**Ontario Amebiasis** **Investigation Tool**

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|  **Legend** | **for interview with case ♦ System-Mandatory ❖ Required Personal Health Information** |

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| **Cover Sheet***Note that this page can be autogenerated in iPHIS* |
| Date Printed: YYYY-MM-DD Bring Forward Date: YYYY-MM-DD iPHIS Client ID #:  Enter number **♦** Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **♦** Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**♦** Investigator:  **Enter name \_ \_** **♦** DOB: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****♦** Branch Office:  Enter office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**♦** Reported Date: YYYY-MM-DD **❖**Diagnosing Health Unit:  Enter health unit Tel. 1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**♦** Disease: AMEBIASIS Type: Home Mobile Work **♦** Is this an outbreak associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Yes, *OB #* ####-####-### [ ]  No, *link to OB # 0000-2005-002 in iPHIS*Is the client in a high-risk occupation/ environment? [ ]  Yes, specify: Specify [ ]  No |  ♦ Client Name:  **Enter name \_ \_**Alias:  **Enter alias \_ \_** |
|  ♦ Gender: Select an option |  ♦ Age: **Age**  |
|  ♦ DOB: YYYY-MM-DD  Address:  **Enter address \_**  **Enter address \_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_** Tel. 1:  **###-###-####** Type: [ ]  Home [ ]  Mobile [ ]  Work [ ]  **Other, specify** Tel. 2:  **###-###-####** Type: [ ]  Home [ ]  Mobile [ ]  Work [ ]  **Other, specify** Email 1: **Enter email address \_ \_** Email 2:  **Enter email address \_ \_** |
| Is the client homeless? [ ]  Yes [ ]  No New Address:  **Enter address \_** **♦** Language:  **Specify \_ \_**Translation required*?* [ ]  Yes [ ]  No**Proxy respondent** Name:  **Enter name \_ \_**[ ]  Parent/Guardian [ ]  Spouse/Partner [ ]  Other  **Specify \_ \_** | **♦** Physician’s Name: **Enter name \_ \_****♦** Role**:** [ ]  Attending Physician [ ]  Family Physician [ ]  Specialist [ ]  Walk-In Physician [ ]  Other [ ]  Unknown**OPTIONAL**Additional Physician’s Name: **Enter name \_** Address:  **Enter address \_**  Tel:  **###-###-####**  Fax:  **###-###-####** Role:  **Enter role \_ \_** |

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| **Verification of Client’s Identity & Notice of Collection** |
| Client’s identity verified? [ ]  Yes, *specify*: [ ]  DOB [ ]  Postal Code [ ]  Physician  [ ]  No  |
| **Notice of Collection***Please consult with local privacy and legal counsel about PHU-specific Notice of Collection requirements under* *PHIPA s. 16*. *Insert Notice of Collection, as necessary.* |

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| **Record of File** |
| **♦ Responsible Health Unit** | **Date** | **♦ Investigator’s Name** | **Investigator’s Signature** | **Investigator’s Initials** | **Designation** |
| Specify | **❖**Investigation Start DateYYYY-MM-DD | Specify | Specify | Specify | [ ]  PHI [ ]  PHN[ ]  Other \_\_\_\_\_\_\_  |
| Specify | Assignment DateYYYY-MM-DD | Specify | Specify | Specify | [ ]  PHI [ ]  PHN[ ]  Other \_\_\_\_\_\_\_  |

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| **Call Log Details**  |
|  | **Date** | **Start Time** | **Type of Call** | **Call To/From** | **Outcome****(contact made, v/m, text, email, no answer, etc.)** | **Investigator’s initials** |
| Call 1 | YYYY-MM-DD |  | [ ]  Outgoing[ ]  Incoming |  |  |  |  |
| Call 2 | YYYY-MM-DD |  | [ ]  Outgoing[ ]  Incoming |  |  |  |  |
| Call 3 | YYYY-MM-DD |  | [ ]  Outgoing[ ]  Incoming |  |  |  |  |
| Call 4 | YYYY-MM-DD |  | [ ]  Outgoing[ ]  Incoming |  |  |  |  |
| Call 5 | YYYY-MM-DD |  | [ ]  Outgoing[ ]  Incoming |  |  |  |  |
| Call 6 | YYYY-MM-DD |  | [ ]  Outgoing[ ]  Incoming |  |  |  |  |
| Date letter sent: YYYY-MM-DD |

