Government of Northwest Territories | Gouvernement des Territoires du Nord-Ouest

COVID-19 OR INFLUENZA
REINFECTION OR SEVERE OUTCOME SURVEILLANCE

Personal health information is being collected under the *NWT Health Information Act* and the *Public Health Act* and will not be used or disclosed, unless allowed or required by these Acts or any other Act

Please indicate the viral respiratory illness you are reporting: **Covid-19**: ☐ **Influenza:** ☐ **Other respiratory pathogen:** ☐

Return ***within 24 hours of lab results*** or ***if directed*** to the Office of the Chief Public Health Officer:
Confidential fax line: 867-873-0442
NWT Reporting Line: 867-920-8646

1.Patient Information (use patient label if possible)

HCP #: DOB:

Name:

Community: other:

Phone # or **best contact method:**

2. Reason for Testing

- ☐ Contact of a case
- ☐ Notified of potential exposure (e.g. outbreak, PH Advisory)
- ☐ Individual sought health care (e.g symptomatic returning travelers)
- ☐ Surveillance of non-COVID respiratory pathogens
- ☐ Other, specify (e.g. repatriated patient):

3. Dwelling Type

- ☐ Private Dwelling (single family home or apartment)
- ☐ Congregate Living (LTC, Rooming house/group home)
- ☐ Isolation hotel/Isolation Centre
- ☐ Shelter, Experiencing Homelessness/Unstable housing
- ☐ Mine/Work camp
- ☐ Other, specify:

4. Race and Ethnicity *(check all that apply)

*Please obtain verbal consent to record patient's racial and ethnic identity for the purpose of eliminating health disparities related to COVID-19 infections.

- ☐ Not asked
- ☐ Prefer not to answer
- ☐ Black (e.g. African, Afro-Caribbean, African Canadian descent)
- ☐ East/ Southeast Asian (e.g. Chinese, Korean, Japanese, Taiwanese descent or Filipino, Vietnamese, Cambodian, Thai, Indonesian, other Southeast Asian descent)
- ☐ Indigenous (e.g. First Nations, Inuk/Inuit, Metis descent)
- ☐ Latino (e.g. Latin American, Hispanic descent)
- ☐ Middle Eastern (e.g. Arab, Persian, West Asian descent – i.e. Afghan, Egyptian, Iranian, Lebanese, Turkish, Kurdish)
- ☐ South Asian (e.g. South Asian descent – i.e. East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)
- ☐ Caucasian (e.g. European descent)
- ☐ Other, specify:
- ☐ Unknown

5. Occupation

- ☐ Health Care worker, specify type:
- ☐ Rotational worker (e.g. travel outside of the Territory for work)
- ☐ School/daycare worker OR attendee
- ☐ LTC/Closed facility, Location:
- ☐ EMS/Fire/RCMP
- ☐ Other Occupation, Specify:

6. Exposure Settings

Is the case currently a healthcare worker? (e.g. any role in a private or public health care setting, including employee, volunteer, student)

☐ Yes ☐ No ☐ Unknown ☐ Not asked

If the case is a healthcare worker, did the case provide direct patient care *in the 14 days prior to the date of symptom onset**?

☐ Yes ☐ No ☐ Unknown ☐ Not asked

*In-person patient care with or without the use of personal protective equipment

**If asymptomatic, refer to the date of collection of the positive lab specimen

7. Clinical Information Update

☐ Asymptomatic ☐ Symptomatic ☐ Unknown

Date of symptom onset:

SAO_2:_____% Temperature: °C

Has the client had a confirmed COVID-19 diagnosis in the past **90** days?

