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

NWT CONFIRMED INFLUENZA REPORT FORM

PATIENT INFORMATION

Name:	HCP #:	Date of Birth: YYYY/MM/DD
Gender: ☐ Male ☐ Female	Ethnicity: ☐ Dene ☐ Metis ☐ Inuit ☐ Non-Aboriginal	
Community of Residence:		

ILLNESS (PLEASE COMPLETE IF INFORMATION AVAILABLE)

Date of symptom onset: YYYY/MM/DD	**ICU:** ☐ **Yes** ☐ **No**

Hospitalized: ☐ **Yes** ☐ **No** If Yes, facility name: ____

Date Admitted: YYYY/MM/DD Date Discharged: YYYY/MM/DD

Death: ☐ **Yes** ☐ **No** If Yes, death caused by influenza? ☐ Yes ☐ No (state other cause):_________________________

VACCINATION STATUS

	Date Vaccinated:	Vaccine Type:
Vaccinated this year: ☐ Yes ☐ No ☐ Unknown	Date Vaccinated: YYYY/MM/DD	Vaccine Type:
If < 6months, did mother receive vaccination during pregnancy: ☐ Yes ☐ No ☐ Unknown	Date Vaccinated: YYYY/MM/DD	Vaccine Type:

RISK FACTORS

Patient is a healthcare worker?	☐ Yes	☐ No	☐ Unknown	
Patient is pregnant?	☐ Yes	☐ No	☐ Unknown	If yes, due date: YYYY/MM/DD
Patient resides in long term care?	☐ Yes	☐ No	☐ Unknown	If yes, facility name:
Institutionalized?	☐ Yes	☐ No	☐ Unknown	If yes, facility name:
Patient is in school/day care?	☐ Yes	☐ No	☐ Unknown	If yes, facility name:
Travel prior to onset?	☐ Yes	☐ No	☐ Unknown	If yes, location & date:
Patient has chronic disease?	☐ Yes	☐ No	☐ Unknown	If yes, please check all that apply

- ☐ Chronic respiratory disease, including asthma
- ☐ Diabetes Mellitus
- ☐ Child/Teen on long-term aspirin therapy
- ☐ Chronic neurological disease
- ☐ Cancer
- ☐ Morbid obesity (BMI≥40)
- ☐ Other
- ☐ Congenital/Chronic heart disease
- ☐ Immunosuppression
- ☐ Chronic liver disease
- ☐ Chronic renal disease
- ☐ Haemoglobinopathy
- ☐ Any condition compromising respiratory function

HEALTH SERVICE PROVIDER INFORMATION

Name:	Community:
Signature:	Date: YYYY/MM/DD

Office of the Chief Public Health Officer
Phone: 867-920-8646 | Fax: 867-873-0442

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OFFICE OF THE CHIEF PUBLIC HEALTH OFFICER (OCPHO):	
Influenza Type: ☐ Influenza A ☐ Influenza B ☐ Other: Subtype: ____________________ Date of lab result: YYYY/MM/DD	
Patient part of an outbreak? ☐ Yes ☐ No ☐ Unknown	
Recommendations/Notes:	
Signature:	Date: YYYY/MM/DD

To be filled out for **CONFIRMED** Influenza Cases and Epidemiologically Linked ILI cases
Please fax completed form to:
The Office of the Chief Public Health Officer: 867-873-0442 (confidential fax line)

Office of the Chief Public Health Officer
Phone: 867-920-8646 | Fax: 867-873-0442