

Canadian National, Provincial, and Territorial COVID-19 Case Report Forms - Field and Data Structure Comparisons							
LAST UPDATE: 2020-07-20							
Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
Form Information	PHAC - Coronavirus Disease (COVID-19) Case Report Form [version 2 Last updated March 3, 2020]	QC - Declaration des cas confirmés et des cas cliniques de COVID-19-20-210-103V [2020]	ON - (Appendix 1) Ontario's SARI Case Report Form [April 15, 2020 version 7.0]	BC CDC - COVID-19 Case Report Form [Version Date: April 20, 2020]	MHSU-6683 COVID-19 Case Investigation Form [2020-05-05]	NB - COVID-19 Combined Referral and Lab Requisition Form [V5 2020-04-09]	NWT - COVID-19 Report Form (Suspect Case/Person Under Investigation) Part A [Updated: April 27, 2020]
		QC - Questionnaire d'enquête des cas de Coronavirus COVID-10 [version du: 2 avril 2020]					NWT COVID-19 Report Form (For All Cases) Part B [Updated: April 27, 2020]
Case Protected Information							
CASE Information							
First name	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Name (doesn't specify first)
Middle name				<input checked="" type="checkbox"/>			Name (doesn't specify middle)
Last name	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Name (doesn't specify last)
Alternate name(s)				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Usual residential address	<input checked="" type="checkbox"/>	Indicates whether address is residential or not.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
City	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Province/Territory	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
Canada							<input checked="" type="checkbox"/>
Postal code	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Local Health Region	<input checked="" type="checkbox"/>				<input type="checkbox"/> WRHA <input type="checkbox"/> NRHA <input type="checkbox"/> PMH <input type="checkbox"/> SH-SS <input type="checkbox"/> IERHA <input type="checkbox"/> FNIHB <input type="checkbox"/> CSC		Community
Phone number #1	<input checked="" type="checkbox"/>	Landline	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Phone number #2	<input checked="" type="checkbox"/>	Cellular	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Phone number #3		Work number and extension					
Email		<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>	Could enter under "best contact me
Date of Birth	dd/mm/yyyy	YYYY-MM-DD	(dd/mm/yyyy)	yyyy/mm/dd	YYYY-MM-DD	<input checked="" type="checkbox"/>	YYYY/MM/DD
Racial/Ethnic Identity (Voluntary/Self-Reported)					<input type="checkbox"/> AFRICAN <input type="checkbox"/> FILIPINO <input type="checkbox"/> LATIN AMERICAN <input type="checkbox"/> CHINESE <input type="checkbox"/> NORTH AMERICAN INDIGENOUS <input type="checkbox"/> SOUTH ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK <input type="checkbox"/> SOUTHEAST ASIAN <input type="checkbox"/> DECLINED <input type="checkbox"/> OTHER (SPECIFY):		
Health Insurance Number		<input checked="" type="checkbox"/>					
Health Card Number				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Alternate ID (Specify Type)					<input checked="" type="checkbox"/>		
Registration Number					<input checked="" type="checkbox"/>	<input type="checkbox"/>	
Preferred Language						<input type="checkbox"/> English <input type="checkbox"/> French <input type="checkbox"/> Other	
Local Case ID	<input checked="" type="checkbox"/>			Primary Access Regional Information System (PARIS) Client ID	<input checked="" type="checkbox"/>		
P/T Case ID	<input checked="" type="checkbox"/>			Panorama Investigation ID	<input checked="" type="checkbox"/>		
Primary Care Provider					<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
PCP Phone						<input checked="" type="checkbox"/>	
PCP Location						<input checked="" type="checkbox"/>	
Immediate Family Members		(First and last name, Date of Birth) x4					
iPHIS Case ID:			<input checked="" type="checkbox"/>				
Responsible Health Unit			<input checked="" type="checkbox"/>				

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Branch office:			<input checked="" type="checkbox"/>				
Diagnosing Health Unit			<input checked="" type="checkbox"/>				
14 day follow-up		<input checked="" type="checkbox"/>					
CASE DETAILS: DISEASE / AETIOLOGIC AGENT / SUBTYPE			<input type="checkbox"/> Severe Acute Respiratory Infection <input type="checkbox"/> Middle East respiratory syndrome coronavirus (MERS-CoV) <input type="checkbox"/> COVID-19, Wuhan, China <input type="checkbox"/> Other Novel Respiratory Pathogen Specify: _____ <input type="checkbox"/> Novel Influenza A <input type="checkbox"/> H1__ <input type="checkbox"/> H3__ <input type="checkbox"/> H5__ <input type="checkbox"/> H7__ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Novel Influenza B _____				
Proxy Information							
Is respondent a proxy?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input checked="" type="checkbox"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	Infer from "sources of information"			
Last name	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				
First name	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
Relationship to case	<input checked="" type="checkbox"/>	<input type="checkbox"/> The patient answered for themselves <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other/someone else answered for the patient ----- <input type="checkbox"/> Mom <input type="checkbox"/> Father <input type="checkbox"/> Guardian	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	
Phone number #1	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>				
Phone number #2	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>				
Phone number (Residential)		<input checked="" type="checkbox"/>					