☐ Yes ☐ No Date of diagnosis (self-reported):

- ☐ Fever
- ☐ Cough
- ☐ Dyspnea
- ☐ Sore Throat
- ☐ Headache
- ☐ Anosmia
- ☐ Dysgeusia
- ☐ Fatigue
- ☐ Myalgia
- ☐ Malaise or Chills
- ☐ Diarrhea
- ☐ Abdominal pain
- ☐ Nausea or Vomiting
- ☐ Anorexia
- ☐ Congestion or Rhinorrhea
- ☐ Skin changes and rashes
- ☐ Acute Respiratory Distress Syndrome
- ☐ Tachypnea
- ☐ Altered mental status
- ☐ Clinical evidence of Pneumonia
- ☐ Radiological evidence of Pneumonia
- ☐ Hypotension
- ☐ Acute Renal Failure
- ☐ Venous/Arterial Thromboembolism
- ☐ Mechanical ventilation
- ☐ Other
  Specify:

COVID-19 or Influenza Reinfection and Severe Outcome Surveillance: Continued

8. Pre-existing Conditions & Risk Factors

☐ None Apply

☐ Yes ☐ No ☐ Not asked Hypertension

☐ Yes ☐ No ☐ Not asked Cardiovascular Disease

☐ Yes ☐ No ☐ Not asked Diabetes

☐ Yes ☐ No ☐ Not asked Chronic Kidney Disease

☐ Yes ☐ No ☐ Not asked COPD

☐ Yes ☐ No ☐ Not asked Asthma

☐ Yes ☐ No ☐ Not asked Immunodeficiency Disease/Condition

☐ Yes ☐ No ☐ Not asked Liver Disease

☐ Yes ☐ No ☐ Not asked Malignancy (cancer)

☐ Yes ☐ No ☐ Not asked Sickle Cell Disease

☐ Yes ☐ No ☐ Not asked Neurological Disorder

☐ Yes ☐ No ☐ Not asked Cerebrovascular Disease

☐ Yes ☐ No ☐ Not asked Obesity

☐ Yes ☐ No ☐ Not asked Smoking Tobacco

☐ Yes ☐ No ☐ Not asked Vaping (in the past 30 days)

☐ Yes ☐ No ☐ Not asked Problematic Substance Use (e.g. alcohol, injection drug, opioid use)

☐ Yes ☐ No ☐ Not asked Pregnant *If yes, Trimester:*

☐ Yes ☐ No ☐ Not asked Post-partum (≤6 weeks)

☐ Yes ☐ No ☐ Not asked Other:

9. Travel History

In the past 14 days did the client travel outside of the NWT (does NOT include travel within NWT)?

☐ Yes ☐ No

if yes:

☐ Domestic ☐ International

Travel from (including layovers):

Date of arrival in the NWT:

10. Exposure History

Exposure to a probable or confirmed case? ☐ Yes ☐ No

Date of last exposure:

11. Laboratory (check all that apply)

Initial specimen collection date:

RT-PCR test ordered (check all that apply): ☐ COVID-19 ☐ RPP ☐ Flu A/B

POCT Completed: ☐ Yes ☐ No

if yes, type: ☐ IDNow ☐ Panbio ☐ At-home rapid Ag (RAT) test

Date of POC test:

POCT test result:

Is this case part of an outbreak? ☐ Yes ☐ No

If yes, provide outbreak ID number:

12. Vaccination Information

Received Covid-19 vaccine? ☐ Yes ☐ No ☐ Not asked

Vaccine Type: ☐ Moderna ☐ Pfizer/BioNTech ☐ Unknown

☐ Other, specify:

Date of first dose:

Date of second dose:

Date of third dose:

Date of fourth dose:

Number of doses administered:

Received current season's flu vaccine? ☐ Yes ☐ No ☐ Unknown

If yes, date received:

13. Disposition Update

☐ Stable ☐ Deteriorating ☐ Deceased

Date of death: Cause of death:

14. Patient Setting

☐ Self-Isolation

☐ Inpatient (ward)	Admission date: Discharged date:
☐ Inpatient (ICU)	Admission date: Discharged date:

☐ Facility (LTC, Corrections), Specify:

15. Clinical Interventions

Is the client eligible for COVID-19 or flu-specific treatment/therapy?

☐ Yes ☐ No ☐ Unknown

If yes, select drug class (if known):

☐ Monoclonal antibody

☐ Antiviral

☐ Other, specify:

Additional Notes:

Health Service Provider Information

Clinic Site or Hospital Unit (e.g. Clinic, ED, ICU, LTC, Corrections:

Name (print): Signature: Date: