF PREVIOUSLY DIAGNOSED	46. LOCATION OF FIRST DIAGNOSIS IF NOT IN MANITOBA
YYYY – MM - DD	YYYY – MM	SPECIFY COUNTRY OR PROVINCE IN CANADA

IF THE CASE IS NON-INFECTIOUS SYPHILIS (BOX 42), SKIP TO SECTION XIII, "REPORTER INFORMATION".

V. METHOD OF DETECTION

investigation > investigation details > investigation information

47. **METHOD OF DETECTION FOR CURRENT INVESTIGATION (REASON FOR TESTING)**
- O CONTACT INVESTIGATION
- O IMMIGRATION MEDICAL SURVEILLANCE
- O PRENATAL SCREENING
- O ROUTINE TESTING (INCIDENTAL FINDING)
- O SYMPTOMS

48. **OTHER METHOD OF DETECTION** — SPECIFY

VI. SIGNS AND SYMPTOMS

investigation > signs and symptoms

49. **SYMPTOMS**
- O ASYMPTOMATIC
- O SYMPTOMATIC (COMPLETE BOX 51 FOR HEPATITIS B/C, BOX 52 FOR SYPHILIS, OR BOX 53 FOR HIV)

50. **EARLIEST SYMPTOM ONSET DATE** — YYYY-MM-DD

51. **HEPATITIS B/C (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)**
- ☐ ABDOMINAL PAIN/CRAMPING (RUQ)
- ☐ ANOREXIA
- ☐ DARK URINE
- ☐ FATIGUE
- ☐ FEVER
- ☐ JAUNDICE
- ☐ NAUSEA
- ☐ STOOL, PALE
- ☐ VOMITING
- ☐ OTHER — SPECIFY

52. **SYPHILIS (CHECK ALL SIGNS/SYMPTOMS THAT APPLY)**
- ☐ ANAL ULCERATIVE LESIONS
- ☐ CHANCRE (OTHER SITE)
- ☐ CONDYLOMATA LATA
- ☐ GENITAL ULCER
- ☐ HAIR LOSS (ALOPECIA)
- ☐ HEADACHE
- ☐ LYMPH NODES ENLARGED – GENERALIZED
- ☐ LYMPH NODES ENLARGED - REGIONAL
- ☐ MENINGITIS
- ☐ OCULAR INVOLVEMENT
- ☐ ORAL ULCERATIVE LESIONS
- ☐ OTHER MUCOSAL LESIONS
- ☐ RASH
- ☐ OTHER — SPECIFY

53. **HIV SIGNS/ SYMPTOMS** — SPECIFY IF NEEDED FOR CASE MANAGEMENT

*	CASE ACCESSION NUMBER	CASE NAME OR INITIALS	CASE PHIN

VII. RISK FACTOR INFORMATION

subject > risk factors

A. BLOOD AND PERCUTANEOUS EXPOSURES (COMPLETE FOR HEP B, HEP C, AND HIV CASES ONLY)

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
ACUPUNCTURE SPECIFY LOCATION AND DATE YYYY-MM-DD	○	○	○	○	○
BLOOD/TISSUE DONATION (E.G. BLOOD, PLASMA, ORGANS, BREAST MILK) SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	○	○	○	○	○
BLOOD/TISSUE RECIPIENT (E.G. BLOOD, PLASMA, TISSUE, ORGANS) SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY – MM – DD	○	○	○	○	○
BODY PIERCING, SCARIFICATION, TATTOO APPLICATION SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD	○	○	○	○	○
DIALYSIS (HEMODIALYSIS OR PERITONEAL) SPECIFY START DATE YYYY-MM-DD	○	○	○	○	○
INJECTION DRUG USE SPECIFY SUBSTANCE(S) AND DATE OF LAST IDU EXPOSURE	○	○	○	○	○
INJECTION DRUG USE OUTSIDE CANADA SPECIFY SUBSTANCE(S), DATES, AND COUNTRY	○	○	○	○	○
MEDICAL OR SURGICAL PROCEDURE SPECIFY TYPE, LOCATION, AND DATE YYYY-MM-DD	○	○	○	○	○
OCCUPATIONAL EXPOSURE (E.G. NEEDLE STICK, SHARPS) SPECIFY TYPE AND DATE YYYY-MM-DD	○	○	○	○	○
RECIPIENT OF POOLED CONCENTRATES OF FACTOR VIII OR IX FOR TREATMENT OF HEMOPHILIA/COAGULATION DISORDER SPECIFY TYPE, HOSPITAL/FACILITY, AND DATE(S) YYYY-MM-DD	○	○	○	○	○
SAFER INJECTION PROGRAM USE (COMPLETE ONLY IF INJECTION DRUG USE REPORTED) ☐ ALWAYS ☐ NEVER ☐ SOMETIMES	○	○	○	○	○
SHARED NEEDLES SPECIFY LOCATION	○	○	○	○	○
SHARED OTHER DRUG PARAPHERNALIA SPECIFY TYPE	○	○	○	○	○

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B. SEXUAL EXPOSURE (COMPLETE ROUTINELY FOR HEP B, HIV, AND SYPHILIS CASES ONLY)