Phone number (Mobile)		<input checked="" type="checkbox"/>					
Phone number (Work, Ext.)		<input checked="" type="checkbox"/>					
Email address		<input checked="" type="checkbox"/>					
Source(s) of information				<input type="checkbox"/> Patient/family interview <input type="checkbox"/> Attending clinician <input type="checkbox"/> Hospital record <input type="checkbox"/> Other, specify: _____			
Contact information for person reporting							
Declarant Type		<input type="checkbox"/> Doctor/Physician ----- <input type="checkbox"/> Laboratory <input type="checkbox"/> Doctor <input type="checkbox"/> Identified by public DSP investigation					
First and Last Names	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Name	<input checked="" type="checkbox"/>	Name	Name of individual completing form	Name
Telephone #	<input checked="" type="checkbox"/>	Establishment/Clinic Telephone #	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Email	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>			
Fax #				<input checked="" type="checkbox"/>			
Health Authority				<input type="checkbox"/> FHA <input type="checkbox"/> FNHA <input type="checkbox"/> IHA <input type="checkbox"/> NHA <input type="checkbox"/> VCH <input type="checkbox"/> VIHA	<input checked="" type="checkbox"/>		
Establishment/Clinic Name where patient consulted		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>

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Establishment/Clinic City		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>		
Referral Date		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Referral Request Details						<input type="checkbox"/> 811 <input type="checkbox"/> Ambulance NB <input type="checkbox"/> ICU <input type="checkbox"/> Vitalité Zone 1 (Moncton) <input type="checkbox"/> Horizon Zone 1 (Moncton) <input type="checkbox"/> Hospital/ED <input type="checkbox"/> Zone 4 (Edmundston) <input type="checkbox"/> Zone 2 (Saint John) <input type="checkbox"/> Clinic/CHC <input type="checkbox"/> Zone 5 (Campbellton) <input type="checkbox"/> Zone 3 (Fredericton) <input type="checkbox"/> Correctional facility <input type="checkbox"/> Zone 6 (Bathurst) <input type="checkbox"/> Zone 7 (Miramichi) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Public Health <input type="checkbox"/> DH-Call Centre <input type="checkbox"/> Other: <input type="checkbox"/> EMP <input type="checkbox"/> Provider Office	
RSS Survey Code		<input checked="" type="checkbox"/>					
Main Form							
P/T Case ID	(duplicate of above field)				<input checked="" type="checkbox"/>		
Reported Date	dd/mm/yyyy	<input checked="" type="checkbox"/>	(dd/mm/yyyy)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		YYYY/MMM/DD
Date Report Received by health authority		YYYY-MM-DD		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
License number of person reporting		<input checked="" type="checkbox"/>					
Assessed in-person							<input checked="" type="checkbox"/>
Assessed in virtual care							<input checked="" type="checkbox"/>
Other Codes/IDS		V10 Code DSP Folder Code (Director of Professional Services)					
Administrative Information							
(Report Status)	<input type="checkbox"/> INITIAL REPORT <input type="checkbox"/> UPDATED REPORT	<input type="checkbox"/> In progress <input type="checkbox"/> Finished <input type="checkbox"/> Lost in Follow-Up	<input type="checkbox"/> INITIAL REPORT <input type="checkbox"/> UPDATED REPORT		<input type="checkbox"/> FOLLOW-UP COMPLETE <input type="checkbox"/> UNABLE TO COMPLETE INTERVIEW <input type="checkbox"/> PENDING		<i>Inferred from forms:</i> Part A: To be completed for all COV Part B: To be complete for all COVIT
Status Validation Date		YYYY-MM-DD					
Reporting Province / Territory	BC / AB / SK / MB ...	<i>No field to declare, can only infer it is from Quebec from the form.</i> ----- <input type="checkbox"/> Outside Quebec					<i>Inferred from form:</i> NWT
Outbreak or cluster related?			<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked		
If yes, local Outbreak #:			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		
Number of ill persons associated with the outbreak:			<input checked="" type="checkbox"/>				
For Provincial Use Only Has the outbreak been declared and made public?			<input type="checkbox"/> Yes <input type="checkbox"/> No				
If case is related to a provincial /territorial outbreak, P/T Outbreak ID			<input checked="" type="checkbox"/>				
Contact information for P/T person reporting							
First Name	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		Name (doesn't specify first) <i>dupl</i>
Last Name	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		Name (doesn't specify last) <i>dupl</i>
Email	<input checked="" type="checkbox"/>						
Telephone #	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>		

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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
Reason for testing	<input type="checkbox"/> Individual sought healthcare <input type="checkbox"/> Contact of a case <input type="checkbox"/> Routine respiratory disease surveillance <input type="checkbox"/> Other, specify:						<input type="checkbox"/> Individual sought health care <input type="checkbox"/> Routine respiratory disease surv <input type="checkbox"/> Contact of a case <input type="checkbox"/> Other, Specify:
