Instructions for Respiratory Virus Severe Outcomes Surveillance Report 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.

When to report:

To fulfill the reporting requirement for reporting cases of reportable viral respiratory disease with severe outcomes, the Respiratory Virus Severe Outcomes Surveillance Report Form should be completed and submitted to the Office of the Chief Public Health Officer (OCPHO) within **24 hours** of diagnosis or opinion.

Severe outcome = illness requiring hospitalization, or death

What to Report

Complete the applicable sections of the Respiratory Virus Severe Outcomes Surveillance Report Form:

Disease	Report Form Sections to complete
COVID-19	All sections
All other viral respiratory pathogens	Sections 1 through 6; Section 13 and 14

Where to find the Report Form

All current reporting forms can be found on the Department of Health and Social Services (HSS) website under **Forms**: https://www.hss.gov.nt.ca/professionals/en/services/forms

How to Report

Please send completed report forms to the OCPHO by:

Report Method	How-to
Medical Confidential Fax	867-873-0442
Secure File Transfer	outbreak@gov.nt.ca

Respiratory Virus Severe Outcome Surveillance Report Form

When to complete this form: Complete for ALL confirmed cases of viral respiratory disease with a SEVERE outcome in NWT. Severe outcome = hospitalization (ward or ICU) or death. Should a case have viral co-infection with severe outcome, please report all viruses contributing to illness in Section 3.

How to submit: Send completed forms within 24 hours of positive lab result to the Office of the Chief Public Health Officer:

By Medical Confidential Fax: 867-873-0442 **Secure File Transfer:** to outbreak@gov.nt.ca

Section 1: Case Information

Affix patient label

Last Name:	**First Name:**	
HCN:	**Date of Birth (dd/mmm/yyyy):**	
Home Community:	**Province/Territory:**	**Other:**
Phone Number/Best contact method:		

Section 2: Reason for Testing

- ☐ Individual sought Healthcare
- ☐ Contact of known case of respiratory disease
- ☐ Notified of potential exposure (e.g. outbreak, public health advisory)
- ☐ Other, please specify:

Section 3: Case Viral Illness Information (check all that apply if co-infection present)

- ☐ **COVID-19 (SARS-CoV-2)** — **Complete ALL report form sections (1 to 14)**
- ☐ Influenza
- ☐ Respiratory syncytial virus (RSV)
- ☐ Enterovirus
- ☐ Other, please specify:

Complete report form sections 1 through 6 and sections 13 and 14 ONLY

Section 4: Laboratory Specimen Testing Information (complete all that apply)

Test Type	Specimen Collection Date	Test Result		
PCR		☐ Negative	☐ Positive	☐ Indeterminate
POCT (e.g. IDNow, PanBio)		☐ Negative	☐ Positive	☐ Indeterminate
Home rapid Antigen Test (RAT)		☐ Negative	☐ Positive	☐ Indeterminate

Section 5: Signs and Symptoms

Symptom onset date: ☐ **Case is asymptomatic at time of report**

Symptoms at time of report (check all that apply):

- ☐ 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 or rashes
- ☐ Tachypnea
- ☐ Acute Respiratory distress syndrome
- ☐ Altered Mental Status
- ☐ Clinical Evidence of pneumonia
- ☐ Radiological Evidence of pneumonia
- ☐ Hypotension
- ☐ Acute renal failure
- ☐ Venous/arterial thromboembolism
- ☐ Mechanical ventilation
- ☐ Other, please specify:

Section 6: Clinical Course and Outcomes			
Admitted to hospital as a result of their illness (does not include ER visits)**:**	☐ **Yes**	☐ **No**	☐ **Unknown**
If hospitalized, was the case admitted to the intensive care unit (ICU):	☐ **Yes**	☐ **No**	☐ **Unknown**
Did the case require transfer to a medical facility out of territory (OOT)? (e.g. transfer to Alberta)	☐ **Yes**	☐ **No**	☐ **Unknown**

Admission Date (ward):	**Admission Date (ICU):**	**OOT Transfer Date:**
Discharge Date (ward):	**Discharge Date (ICU):**	**Receiving Facility:**

Deceased: ☐ **Yes** ☐ **No** ☐ **Unknown**

Indicate cause of death:

Death Date:

If completing form for COVID-19, please complete ALL sections. For all other diseases, skip to Section 13

COVID-19 ONLY

The following sections 7 through 12 are to be completed for cases of COVID-19 ONLY

Section 7: COVID-19 reinfection

The case had a previous confirmed COVID-19 diagnosis more than 90 days (3 months) ago: ☐ **Yes** ☐ **No** ☐ **Unknown**

Section 8: COVID-19 risk factors

Condition / Risk Factor	Yes	No	Unknown	Not Asked
Pregnancy	☐	☐	☐	☐

Section 9: Occupation

	Yes	No	Unknown	Not asked
Is the case currently a healthcare worker*? *Any role in a private or public health setting, including employee, volunteer, student	☐	☐	☐	☐
Is the case a rotational worker* (travel outside of province/territory for work)? * A worker whose shifts rotate or change according to a set schedule. This includes workers who work in remote or isolated regions at worksites that employ a fly-in-fly-out (FIFO) or drive-in-drive-out (DIDO) model (e.g., oil sands or mine workers).	☐	☐	☐	☐
Is the case a temporary foreign worker*? *Individuals who are neither a Canadian citizen nor a permanent resident who work in Canada	☐	☐	☐	☐

Section 10: Exposures

If the case was exposed to a known cluster or outbreak in the 14 days prior to symptom onset (or specimen collection date if asymptomatic), please specify outbreak or outbreak ID:

Section 11: additional Case Details

Sex assigned at birth: ☐ **Male** ☐ **Female** ☐ **Intersex** ☐ **Unknown**

Gender identity: ☐ **Male** ☐ **Female** ☐ **Other Gender** ☐ **Unknown**

COVID-19 ONLY

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

- ☐ **Black (e.g. African, Afro-Caribbean, African Canadian Descent)**
- ☐ **East/Southeast Asian (e.g. Chinese, Korean, Japanese, Taiwanese descent, 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, Turkish, Kurdish)**
- ☐ **South Asian (e.g. South Asian descent – i.e. East Indian, Pakistani, Bangladeshi, Sri Lankan, Indo-Caribbean)**
- ☐ **White (e.g. European descent)**
- ☐ **Other, please specify:**
- ☐ **Not asked**
- ☐ **Prefer not to answer**
- ☐ **Unknown**

If Indigenous, indicate which Indigenous identity the case self-identifies as:

First Nations	Metis	Inuk/Inuit	Not asked	Prefer not to answer	Unknown	Other, specify:
☐	☐	☐	☐	☐	☐	☐

Does the case reside in a First Nations community (on-reserve or Crown land) or Inuit Community?

☐ **Yes** ☐ **No** ☐ **Prefer not to answer** ☐ **Unknown**

Section 12: COVID-19 Vaccination Information

Dose Number	Date administered	Vaccine received
Dose 1		Other:
Dose 2		Other:
Dose 3		Other:
Dose 4		Other:
Dose 5		Other:
Subsequent dose		Other:

The following sections are to be completed for ALL cases reported

Section 13. Additional Notes

Section 14: Reporting Health Service Provider Information

Clinic site or Hospital Unit:

Name (print):	Signature:	Date:

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