☐ PREGNANT AT TIME OF DIAGNOSIS	☐ DATE OF LAST SEXUAL EXPOSURE
SPECIFY EDC: YYYY-MM-DD	SPECIFY DATE YYYY-MM-DD

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
HAS GIVEN GOODS IN EXCHANGE FOR SEX	O	O	O	O	O
HAS RECEIVED GOODS IN EXCHANGE FOR SEX	O	O	O	O	O
MALE WHO HAS SEX WITH MEN	O	O	O	O	O
NEW SEX PARTNER IN PERIOD OF COMMUNICABILITY	O	O	O	O	O
SEXUAL ASSAULT (NON-CONSENSUAL SEX)	O	O	O	O	O
SEXUAL EXPOSURE TYPE: ANAL	O	O	O	O	O
SEXUAL EXPOSURE TYPE: ORAL	O	O	O	O	O
SEXUAL EXPOSURE TYPE: VAGINAL	O	O	O	O	O

C. HISTORY OF STBBI AND EXPOSURE RISKS (COMPLETE FOR ALL CASES EXCEPT WHERE INDICATED)

☐ BORN TO INFECTED MOTHER	CONTACT TO A CASE OF:	O HEPATITIS B	O HEPATITIS C	O HIV	O SYPHILIS
SPECIFY INFECTION(S)	SPECIFY DATE OF INITIAL CONTACT:	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD	YYYY-MM-DD

COMPLETE THE FOLLOWING AND SPECIFY DETAILS WHERE REQUESTED:	YES	NO	UN-KNOWN	DECLINED TO ANSWER	NOT ASKED
HISTORY OF INCARCERATION SPECIFY LOCATION AND DATE RANGE	O	O	O	O	O
HISTORY OF RESIDENCE IN AN ENDEMIC COUNTRY (FOR CASES OF HEP B/C AND HIV) SPECIFY COUNTRY AND DATES	O	O	O	O	O
HISTORY OF STI SPECIFY INFECTION(S) AND DATE(S)	O	O	O	O	O
HOUSEHOLD CONTACT WITH CONFIRMED OR SUSPECTED CASE (HEP B CASES ONLY)	O	O	O	O	O
PREVIOUS ANTI-RETROVIRAL THERAPY (HIV CASES ONLY) SPECIFY PROVINCE/COUNTRY AND DATE(S)	O	O	O	O	O
PREVIOUSLY DIAGNOSED HEPATITIS B CASE SPECIFY PROVINCE/COUNTRY AND DATE OF DIAGNOSIS YYYY-MM	O	O	O	O	O
PREVIOUSLY DIAGNOSED HEPATITIS C CASE SPECIFY PROVINCE/COUNTRY AND DATE OF DIAGNOSIS YYYY-MM	O	O	O	O	O
PREVIOUSLY DIAGNOSED HIV CASE SPECIFY PROVINCE/COUNTRY AND DATE OF FIRST POSITIVE TEST YYYY-MM	O	O	O	O	O
PREVIOUS TREATMENT FOR SYPHILIS (SYPHILIS CASES ONLY) SPECIFY PROVINCE/COUNTRY AND DATE(S)	O	O	O	O	O
OTHER RISK FACTOR SPECIFY	O	O	O	O	O
NO IDENTIFIABLE RISK FACTORS IN SECTIONS A, B, OR C	O	O	O	O	O

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VIII. TREATMENT INFORMATION (COMPLETE FOR SYPHILIS ONLY)

investigation > prescriptions > prescription summary

54. PRESCRIBER NAME	55. TREATMENT FACILITY	
☐ BENZATHINE PENICILLIN G 2.4 million units IM as single dose SPECIFY START DATE: YYYY-MM-DD	☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 2 doses SPECIFY START DATE: YYYY-MM-DD	☐ BENZATHINE PENICILLIN G 2.4 million units IM weekly for 3 doses SPECIFY START DATE: YYYY-MM-DD
☐ CEFTRIAXONE 1 g OD for 10 days ○ IV ○ IM SPECIFY IM OR IV AND START DATE: YYYY-MM-DD	☐ CEFTRIAXONE 2 G OD FOR 10 DAYS ○ IV ○ IM SPECIFY IM OR IV AND START DATE: YYYY-MM-DD	☐ DOXYCYCLINE 100 mg PO BID X 14 days SPECIFY START DATE: YYYY-MM-DD
☐ DOXYCYCLINE 100 mg PO BID X 28 days SPECIFY START DATE: YYYY-MM-DD	☐ PENICILLIN G 3-4 MILLION UNITS IV Q4H X 10-14 days SPECIFY START DATE: YYYY-MM-DD	☐ OTHER (SPECIFY TREATMENT AND START DATE): SPECIFY START DATE: YYYY-MM-DD
56. ALLERGIES SPECIFY		