Surveillance Case Classification	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Person Under Investigation <input type="checkbox"/> Does not meet	<input type="checkbox"/> Confirmed Case <input type="checkbox"/> Clinical Case ----- <input type="checkbox"/> Confirmed Case <input type="checkbox"/> Case Confirmed by Epidemiological link <input type="checkbox"/> Probable Case <input type="checkbox"/> Contact	<input type="checkbox"/> Confirmed <input type="checkbox"/> Presumptive Confirmed <input type="checkbox"/> Probable	<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Person Under Investigation <input type="checkbox"/> Not a Case	<input type="checkbox"/> Lab Confirmed <input type="checkbox"/> Probable <input type="checkbox"/> Not A Case		
Most Likely Acquisition Type (Staging)					<input type="checkbox"/> Travel Acquired <input type="checkbox"/> Close Contact of Known Case <input type="checkbox"/> Unknown		
Case Details							
Residency	<input type="checkbox"/> Canadian resident <input type="checkbox"/> Non-Canadian Resident, Country	Quebec resident, if not will be required to depart before isolation period is up.		<input checked="" type="checkbox"/>			
Detected at point of entry?	<input type="checkbox"/> No <input type="checkbox"/> Yes						
Location of entry	<input checked="" type="checkbox"/>						
Date of entry	dd/mm/yyyy						
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other ----- <input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unk <input type="checkbox"/> Other	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE <input type="checkbox"/> INTERSEX <input type="checkbox"/> UNKNOWN	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> X
Age	integer	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Would have to infer from DOB		<input checked="" type="checkbox"/>	
Guardian Name if age<16						<input checked="" type="checkbox"/>	
If under 2 Years			____ months <input type="checkbox"/> Unk				
Age unit	<input type="checkbox"/> years <input type="checkbox"/> months						
Received current season's flu vaccine (self-reported)?					<input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Does the case identify as Indigenous?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to Answer <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Aboriginal: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to Answer <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Non-BC Resident <input type="checkbox"/> Not asked	<input checked="" type="checkbox"/>		
If yes, indicate which group	<input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit <input type="checkbox"/> Refused to Answer <input type="checkbox"/> Unknown	<input type="checkbox"/> First Nations <input type="checkbox"/> Inuit <input type="checkbox"/> Unknown	<input type="checkbox"/> First Nations <input type="checkbox"/> Metis <input type="checkbox"/> Inuit	<input type="checkbox"/> Asked, but unknown <input type="checkbox"/> Asked, not provided <input type="checkbox"/> First Nations <input type="checkbox"/> First Nations and Inuit <input type="checkbox"/> First Nations and Métis <input type="checkbox"/> First Nations, Inuit and Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Inuit and Métis <input type="checkbox"/> Métis <input type="checkbox"/> Not asked	<input type="checkbox"/> FIRST NATIONS <input type="checkbox"/> INUIT <input type="checkbox"/> MÉTIS <input type="checkbox"/> DECLINED		
First Nations Status					<input type="checkbox"/> STATUS <input type="checkbox"/> NON-STATUS <input type="checkbox"/> DECLINED		
Indigenous organization				<input checked="" type="checkbox"/>			
Does the case reside on a First Nations Reserve most of the time?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to Answer <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to Answer <input type="checkbox"/> Unknown		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

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Vulnerable group		<input type="checkbox"/> Native <input type="checkbox"/> Member of a religious community <input type="checkbox"/> Homeless <input type="checkbox"/> Other Specify: ____					<input type="checkbox"/> Resident of LTC/Institution: <input type="checkbox"/> Experiencing Homelessness <input type="checkbox"/> Other, specify:
Patient lives at home		<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>		
Is the patient a resident of a long-term care facility?		<input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input checked="" type="checkbox"/>		
Patient lives in closed environment		<input type="checkbox"/> Hospital centre <input type="checkbox"/> Residential and long-term care centre <input type="checkbox"/> Private seniors' residence <input type="checkbox"/> Intermediate resource (IR) <input type="checkbox"/> Family-type intermediate resource (FTR) <input type="checkbox"/> Community accommodation <input type="checkbox"/> Rehab center <input type="checkbox"/> Prison <input type="checkbox"/> Religious congregation <input type="checkbox"/> Other Contact: ____					
Environment Information		Name, Address, City, Postal Code, Professional Contact, Telephone, Extension, Email Address			<input type="checkbox"/> ANIMAL HANDLER (FARMER,VET,ABBATOIR,ETC.) <input type="checkbox"/> CHILD CARE (WORK/VOLUNTEER/ATTENDEE) <input type="checkbox"/> CORRECTIONAL CENTER (RESIDENT) <input type="checkbox"/> CORRECTIONAL CENTER (WORK/VOLUNTEER) <input type="checkbox"/> HEALTH CARE FACILITY (RESIDENT/PATIENT) <input type="checkbox"/> HEALTH CARE FACILITY (WORK/VOLUNTEER) <input type="checkbox"/> PERSONAL CARE HOME (RESIDENT) <input type="checkbox"/> PERSONAL CARE HOME (WORK/VOLUNTEER) <input type="checkbox"/> SHELTER (RESIDENT) <input type="checkbox"/> SHELTER (WORK/VOLUNTEER) <input type="checkbox"/> LABORATORY WORKER <input type="checkbox"/> OTHER CONGREGATE SETTING (WORK/VOLUNTEER/RESIDENT, SPECIFY)		
