Government of
Northwest Territories

Instructions for NWT Poliomyelitis Investigation Reporting Form

Healthcare professionals (HCPs) have a legislative duty to report notifiable and reportable diseases to the Chief Public Health Officer (CPHO) as required in the NWT *Public Health Act* (2009, SNWT 2007, c.17, SI-007-2009), with required information and timelines for reporting as defined in the *Disease Surveillance Regulations* (2009, R-096-2009). This information is used for territorial and national surveillance and informs public health planning and interventions. This reporting by the HCP is accomplished by submitting the NWT Poliomyelitis Form to the Office of the Chief Public Health Officer (OCPHO). Information on cases/suspected cases of the following is reportable within specific time frames:

Type	**Call CDCU (867) 920-8646 IMMEDIATLY** **Timeline for submitting the *Form* to OCPHO after making a diagnosis or opinion**
Poliomyelitis	24 hours

Further direction on contact tracing will be provided by OCPHO please contact (867) 920-8646.

What to Report

Information within this reporting form is used for surveillance. It can help track the progression of an outbreak through different sub-populations (i.e., underhoused). Data from these sections are also used to fulfill reporting requirements to federal partners.

Case information for suspect, probable and confirmed Poliomyelitis should always be filled in. IIf there is not enough room on the form to provide all information, please attached additional sheet with HCN on top right-hand corner.

Important!

A NWT Poliomyelitis Form, even if not fully complete, must still be reported (submitted) to the OCPHO within the timeframes identified above. It is expected that HCPs submit an *updated* form as new information is received. For example, it is unlikely that results from testing will be fully complete within the initial reporting timeframe but will be received later on these updates need to be reported (submitted) as information is provided. **This form is considered the only approved method to report this communicable disease to the OCPHO. Any other method, unless explicitly stated by the OCPHO, will not be accepted as completion of legislative reporting requirements.**

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Completed report form (initial form and updates) should be sent to OCPHO by
Medical Confidential Fax: 867-873-0442

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NWT POLIOMYELITIS INVESTIGATION REPORTING FORM

Report is: ☐ Initial ☐ Update **New information provided on section(s):**

SECTION 1 – PATIENT INFORMATION

Affix Label

Last Name:	**Current Occupation:**
First Name:	**Current Employer:**
HCN (including OOT HCNs): ☐ No HCN	**Work/Live/Frequent:** ☐ School ☐ Childcare ☐ Healthcare facility ☐ LTCF ☐ Group home/assisted living
Birthdate (dd/mmm/yyyy):	**Reason for Visit:** ☐ Symptomatic/suspect (ex. cough, paralysis) ☐ Potential Exposure ☐ Contact of a case ☐ General exam ☐ Referral from IRSCC (Immigration) ☐Other: _____
Sex at Birth: ☐Male ☐Female ☐ Intersex	
Current Address (include community):	
Preferred method of contact (fill in): ☐ Phone: _____ ☐ Email: _____ ☐ Other: _____	

SECTION 2 – IMMUNIZATION HISTORY

Type of Vaccine ☐ IPV-containing ☐ OPV ☐ Other: _____	Total doses:	Date of Last Dose:

SECTION 3 – INITIAL ASSESSMENT & FOLLOW-UP

Symptoms & Conditions (check all that apply)

Symptom	Date of onset	Condition	Date of onset
☐ Fever, temp(ºC):_____		☐ Aseptic meningitis	
☐ Sore throat		☐ Acute Flaccid Paralysis	
☐ Headache		**Sites of Paralysis:** ☐ Spinal ☐ Bulbar ☐ Spino-bulbar	
☐ Nausea		**Specific Sites:**	
☐ Vomiting		**Residual:** ☐ None ☐ Minor ☐ Significant (<2 extremities) ☐ Severe (<3 extremities) ☐ Unknown	
☐ Abdominal pain			
☐ Loss of appetite		☐ Abnormal neurological history:	
☐ Aching muscles		☐ Immune compromised:	
☐ Stiff neck/back		☐ Other:	
☐ Weakness or inability to move muscles (arms/legs/face/etc.)			
☐ Decreased/absent deep tendon reflexes			
☐ No sensory/cognitive loss			
☐ Neurological deficit present (no other apparent cause)			

Outcomes

Date of Death: ☐ N/A	
Hospitalized: ☐ No ☐ Yes, date admitted:	**Date discharged:**
ICU: ☐ No ☐ Yes, On ventilator ☐ No ☐ Yes	**Dates in ICU:**
Transfer Care: ☐ No ☐ Yes, Where:_____	**Date of Death:** ☐ N/A

SECTION 4 – LABORATORY INFORMATION

Specimens Collected (dd/mmm/yyyy)

Stool 1:	**Stool 2:**	**Throat Swab (viral):**
Other (type & date)		

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HCN:

SECTION 5 – RISK FACTORS & EXPOSURE HISTORY

Travel History (within past 30 days, please add additional sheet with HCN number top right corner if needed)

Did Case/Household Member live/travel in Endemic/Epidemic Area(s): ☐ No ☐ Yes to both (fill out separate sheet for household locations)

☐ Yes, Case ☐ Yes, Household (list for all locations)	Location:	Date Arrived:	Date Left:
	Location:	Date Arrived:	Date Left:
	Location:	Date Arrived:	Date Left:

Was Case/Household Member Exposed to Person(s) who Travelled from an Endemic/Epidemic Area(s)? ☐ No ☐ Yes to both (fill out separate sheet for household locations)

☐ Yes, Case ☐ Yes, Household (list for all locations)	Location:	Date Arrived:	Date Left:
	Location:	Date Arrived:	Date Left:
	Location:	Date Arrived:	Date Left:

Exposure

Did case/household member have contact with known case? ☐ No ☐ Yes, date:_____ where: _____

Did the case have contact with OPV Recipient? ☐ No ☐ Yes, date of last exposure:

Did case have contact with a person who travelled to an endemic/epidemic area? ☐ No ☐ Yes, date of last exposure:

Immigration Information (if applicable)

Date of Arrival to Canada:	**Port of Entry:**
Country of Immigration:	**Country of Birth:**

Spent time in refugee camp: ☐No ☐Unknown ☐Yes, Name of Camp:

SECTION 6 - REPORTING INFORMATION

Office of the Chief Public Health Officer
Phone: (867) 920-8646 | **Medical Confidential Fax: (867) 873-0442**

Completed by:	**(Sign)**
Phone:	**Date (dd/mmm/yyyy):**

Comments:

SECTION 7 – FOR OCPHO USE ONLY

OCPHO Notes/Recommendations (for OCPHO staff only)

Date (dd/mmm/yyyy):	**OCPHO Signature:**