IX. OUTCOMES AT TIME OF INVESTIGATION

investigation > outcomes

○ FATAL SPECIFY DATE OF DEATH YYYY-MM-DD	○ OTHER SIGNIFICANT OUTCOME/SEQUELAE SPECIFY

X. EVIDENCE-BASED INTERVENTIONS

investigation > treatment and interventions >interventions summary

57. RECOMMENDED IMMUNIZATIONS	
☐ **HBV** ○ RECOMMENDED ○ ADMINISTERED ○ IMMUNE ○ DECLINED	☐ **HAV** ○ RECOMMENDED ○ ADMINISTERED ○ IMMUNE ○ DECLINED

58. STBBI TESTING RECOMMENDED/COMPLETED	59. LOCATION OF TESTING IF KNOWN	60. DATE (YYYY-MM-DD)
☐ CHLAMYDIA ○ POSITIVE ○ NEGATIVE ○ UNKNOWN		
☐ GONORRHEA ○ POSITIVE ○ NEGATIVE ○ UNKNOWN		
☐ HEPATITIS B ○ POSITIVE ○ NEGATIVE ○ UNKNOWN		
☐ HEPATITIS C ○ POSITIVE ○ NEGATIVE ○ UNKNOWN		
☐ HIV ○ POSITIVE ○ NEGATIVE ○ UNKNOWN		
☐ SYPHILIS ○ POSITIVE ○ NEGATIVE ○ UNKNOWN		

61. OTHER INTERVENTIONS	62. DATE (YYYY-MM-DD)
☐ REFERRAL FOR TREATMENT (SPECIFY)	
☐ REFERRAL TO PEDIATRIC INFECTIOUS DISEASES (SPECIFY DATE)	
☐ FOLLOW-UP STBBI TESTING IN 6 MONTHS	
☐ NOTIFICATION OF CANADIAN BLOOD SERVICES (IF APPLICABLE)	
☐ IMMUNIZATION: NEWBORN PROPHYLAXIS FOR HEPATITIS B (IF APPLICABLE)	
☐ OTHER (SPECIFY)	

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Health, Seniors and Active Living

XI. HEPATITIS B IMMUNIZATION HISTORY INTERPRETATION

Subject > imms history interpretation
Immunization

63. INTERPRETATION OF HEPATITIS B IMMUNITY PRIOR TO INVESTIGATION	O IMMUNITY- LAB EVIDENCE O SUSCEPTIBLE – LAB EVIDENCE O INDETERMINATE- LAB EVIDENCE O FULLY IMMUNIZED O PARTIALLY IMMUNIZED O UNIMMUNIZED O UNKNOWN/NOT DETERMINED	64. REASON FOR IMMUNITY/ IMMUNIZATION INTERPRETATION	**SOURCE OF SEROLOGY/ IMMUNIZATION RECORD:** O CLIENT/PARENT/GUARDIAN O CLIENT/PARENT/GUARDIAN – OFFICIAL RECORD O HEALTH RECORD/ HEALTHCARE PROVIDER **REASON IF NOT FULLY IMMUNIZED OR UNKNOWN:** O GENERAL OBJECTION (NON-PHILOSOPHICAL) O IMMUNOCOMPROMISED O MEDICAL CONTRAINDICATION O NOT ELIGIBLE FOR ROUTINE IMMUNIZATION O NOT UP TO DATE WITH IMMUNIZATIONS O PHILOSOPHICAL OBJECTION O UNKNOWN/ NOT DETERMINED

65. HEPATITIS B VACCINES AND DATES (LIST AGENTS AND DATES ONLY IF NOT ALREADY ENTERED IN MB IMMUNIZATION REGISTRY)			
	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD
	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD	SPECIFY AGENT AND DATE YYYY-MM-DD

XII. CONTACTS

investigation > exposure summary > transmission event details

66. NUMBER OF CONTACTS IDENTIFIED BY NAME ➔	SPECIFY NUMBER	67. NUMBER OF ANONYMOUS CONTACTS ➔	SPECIFY NUMBER	68. EARLIEST ANONYMOUS EXPOSURE START DATE ☐ ESTIMATED YYYY-MM-DD
☐ CASE DECLINED TO IDENTIFY CONTACTS				

XIII. * REPORTER INFORMATION (IF NOT RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE)

69. FORM COMPLETED BY (PRINT NAME)	70. FACILITY NAME/ADDRESS/PHONE#	REPORTER USE ONLY
71. SIGNATURE		
72. FORM COMPLETION DATE YYYY-MM-DD	73. ORGANIZATION (IF APPLICABLE) O WRHA O NRHA O PMH O SH-SS O IERHA O FNIHB O CSC	STAMP HERE

XIV. * RESPONSIBLE REGIONAL PUBLIC HEALTH OFFICE USE ONLY

74. FORM COMPLETED BY (PRINT NAME)	75. SIGNATURE	76. FORM COMPLETION DATE YYYY-MM-DD
77. FORM REVIEWED BY (PRINT NAME)	78. FORM REVIEWED DATE YYYY-MM-DD	RHA USE ONLY
79. INVESTIGATION STATUS O ONGOING O CLOSED TO THE REGION	80. ORGANIZATION O WRHA O NRHA O PMH O SH-SS O IERHA O FNIHB O CSC	STAMP HERE

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