Case is (professional role)	<input type="checkbox"/> Healthcare worker/volunteer with direct patient contact <input type="checkbox"/> Laboratory worker handling biological specimens <input type="checkbox"/> Veterinary/animal worker <input type="checkbox"/> School or daycare worker/attende <input type="checkbox"/> Farm worker <input type="checkbox"/> Resident of long-term care facility/institutional facility <input type="checkbox"/> Other, specify: _____		<input type="checkbox"/> Resident in an institutional facility (dormitory, shelter/group home, prison) <input type="checkbox"/> Laboratory worker handling biological specimens <input type="checkbox"/> Veterinary worker <input type="checkbox"/> School or daycare worker/ attendee <input type="checkbox"/> Farm worker <input type="checkbox"/> Resident of a retirement residence or long-term care facility <input type="checkbox"/> Other:	(Reference 'Environment Information')			<input type="checkbox"/> Health Care Worker <input type="checkbox"/> School/daycare worker OR atten <input type="checkbox"/> Lab worker/handles biological sp
Did the patient work outside the home in the two weeks before symptoms started?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input checked="" type="checkbox"/>		
In the 48 hours before the onset of symptoms, did the patient have close and prolonged contact during work? if yes, identify occupation		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input checked="" type="checkbox"/>		
Healthcare worker		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Health care worker or health care volunteer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input checked="" type="checkbox"/>		<input type="checkbox"/> Health Care Worker

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if yes,		<input type="checkbox"/> Hospital centre <input type="checkbox"/> Residential and long-term care centre <input type="checkbox"/> Local Community Service Centre - Routine service <input type="checkbox"/> Local Community Service Centre - Home Support <input type="checkbox"/> Private seniors' residence <input type="checkbox"/> Intermediate resource <input type="checkbox"/> Family-type intermediate resource <input type="checkbox"/> First responder <input type="checkbox"/> Laboratory <input type="checkbox"/> Unknown	If yes, with direct patient contact? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Nurse <input type="checkbox"/> Physician <input type="checkbox"/> Laboratory technician <input type="checkbox"/> Emergency medical personnel <input type="checkbox"/> Housekeeping <input type="checkbox"/> Administrative <input type="checkbox"/> Dental professional <input type="checkbox"/> Licensed practical nurse (LPN) <input type="checkbox"/> Care aide <input type="checkbox"/> Kitchen staff <input type="checkbox"/> Volunteer <input type="checkbox"/> Student (medical, dental, nursing, lab) <input type="checkbox"/> Other, specify:		<input type="checkbox"/> EM/ANB <input type="checkbox"/> First Responder <input type="checkbox"/> NH/LTC/ARF <input type="checkbox"/> Physician Office <input type="checkbox"/> Childcare centre <input type="checkbox"/> Horizon <input type="checkbox"/> Vitalité <input type="checkbox"/> Hospital <input type="checkbox"/> Lab <input type="checkbox"/> Clinic <input type="checkbox"/> Community Health Centre <input type="checkbox"/> Community Pharmacy <input type="checkbox"/> Other	
Worksite(s)		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>			
School or daycare worker		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed			<input type="checkbox"/> School/daycare worker OR atten
School or daycare attendee				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed			(duplicate of above)
Other worker		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			(Reference 'Environment Information')		
Worker providing essential services		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			(Reference 'Environment Information')		
Worker at risk of outbreak		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
if yes		<input type="checkbox"/> Private seniors' residence <input type="checkbox"/> Prison <input type="checkbox"/> Hospital centre <input type="checkbox"/> Residential and long-term care centre <input type="checkbox"/> Trade with customer service <input type="checkbox"/> Other					
Description of the job or main task (e.g. nurse, cook, police)		<input checked="" type="checkbox"/>					
Worker in direct contact with customers?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
Workplace name		<input checked="" type="checkbox"/>					
Workplace address		<input checked="" type="checkbox"/>					
Workplace contact name		<input checked="" type="checkbox"/>					
Workplace contact phone #		<input checked="" type="checkbox"/>					
Risk Level		<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low					
Symptoms							
Symptom Onset Date	mm/dd/yyyy BREAKS PATTERN!	YYYY-MM-DD	(dd/mm/yyyy)	yyyy/mm/dd	YYYY/MM/DD	<input checked="" type="checkbox"/>	YYYY/MM/DD
Symptom Onset Time (if applicable)					HH:MM		
Estimated					<input checked="" type="checkbox"/>		
Asymptomatic	<input type="checkbox"/> Asymptomatic	<input checked="" type="checkbox"/>	<input type="checkbox"/> No Symptoms	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input type="checkbox"/> Asymptomatic
Contagious Period		From (Date of Symptom Onset) ____ + 14 days To YYYY-MM-DD					

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Symptom							
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked/assessed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Cough, Dry <input type="checkbox"/> Cough, Productive	<input type="checkbox"/> New onset/exacerbation of chronic cough	<input type="checkbox"/> Cough
Fever (≥38°C)	"	"	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes if yes, specify the highest temperature recorded: ____ °C <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Fever (>38°C)	<input checked="" type="checkbox"/>	<input type="checkbox"/> Fever (Temperature, if known:)
Feverish/chills (temperature not taken)	"	"	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Chills		
Sore throat	"	"	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Sore Throat
Runny nose	"	"	Rhinorrhea/nasal congestion	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Rhinorrhea
Shortness of breath/difficulty breathing	"	"	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Dyspnea
Nausea/vomiting	"	"	<input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting	"	<input type="checkbox"/> Vomiting		
Headache	"	"	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Headache
General weakness	"	"		"	<input checked="" type="checkbox"/>		
Pain (muscular, chest, abdominal, joint, etc.)	"	"	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Chest pain	"	<input checked="" type="checkbox"/>		
Arthralgia (painful joints)			<input checked="" type="checkbox"/>	"			
Myalgia (muscle pain)			<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Myalgia
Irritability/confusion	" (page 3)	"		"	<input type="checkbox"/> Confusion, Altered Mental State		
Diarrhea	"	"	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Diarrhea/vomiting
Other, specify	"	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Other, specify:
Brutal anosmia without nasal obstruction, with or without ageusia		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input checked="" type="checkbox"/>		<input type="checkbox"/> Anosmia
Fatigue			<input type="checkbox"/> Fatigue/prostration		<input checked="" type="checkbox"/>		<input type="checkbox"/> Fatigue
Malaise			<input type="checkbox"/> Malaise/chills		<input checked="" type="checkbox"/>		<input type="checkbox"/> Malaise
Sputum production			<input checked="" type="checkbox"/>				
Swollen lymph nodes			<input checked="" type="checkbox"/>				
Sneezing			<input checked="" type="checkbox"/>				
Conjunctivitis			<input checked="" type="checkbox"/>				
Otitis			<input checked="" type="checkbox"/>				
Anorexia/decreased appetite			<input checked="" type="checkbox"/>				
Nose bleed			<input checked="" type="checkbox"/>				
Rash			<input checked="" type="checkbox"/>				
Seizures			<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		
Dizziness			<input checked="" type="checkbox"/>				
Coryza						<input checked="" type="checkbox"/>	
PRE-EXISTING CONDITIONS and RISK FACTORS							
Cardiac disease	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not asked	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked

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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
Chronic neurological or neuromuscular disorder	"	"	Neurologic Disorder If yes, please specify: <input type="checkbox"/> Neuromuscular Disorder <input type="checkbox"/> Epilepsy <input type="checkbox"/> Other: _____	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Diabetes	"	"	Metabolic Disease If yes, please specify: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Diabetes <input type="checkbox"/> Obese (BMI > 30) <input type="checkbox"/> Other: _____	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Immunodeficiency disease/condition	"	Immunosuppressed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Liver Disease	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Hepatic Disease " <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:"	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Malignancy	"		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:	"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Post-partum (≤6 weeks)	"	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Pregnancy	"	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	"	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
If yes, trimester Specify EDC	1st / 2nd / 3rd		If yes, week gestation:	<input checked="" type="checkbox"/>			<input checked="" type="checkbox"/>
Renal Disease	"	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:	"	YYYY-MM-DD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Age 60+						<input checked="" type="checkbox"/>	
Respiratory Disease	"	Respiratory illness (e.g. emphysema, chronic bronchitis)	Respiratory Disease If yes, please specify: <input type="checkbox"/> Asthma <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other: _____	"	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Hypertension		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	<input checked="" type="checkbox"/>	
Cancer		"		"		<input checked="" type="checkbox"/>	
Other, specify		<input checked="" type="checkbox"/>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline	<input checked="" type="checkbox"/>	
Additional Information						<input checked="" type="checkbox"/>	
Chronic health condition			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:		<input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked If yes, specify:
Hemoglobinopathy/Anemia			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:				
Receiving immunosuppressing medications			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, please specify:				
Substance use		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		
Smoking		<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed		
Vaping					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed		
Other (specify					<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed		
None Identified			<input checked="" type="checkbox"/>				
Severe obesity		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					
CLINICAL EVALUATIONS, COMPLICATIONS, and DIAGNOSES							

Canadian National, Provincial, and Territorial COVID-19 Case Report Forms - Field and Data Structure Comparisons