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| **Case Details** |
| **♦ Aetiologic Agent** | [ ]  *Entamoeba histolytica* (Confirmed case)[ ]  *Entamoeba histolytica/ dispar* (Probable case) |
| **Subtype** |  Specify | **Further Differentiation** | Specify |
| **♦ Classification** | [ ]  Confirmed [ ]  Probable [ ]  Does Not Meet Definition  | **♦ Classification Date**  | YYYY-MM-DD |
| **♦ Outbreak Case Classification** | [ ]  Confirmed [ ]  Probable [ ]  Does Not Meet Definition  | **♦ Outbreak Classification Date** | YYYY-MM-DD |
| **♦ Disposition** | [ ]  Complete [ ]  Closed- Duplicate-Do Not Use [ ]  Entered In Error [ ]  Lost to Follow Up [ ]  Does Not Meet Definition [ ]  Untraceable  | **♦ Disposition Date**  | YYYY-MM-DD |
| **♦ Status** | [ ]  Closed  | Initial here | **♦ Status Date** | YYYY-MM-DD |
| [ ]  Open (re-opened)  | Initial here | **♦ Status Date** | YYYY-MM-DD |
| [ ]  Closed  | Initial here | **♦ Status Date** | YYYY-MM-DD |
| **♦ Priority** | [ ]  High | [ ]  Medium [ ]  Low |  *(At health unit’s discretion)* |
| **Symptoms** |
| ***Incubation period*** *is from a few days to several months or years; commonly 2 to 4 weeks.****Communicability:*** *Period of communicability is during the period that E. histolytica cysts are passed, which may continue for years.* |
| ***Specimen collection date:*** YYYY-MM-DD |
| **♦ Symptom***Ensure that symptoms in* ***bold font*** *are asked* | **♦ Response**  | **❖ Use as Onset***(choose one)* | **❖ Onset Date**YYYY-MM-DD | **Onset Time**24-HR ClockHH:MM*(discretionary)* | **❖ Recovery Date**YYYY-MM-DD*(one date is sufficient)* |
| **Yes** | **No** | **Don’t Know** | **Not Asked** | **Refused** |
| Asymptomatic | [ ]  | [ ]  | *Enter zero (0) for the duration days. DO NOT enter an Onset Date and DO NOT check the ‘Use as Onset’ box* |
| Loss of weight | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| **Diarrhea** | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Diarrhea - Bloody | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Fever | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| Other, *specify*  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  | YYYY-MM-DD | HH:MM | YYYY-MM-DD |
| ***Note: This list is not comprehensive. There are additional symptoms listed in iPHIS.*** |

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| ♦ **Complications** |
| [ ]  None [ ]  Other [ ]  Unknown |

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| **Incubation Period**  |
| *Enter onset date and time, using this as day 0, then count back to determine the incubation period.* *Note that the ‘common’ incubation period is used throughout the questionnaire. It may be more appropriate in some situations to use the range of ‘a few days to several months’ as the incubation period.* |
|   - 4 weeks - 2 weeks Onset  Select a date Select a date Select a date & time |

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| **Medical Risk Factors** | **❖ Response** | **Details***iPHIS character limit: 50.* |
|  | **Yes** | **No** | **Unknown** | **Not asked** |  |
| **❖** Immunocompromised (e.g., by medication or by disease such as cancer, diabetes, etc.)  |[ ] [ ] [ ] [ ]  If yes, specify |
| **❖** Other (specify)(e.g., use of antacid, surgery, etc.) |[ ] [ ] [ ] [ ]  If yes, specify |
| **❖** Unknown |[ ] [ ]  *→ For iPHIS data entry – check Yes for Unknown if all other Medical Risk Factors are No or Unknown.* |

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| **Hospitalization & Treatment** *Mandatory in iPHIS only if admitted to hospital* |
| Did you go to an emergency room?  | [ ]  Yes [ ]  No  | If yes, Name of hospital: Enter nameDate(s): YYYY-MM-DD |
| **♦** Were you admitted to hospital as a result of your illness (not including stay in the emergency room)? | [ ]  Yes [ ]  No [ ]  Don’t recall  | If yes, Name of hospital: Enter name **♦** Date of admission: YYYY-MM-DD**❖** Date of discharge: YYYY-MM-DD[ ]  Unknown discharge date |
| *→ For iPHIS data entry – if the case is hospitalized enter information under Interventions.*  |
| Were you prescribed medication for your illness?  | [ ]  Yes [ ]  No[ ]  Don’t recall  | If yes, Medication: Enter name Start date: YYYY-MM-DDEnd date: YYYY-MM-DDRoute of administration: Enter route Dosage: Enter dosage  |
| Did you take over-the-counter medication?  | [ ]  Yes [ ]  No[ ]  Don’t recall  |  If yes, specify  |
| *Treatment information can be entered in iPHIS under* ***Cases > Case > Rx/Treatments> Treatment*** *as per current iPHIS User Guide* |

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| **Date of Onset, Age and Gender** *Complete this section if submission of pages 5-6 to Public Health Ontario is required* |
| Date of Onset: | YYYY-MM-DD | Age: | **Age**  | Gender: | Select an option |

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| **Preliminary Questions**  | **Response** | **Details** |
|  | **Yes** | **No** | **Unsure** |  |
| Do you have any idea how you became sick? |[ ] [ ] [ ]  If yes, specify |
| Were you on any specific diet(s) in the 2 to 4 weeks prior to the onset of your illness (e.g., vegetarian, vegan, gluten-free, kosher, halal, etc.)? |[ ] [ ] [ ]  If yes, specify  |
| Did you attend any special functions such as weddings, parties, showers, family gatherings or group meals in the 2 to 4 weeks prior to the onset of your illness? |[ ] [ ] [ ]  If yes, specify *(e.g., location, number attended, any ill)*  |

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| **Behavioural Social Risk Factors in the 2-4 weeks prior to onset of illness****Travel** | **❖ Response** | **Details***iPHIS character limit: 50* |
|  | **Yes** | **No** | **Unknown** | **Not asked** |  |
| **❖** Travel outside province in the 2 to 4 weeks prior to illness (specify) |[ ] [ ] [ ] [ ]   |
| Within Canada  |[ ] [ ] [ ] [ ]  From: YYYY-MM-DD To: YYYY-MM-DDWhere: Specify |
| Outside of Canada  |[ ] [ ] [ ] [ ]  From: YYYY-MM-DD To: YYYY-MM-DDWhere: SpecifyHotel/Resort: Specify |

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| **Behavioural Social Risk Factors in the 2-4 weeks prior to onset of illness** | **❖ Response** | **Details***iPHIS character limit: 50.* (e.g., Brand name, purchase/consumption location, product details, date of exposure) |
|  | **Yes** | **No** | **Unknown** | **Not asked** |  |
| ***Attention!*** *If the case travelled during the entire incubation period, you can skip the remainder of the behavioural social risk factor section and go to the* **High Risk Occupation/High Risk Environment** *section on page ##. If the case travelled for part of their incubation period, please collect information for the behavioural social risk factors in Canada.* |
| **Other Modes of Transmission** |
| **❖** Anal-oral contact |[ ] [ ] [ ] [ ]  Specify |
| **❖** Close contact with case |[ ] [ ] [ ] [ ]  Specify |
| **❖** Lived outside of province in the six months prior to illness (specify province or country) |[ ] [ ] [ ] [ ]  Specify |
| **❖** Poor hand hygiene |[ ] [ ] [ ] [ ]  Specify |
| **❖** Other (specify) *for all modes of transmission* |[ ] [ ] [ ] [ ]  Specify |
| **❖** Unknown |[ ] [ ]  *→ For iPHIS data entry – check Yes for Unknown if all other Behavioural Risk Factors are No or Unknown.* |
| **♦** CreateExposures*Identify Exposures to be entered in iPHIS. → For iPHIS data entry – record details of exposure(s) in iPHIS Case Exposure Form as required.*  |

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| **Premises Referral** |
| Has a food premises been identified as a possible source?  | [ ]  Yes  [ ]  No  | *If yes, refer premises to the Food Safety Program and create an exposure as appropriate.* |

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| **High Risk Occupation/High Risk Environment** |
| Are you/ your child in a high risk occupation or high risk environment (including paid and unpaid/volunteer position)?  | [ ]  Yes [ ]  No  | [ ]  Child care/kindergarten staff or attendees [ ]  Food handler [ ]  Health care provider [ ]  Other (specify) Occupation: Specify |
| Name of Child care/ Kindergarten/ Employer | Enter name |
| Child care/Kindergarten/Employer Contact Information (name, phone number, etc.) | Enter contact information |
| Address | **Enter address** |
| Are you/ your child still experiencing diarrhea? | [ ]  Yes [ ]  No  | Last day case attended child care/kindergarten/work: | YYYY-MM-DD |
| *Exclusion required from Child care/kindergarten/work?*  | [ ]  Yes [ ]  No  | *Case/Parent/Guardian advised that public health unit will contact child care/ kindergarten/work?*  | [ ]  Yes [ ]  No  |
| Could we have your permission to release your/ your child’s diagnosis to child care/kindergarten/work?  | [ ]  Yes Enter name of individual permission granted by[ ]  No  |
| *Refer to the current Infectious Diseases Protocol, Amebiasis chapter, Appendix A, Management of Cases section for exclusion pertaining to child care staff and attendees, food handlers, and health care providers.* *→**For iPHIS data entry – if the case is excluded from work or child care/kindergarten, enter information under Interventions.*  |

*Where appropriate, advise probable cases to discuss with their physician subsequent stool specimen testing for differentiation of E. histolytica and E. dispar, before treatment is initiated. See the* [*Labstract*](http://www.publichealthontario.ca/en/eRepository/LAB_SD_013_Entamoeba_histolytica_dispar_differentiation_test.pdf) *for more information.*

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| **Symptomatic Contact Information**  |
| **Are you aware of anyone who experienced similiar symptoms before, during, or after you (or your child) became ill? This includes those in your family, household, child care or kindergarten class, sexual partner(s), friends or coworkers.**  | [ ]  Yes [ ]  No [ ]  N/A  |
| Contact 1 |
|  Name | Enter name | Relation to case | Specify |
|  Contact information(phone, address, email)  | Enter contact information |
| Notes | Enter notes |
| Recommend contact seek medical attention/testing?  | [ ]  Yes [ ]  No [ ]  N/A  |
| Contact 2 |
|  Name | Enter name | Relation to case | Specify |
|  Contact information(phone, address, email)  | Enter contact information |
| Notes | Enter notes |
| Recommend contact seek medical attention/testing?  | [ ]  Yes [ ]  No [ ]  N/A  |

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| **Education/Counselling** *Discuss the relevant sections with case* |
| **Hand Hygiene** |[ ]  Wash hands with soap and water after using the bathroom, after changing diapers, handling animals or pet food, and before preparing meals or eating meals is shown to be an effective measure to reduce transmission of diseases.  |
| **Recovery** |[ ]  If you continue to feel unwell, or new symptoms appear, or symptoms change – seek medical attention. |
| **Travel-related Illness** |[ ]  Refer to the Government of Canada’s Travel Health and Safety Page: [www.phac-aspc.gc.ca/tmp-pmv/info/index-eng.php](http://www.phac-aspc.gc.ca/tmp-pmv/info/index-eng.php). |
|  |[ ]  In areas where hygiene and sanitation are inadequate:* Bottled water from a trusted source is recommended instead of tap water. Use bottled water for drinking, preparing food and beverages, making ice, cooking, and brushing teeth. Alternatively, water can be boiled, chemically disinfected or filtered. Instructions for each method should be consulted.
* Avoid salads, already peeled or pre-cut fresh fruit and uncooked vegetables.
* Eat only food that has been fully cooked and is still hot, and fruit that has been washed in clean water and then peeled by the traveler. Avoid buying ready to eat foods from a street vendor.
 |
| **Education/Counselling** *Discuss the relevant sections with case* |
| **Travel-related Illness** |[ ]  Accidental ingestion or contact with recreational water from lakes, rivers, oceans, and inadequately treated swimming pools can cause many enteric illnesses. |
| **Sexual Transmission** |[ ]  Certain sexual activities increase the risk of transmission.* Avoid anal-oral sexual contact.
 |
|  |[ ]  Review importance of personal hygiene. |
| **Food Safety** |[ ]  Avoid preparing or serving food while ill with diarrhea. Consider reassignment of duties. |
|  |[ ]  Prevent cross contamination when preparing/handling food. |
|  |[ ]  Keeping produce dry and thoroughly wash using potable water may help with preventing illness. |

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| **Outcome** *Mandatory in iPHIS only if Outcome is Fatal* |
| [ ]  Unknown [ ]  ♦ Fatal [ ]  Ill [ ]  Pending [ ]  Residual effects [ ]  Recovered If fatal, please complete additional required fields in iPHIS |

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| **Thank you** |
| Thank you for your time. This information will be used to help prevent future illnesses caused by *Amebiasis*.  |

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| **Interventions** |
| **❖ Intervention Type** | **Intervention Implemented (check all that apply)** | **Investigator’s Initials** | ♦ **Start Date****YYYY-MM-DD** | **❖ End Date****YYYY-MM-DD** |
| Counselling | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| Education (e.g., disease fact sheet, general food safety education, hand washing information) | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| ER visit  | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| Exclusion | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| Food Recall | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| Hospitalization | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| Letter - Client | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| Letter - Physician | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| **Interventions** |
| **❖ Intervention Type** | **Intervention Implemented (check all that apply)** | **Investigator’s Initials** | ♦ **Start Date****YYYY-MM-DD** | **❖ End Date****YYYY-MM-DD** |
| Other (i.e., contacts assessed, PHI/PHN contact information) | [ ]  |  | YYYY-MM-DD | YYYY-MM-DD |
| *→ For iPHIS data entry – enter information under* ***Cases > Case > Interventions****.* |

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| **Progress Notes** |
| **Enter notes** |

If you have any comments or feedback regarding this Investigation Tool, please email us at ezvbd@oahpp.ca.