**Ontario Typhoid Fever** **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: TYPHOID FEVER Type: Home Mobile Work  **♦** Is this an outbreak associated case? Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Yes, *OB #* ####-####-###  No, *link to OB # 0000-2005-050 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** |
|  | **❖**Investigation Start Date |  |  |  | PHI  PHN  Other \_\_\_\_\_\_\_ |
|  | Assignment Date |  |  |  | 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 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 2 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 3 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 4 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 5 |  |  | Outgoing  Incoming |  |  |  |  |
| Call 6 |  |  | Outgoing  Incoming |  |  |  |  |
| Date letter sent: | | | | | | | |

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| **Case Details** | | | | | | | | | | | | | | | | | |
| **♦ Aetiologic Agent** | | *S. Typhi* | | | | | | | | | | | | | | | |
| **Subtype** | |  | | | | | | | | **Further Differentiation** | | | |  | | | |
| **♦ 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 | | | | | | |  | | | | | **♦ Status Date** | | YYYY-MM-DD | |
| Open (re-opened) | | | | | | |  | | | | | **♦ Status Date** | | YYYY-MM-DD | |
| Closed | | | | | | |  | | | | | **♦ Status Date** | | YYYY-MM-DD | |
| **♦ Priority** | | High | | | | | Medium  Low | | | | | | *(At health unit’s discretion)* | | | | |
| **Symptoms** | | | | | | | | | | | | | | | | |
| ***Incubation period*** *can range from 3 to more than 60 days, usually 8-14 days.*  ***Communicability*** *can be as long as the bacilli appear in the excreta. 2-5% of cases become chronic carriers. Chronic carriers may secrete the bacteria for years, often without being ill.* | | | | | | | | | | | | | | | | |
| ***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 Clock  HH: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* | | | | | | | | | | | | |
| **Abdominal Pain** |  | |  |  |  | | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD |
| Anorexia |  | |  |  |  | | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD |
| **Constipation** |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| Cough, not productive |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| **Diarrhea** |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| **Fever** |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| **Headache** |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| Malaise |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| **Rash, Rose Spots** |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | YYYY-MM-DD | |
| Other, *specify* |  | |  |  | |  | |  | | |  | YYYY-MM-DD | | |  | 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.* |
| - 60 days - 3 days 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 (specify)  (e.g., by medication or by disease such as cancer, diabetes, etc.) |  |  |  |  |  |
| **❖**Unimmunized (against Typhoid Fever) |  |  |  |  |  |
| **❖**Other (specify)  (e.g., use of antacid, surgery, etc.) |  |  |  |  |  |
| **❖**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:  Date(s): | | |
| **♦** 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:  ♦ Date of admission:  ❖ Date of discharge:  Unknown discharge date | | |
| *→ For iPHIS data entry – if the case is hospitalized enter information under Interventions.* | | | | | | | |
| Were you prescribed antibiotics or medication for your illness? | | Yes  No  Don’t recall | | | If yes, Medication:  Start date: End date:  Route of administration:  Dosage: | | |
| Did you take over-the-counter medication? | | Yes  No  Don’t recall | | |  | | |
| *Treatment information can be entered in iPHIS under* ***Cases > Case > Rx/Treatments>Treatment*** *as per current iPHIS User Guide* | | | | | | | |
| **Date of Onset, Age and Gender**  *Complete this section if submission of pages 5-7 and 12-13 to Public Health Ontario is required* | | | | | | | |
| Date of Onset: |  | | 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? |  |  |  |  |
| Were you on any specific diet(s) in the 3-60 days prior to the onset of your illness (e.g., vegetarian, vegan, gluten-free, kosher, halal, etc.)? |  |  |  |  |
| Chronic carriers can harbor the *S. Typhi* bacteria unknowingly for extended periods of time, often years and without being ill.  Have you had contact with anyone who is a known Typhoid Fever carrier? |  |  |  |  |
| Did you attend any special functions such as weddings, parties, showers, family gatherings or group meals in the 3-60 days prior to the onset of your illness? |  |  |  |  |

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| **Behavioural Social Risk Factors in the 3-60 days prior to onset of illness**  **Travel** | | **❖ Response** | | | | **Details**  *iPHIS character limit: 50* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **❖** Travel outside province in the 3-60 days prior to illness (specify) | |  |  |  |  |  |
| Within Canada |  |  |  |  | From:  To:  Where: |
| Outside of Canada |  |  |  |  | From:  To:  Where:  Hotel/Resort: |
| ***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 7. If the case travelled for part of their incubation period, please collect information for the behavioural social risk factors acquired in Canada.* | | | | | |
| Foodborne | | | | | | |
| **❖** Consumption of food brought from abroad | |  |  |  |  |  |
| **❖** Consumption of food prepared by an ill or unwell person  (i.e., ill with symptoms of Typhoid Fever or diarrhea) | |  |  |  |  |  |
| **❖** Consumption of raw/unpasteurized milk or milk products *(specify location of purchase)* | |  |  |  |  |  |
| **❖** Consumption of raw fruits (specify)  (e.g., sugar cane juice, mamey (a south/central American fruit) or other exotic produce) | |  |  |  |  |  |
| **❖** Consumption of raw vegetables (specify) | |  |  |  |  |  |
| **❖** Consumption of raw/undercooked shellfish (e.g., oysters) | |  |  |  |  |  |
| **Other Modes of Transmission** | | | | | | |
| **❖** Poor hand hygiene | |  |  |  |  |  |
| **❖** Anal-oral contact | |  |  |  |  |  |
| **Behavioural Social Risk Factors in the 3-60 days prior to onset of illness** | | **❖ Response** | | | | **Details**  *iPHIS character limit: 50* |
| **Yes** | **No** | **Unknown** | **Not asked** |
| **Other Modes of Transmission** | | | | | | |
| **❖** Close contact with case | |  |  |  |  |  |
| **❖** Close contact with visitors from abroad | |  |  |  |  |  |
| **❖** Other (specify) *for all modes of transmission* | |  |  |  |  |  |
| **❖** 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: | |
| Name of Child care/Kindergarten/Employer |  | | |
| Child care/Kindergarten/Employer Contact Information (name, phone number, etc.) |  | | |
| Address |  | | |
| Are you/ your child currently experiencing diarrhea? | Yes  No | Last day case attended child care/kindergarten/work: |  |

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| **High Risk Occupation/High Risk Environment** | | | |
| 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  No | | |
| *Refer to the current Infectious Diseases Protocol, Typhoid Fever chapter, Appendix A, Management of Cases section for exclusion pertaining to day 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.* | | | |

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| **Laboratory Specimen Clearance Results** | | | | | | |
|  | **Case or Contact?** | **Specimen Type** | **Collection Date** | **Result Date** | **Result** | **Comments/Client Notification** |
| 1 | Case  Contact |  |  |  |  |  |
| 2 | Case  Contact |  |  |  |  |  |
| 3 | Case  Contact |  |  |  |  |  |
| 4 | Case  Contact |  |  |  |  |  |
| 5 | Case  Contact |  |  |  |  |  |
| 6 | Case  Contact |  |  |  |  |  |

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| **Symptomatic/Asymptomatic 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 |  | | Relation to case | |  |
| Contact information  (phone, address, email) |  | | | | |
| Notes |  | | | | |
| Recommend contact seek medical attention/testing? | | Yes  No  N/A | | | |
| Contact 2 | | | | | |
| Name |  | | Relation to case | |  |
| Contact information  (phone, address, email) |  | | | | |
| 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.  Duration of excretion of the pathogen can persist for several days to several weeks after the acute phase. |
| **Recovery** |  | If you continue to feel unwell, or new symptoms appear, or symptoms change – seek medical attention. |
| **Food Safety** |  | Avoid preparing or serving food while ill with diarrhea. 2-5% of cases may become chronic carriers. Thus, there is still the potential for transmission after diarrhea has resolved. Consider reassignment of duties. |
|  | Proper cooking temperatures for all food.   * Shellfish should be boiled or steamed for at least 10 minutes before consumption. * Cook raw foods according to instructions. |
|  | Prevent cross contamination when preparing/handling food:   * Clean raw vegetables and fruits, including those used as garnishes, and * Refrigerate foods (including leftover cooked foods) as soon as possible. |
|  | Wash all produce before consumption, especially those eaten uncooked. |
|  | Avoid unpasteurized milk, dairy products, juices or cider. |
| **Water** |  | Avoid swimming or using a pool/spa, hot tub or splash pad if ill with diarrhea. |
|  | If using well water, test water regularly as water quality can change frequently. If results are adverse, boil or treat water for consumption. |
|  | If using surface water, boil or treat if testing is not readily available (e.g., while camping) or if test results indicate it is unsafe for consumption. |
|  | For more information on small drinking water systems and well disinfection, please visit  https://www.ontario.ca/page/drinking-water  and Public Health Ontario’s [Well Disinfection Tool](http://www.publichealthontario.ca/en/ServicesAndTools/Tools/Pages/Well-Disinfection-Tool.aspx) at <http://www.publichealthontario.ca/en/ServicesAndTools/Tools/Pages/Well-Disinfection-Tool.aspx>. |
| **Vaccination** |  | Vaccination should be considered for laboratory workers, household members of known carriers and persons travelling to endemic high-risk areas. |
| **Fomites** |  | Clean and disinfect surfaces (e.g., cutting boards, counters, utensils, diaper changing area, etc.).   * A 200 ppm chlorine solution should be sufficient to reach a medium level disinfection to kill or reduce most bacteria, viruses and fungi to acceptable levels. Mix 1 teaspoon (4mL) of bleach with 4 cups (1 litre) of water. * A 400 ppm is more appropriate for disinfecting more heavily soiled utensils and surfaces. Mix 2 teaspoons (8mL) of bleach with 4 cups (1 litre) of water. * For a chlorine dilution calculator, visit Public Health Ontario’s website: <http://www.publichealthontario.ca/en/ServicesAndTools/Tools/Pages/Dilution-Calculator.aspx> |

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| **Education/Counselling** *Discuss the relevant sections with case* | | |
| **Sexual Transmission** |  | Certain sexual activities increase the risk of transmission.   * Avoid anal-oral sexual contact while symptomatic or with symptomatic individuals. | |
|  | Review importance of personal hygiene. | |
| **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. * Avoid salads, already peeled or pre-cut fresh fruit, uncooked vegetables, raw/undercooked shellfish, and unpasteurized milk and milk products, such as cheese. * 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. | |
|  | Travellers, particularly Visiting Friends and Relatives (VFRs), should be referred to travel clinics to assess their personal risk and appropriate prevention measures. | |
|  | Accidental ingestion or contact with recreational water from lakes, rivers, oceans, and inadequately treated swimming pools can cause many enteric illnesses. | |

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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 *S. Typhi*. Please note that another investigator may contact you again to ask additional questions if it is identified that there is a possibility that you are included in an outbreak. |

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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 chart/cooking temperature chart, 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 |
| 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** |
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| **Shopping Venues** *Optional for sporadic cases* | | | | |
| **Where do you usually purchase food for home consumption (include grocery stores, farmers markets, specialty stores, ethnic markets, food banks, etc.)?** | | | | |
| **Types of food premises** | **Response** | | | **Name(s), Address(es) and Date(s) of purchase** |
| **Yes** | **No** | **Don’t know** |
| Grocery store/supermarkets/food warehouse (e.g., Costco)  If yes, do you use any loyalty cards at the grocery stores identified (e.g., Costco membership, PC points, etc.)?  Yes  No  Don’t know |  |  |  |  |
| Ethnic specialty markets |  |  |  |  |
| Delicatessens/bakeries |  |  |  |  |
| Fish shop, meat shop, butcher’s shop |  |  |  |  |
| Farmer’s market |  |  |  |  |
| Other |  |  |  |  |

If you have any comments or feedback regarding this Investigation Tool, please email us at [ezvbd@oahpp.ca](mailto:ezvbd@oahpp.ca).