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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
Date of first presentation to medical care			(dd/mm/yyyy)				
Meningismus/nuchal rigidity			<input checked="" type="checkbox"/>				
Arrhythmia			<input checked="" type="checkbox"/>				
Abnormal lung auscultation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not assessed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Altered mental status	"	"	<input checked="" type="checkbox"/>	"	<input type="checkbox"/> Confusion, Altered Mental State [3]		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Clinical or radiological evidence of pneumonia	"	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Pneumonia		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Coma	"	"		"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Conjunctival injection	"			"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Diagnosed with Acute Respiratory Distress Syndrome	"	"	<input checked="" type="checkbox"/>	"	<input type="checkbox"/> Acute Respiratory Distress Syndrome		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
O2 saturation <95%	"	"	<input checked="" type="checkbox"/>	"			
Encephalitis	"	"	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Hypotension	"	"	<input checked="" type="checkbox"/>	"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Neonatal complications		"					
Pharyngeal exudate	"			"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Pregancy Complications and unfavorable issues		"					
Renal failure	"	"	<input checked="" type="checkbox"/>	"	<input type="checkbox"/> Renal Failure		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Seizure	"			"	<input type="checkbox"/> Seizure		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Sepsis	"	"	<input checked="" type="checkbox"/>	"	<input type="checkbox"/> Septicemia or Sepsis		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Tachypnea (accelerated respiratory rate)	"	"	<input checked="" type="checkbox"/>	"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Other, specify	<input checked="" type="checkbox"/>	"	<input checked="" type="checkbox"/>	"			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not asked
Convulsions		"					
CLINICAL COURSE and OUTCOMES (complete if applicable) (Page 4)							
Patient Setting							<input type="checkbox"/> Physician office/clinic <input type="checkbox"/> ED (not admitted) <input type="checkbox"/> Inpatient (ward) admission date <input type="checkbox"/> Inpatient (ICU) admission date <input type="checkbox"/> Home visit <input type="checkbox"/> Self-Isolation <input type="checkbox"/> Facility (LTC, Corrections) Specify: <input type="checkbox"/> Experiencing Homelessness
Hospitalization	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/>		<input type="checkbox"/> Inpatient (ward) <i>duplicate of above</i>
H. Admission date	<input checked="" type="checkbox"/>	YYYY-MM-DD	(dd/mm/yyyy)	yyyy/mm/dd	<input checked="" type="checkbox"/>		YYYY/MMM/DD
H. Discharge date	<input checked="" type="checkbox"/>	YYYY-MM-DD	(dd/mm/yyyy)	yyyy/mm/dd	<input checked="" type="checkbox"/>		
Discharge date 2			(dd/mm/yyyy)				
Case Discharged from Hospital			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
Case Transferred to another hospital			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
Re Admission Date			(dd/mm/yyyy)				
Diagnosis at time of admission:			<input checked="" type="checkbox"/>				
Intensive Care Unit (ICU)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/>		<input type="checkbox"/> Inpatient (ICU) <i>duplicate of above</i>
ICU Start Date	<input checked="" type="checkbox"/>	YYYY-MM-DD	(dd/mm/yyyy)	yyyy/mm/dd	<input checked="" type="checkbox"/>		YYYY/MMM/DD
ICU End Date	<input checked="" type="checkbox"/>	YYYY-MM-DD	(dd/mm/yyyy)	yyyy/mm/dd	<input checked="" type="checkbox"/>		
Isolation (e.g. negative pressure)		Home Isolation: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Patient isolated in hospital? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, specify type of isolation (e.g., respiratory droplet precaution, negative pressure):		<input type="checkbox"/> Facility Isolation <input type="checkbox"/> Home Isolation <input type="checkbox"/> Self Isolation (Other Location)		Self-isolation advice given <input type="checkbox"/> Yes <input type="checkbox"/> No ----- <input type="checkbox"/> Self-Isolation
Isolation Start Date	<input checked="" type="checkbox"/>	YYYY-MM-DD			<input checked="" type="checkbox"/>		

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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
Isolation End Date	<input checked="" type="checkbox"/>	YYYY-MM-DD			<input checked="" type="checkbox"/>		
Location if isolation is at different address than home					<input checked="" type="checkbox"/>		
Supplemental oxygen therapy			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
Mechanical ventilation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/>		
If yes, number of days on ventilation			<input checked="" type="checkbox"/>				
MV. Start Date	<input checked="" type="checkbox"/>	YYYY-MM-DD			<input checked="" type="checkbox"/>		
MV. End Date	<input checked="" type="checkbox"/>	YYYY-MM-DD			<input checked="" type="checkbox"/>		
Chest X-ray				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			YYYY/MMM/DD
Chest X-ray summary				<input checked="" type="checkbox"/>			<input type="checkbox"/> Not Applicable <input type="checkbox"/> No abnormalities suggestive of C <input type="checkbox"/> Evidence of lower respiratory tra
Physician diagnosis at time of this report				<input type="checkbox"/> Pneumonia / bronchitis <input type="checkbox"/> Other, Specify:			
Current Disposition <small>*Definition: resolution of symptoms followed by two negative tests at least 24 hours apart</small>	<input type="checkbox"/> Recovered* <input type="checkbox"/> Stable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Deceased	<input type="checkbox"/> Recovered <input type="checkbox"/> Stable <input type="checkbox"/> Deteriorated <input type="checkbox"/> Deceased	<input type="checkbox"/> Recovered* <input type="checkbox"/> Stable <input type="checkbox"/> Deteriorating <input type="checkbox"/> Deceased"	<input type="checkbox"/> Fully Recovered <input type="checkbox"/> Not yet recovered/recovering <input type="checkbox"/> Fatal <i>if died, date of death</i> <input type="checkbox"/> Permanent disability <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify:	<input type="checkbox"/> Fatal <input type="checkbox"/> Home Isolation <input type="checkbox"/> Hospitalization <input type="checkbox"/> ICU <input type="checkbox"/> Mechanical Ventilation <input type="checkbox"/> Recovered <input type="checkbox"/> Unknown ----- <input type="checkbox"/> Follow-Up Performed by Region <input type="checkbox"/> Follow Up Performed by Call Centre <input type="checkbox"/> Follow Up Complete		<input type="checkbox"/> Stable <input type="checkbox"/> Deceased <input type="checkbox"/> Deteriorating
Disposition date	mm/dd/yyyy BREAKS PATTERN!	YYYY-MM-DD	(dd/mm/yyyy)	(duplicate of report date)	YYYY-MM-DD to YYYY-MM-DD (if applicable)		
Location / Address (if Applicable)					<input checked="" type="checkbox"/>		
If deceased							
post-mortem:			<input type="checkbox"/> Performed <input type="checkbox"/> Pending <input type="checkbox"/> None <input type="checkbox"/> Unk				
Death attributed/linked to respiratory illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Respiratory illness contributed to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Contributed but wasn't underlying cause <input type="checkbox"/> Did not contribute to death/incidental <input type="checkbox"/> Underlying cause of death <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify:			
Respiratory illness was the underlying cause of death?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
Cause of death (as listed on death certificate)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>				<input checked="" type="checkbox"/>
Date of Death	mm/dd/yyyy BREAKS PATTERN!	YYYY-MM-DD		yyyy/mm/dd			YYYY/MMM/DD
Notes		<input checked="" type="checkbox"/>					
EXPOSURES (add additional details in the comments section as necessary)							
In the 14 days prior to symptom onset, did the case travel outside of their province/territory of residence or outside of Canada?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to Answer <input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked	<input type="checkbox"/> Travelled outside of New Brunswick within past 14 days	
If yes, specify the following (REPEATABLE)							
Departure Country	(city/country)	<input checked="" type="checkbox"/>	country/city, City of Origin		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>
Destination Country	(city/country)	<input checked="" type="checkbox"/>	Country/City Visited (For trips 1 and 2)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	(Location)	
Start Date	(mm/dd/yyyy)	Date of departure from Quebec (YYYY-MM-DD)	Dates of travel		<input checked="" type="checkbox"/>		YYYY/MMM/DD
End Date	(mm/dd/yyyy)	Date of arrival in Quebec (YYYY-MM-DD)	Dates of travel	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	YYYY/MMM/DD

Canadian National, Provincial, and Territorial COVID-19 Case Report Forms - Field and Data Structure Comparisons							
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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
Date of Arrival in Province		Date of arrival in Quebec (YYYY-MM-DD)					
Date of Departure from Province		Date of departure from Quebec (YYYY-MM-DD)					
Hotel/Residence	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>		
In the 14 days prior to symptom onset, did the case travel on a plane or other public carrier(s)?		<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		Cruise, Plane, Other mode of transportation		
Flight/Carrier Details (carrier name, flight #, seat #)	<input checked="" type="checkbox"/>	For any trip outside the region, province, country, involving a public transport (bus, boat, plane): transport company, flight no., route no., seat no., etc.	Flight /Carrier #, Carrier Name, Seat #, Travel type		<input checked="" type="checkbox"/>		
Was the case in close contact* with a symptomatic confirmed or probable case in the 14 days prior to symptom onset?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	Symptom onset irrelevant <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <i>(within 2 meters or 6 feet, more than 15 mins in total)</i>	<input checked="" type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked If yes, provide brief description	<input checked="" type="checkbox"/>	
If yes, complete the following (REPEATABLE)							
Case ID(s)	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	A confirmed case of the same disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, specify the Case ID: _____ A probable case of the same disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk If yes, specify disease: _____ at Case ID: _____	Panorama Investigation ID or Case identifiers (e.g., name, PHN)	<input checked="" type="checkbox"/>		
V10 number		<input checked="" type="checkbox"/>					
Date of First Contact	(mm/dd/yyyy)			yyyy/mm/dd	YYYY-MM-DD		
Sustained contact	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> DK			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UK	<input checked="" type="checkbox"/>		
Date of Last Contact	(mm/dd/yyyy)	<input checked="" type="checkbox"/>		yyyy/mm/dd	YYYY-MM-DD		
Contact Setting Comments	<input type="checkbox"/> Healthcare setting <input type="checkbox"/> Family Setting <input type="checkbox"/> Work place <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify _____	<input type="checkbox"/> Not investigated <input type="checkbox"/> Family <input type="checkbox"/> Residential and long-term care centre <input type="checkbox"/> Private seniors' residence <input type="checkbox"/> Hospital centre <input type="checkbox"/> Other healthcare setting <input type="checkbox"/> Prison <input type="checkbox"/> School <input type="checkbox"/> Nursery <input type="checkbox"/> Workplace <input type="checkbox"/> Transport <input type="checkbox"/> Other		<input type="checkbox"/> Household <input type="checkbox"/> Workplace <input type="checkbox"/> Health care <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify:	<input checked="" type="checkbox"/>		
Name of Environment/Location		<input checked="" type="checkbox"/>					
Name of contact		<input checked="" type="checkbox"/>					
comments				<input checked="" type="checkbox"/>			
Case known to have traveled outside Canada		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown					

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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)	
<p>Was the case in close contact* with a person with fever and/or cough who has been to an affected area** in the 14 days prior to their illness onset?</p> <p>* close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact OR who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill. (REPEATABLE)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown (page 5)		<p>A person who had fever, respiratory symptoms like cough or sore throat, or respiratory illness like pneumonia</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</p>		<p>Contact with someone with similar illness within 14 days of symptom onset:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked</p>			
Date of last contact	(mm/dd/yyyy)				YYYY-MM-DD to YYYY-MM-DD			
If yes, specify the type of contact:			<input type="checkbox"/> Household member <input type="checkbox"/> Person who works in a healthcare setting <input type="checkbox"/> Works with Patients <input type="checkbox"/> Person who works with animals <input type="checkbox"/> Person who travelled outside of Canada <input type="checkbox"/> Person who works in a laboratory <input type="checkbox"/> Other (specify): _____					
If yes, specify contact setting	<input type="checkbox"/> Healthcare setting <input type="checkbox"/> Family Setting <input type="checkbox"/> Work place <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify		<input type="checkbox"/> In a household setting <input type="checkbox"/> School/daycare <input type="checkbox"/> Farm <input type="checkbox"/> Other (please specify) <input type="checkbox"/> In a health care setting (e.g., hospital, long-term care home, community provider's office) <input type="checkbox"/> Other institutional setting (dormitory, shelter/group home, prison, etc.) <input type="checkbox"/> In means of travel (place, train, etc.)		<input checked="" type="checkbox"/>			
Exposure occurred in Canada	<input type="checkbox"/> Yes <input type="checkbox"/> No , specify _____ <input type="checkbox"/> Unknown				<input checked="" type="checkbox"/>			
In the 14 days prior to symptom onset, was this client exposed to a known cluster or outbreak (e.g. communal setting with cases, community cluster.)?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed				
Setting type:		<input checked="" type="checkbox"/>		<input type="checkbox"/> Acute care facility <input type="checkbox"/> Long term care facility <input type="checkbox"/> Assisted living <input type="checkbox"/> Independent living <input type="checkbox"/> Group home (community living) <input type="checkbox"/> Other residential facility type, specify: <input type="checkbox"/> Correctional facility <input type="checkbox"/> School or daycare <input type="checkbox"/> Shelter <input type="checkbox"/> Conference <input type="checkbox"/> Workplace not otherwise specified <input type="checkbox"/> Other, specify:				
Location Name		<input checked="" type="checkbox"/>						
Role/group				<input type="checkbox"/> Staff <input type="checkbox"/> Resident / patient <input type="checkbox"/> Inmate <input type="checkbox"/> Student <input type="checkbox"/> Other, specify:				
Cluster/outbreak name		<input checked="" type="checkbox"/>		<input checked="" type="checkbox"/>				
Start date				yyyy/mm/dd				
End date				yyyy/mm/dd				

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Field Name	Interim National	Quebec	Ontario	British Columbia	Manitoba	New Brunswick	North West Territories (Forms A/B)
<p>In the 14 days prior to symptom onset, did the case have contact with live animals (not considered household pets) or animal products in any of the affected areas**?</p> <p><i>This includes direct contact with animals, or contact with their feces or urine, soiled bedding/litter, or contact with other animal products (e.g. organs, exotic meats)</i></p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Declined To Answer <input type="checkbox"/> Not Asked		
<p>If yes, specify what animals or animal products that you had contact with</p>	<input checked="" type="checkbox"/>		<input type="checkbox"/> Cat(s) <input type="checkbox"/> Dogs <input type="checkbox"/> Horses <input type="checkbox"/> Cows <input type="checkbox"/> Poultry <input type="checkbox"/> Sheep / Goat <input type="checkbox"/> Wild Birds <input type="checkbox"/> <input type="checkbox"/> Rodents <input type="checkbox"/> Swine <input type="checkbox"/> Camel <input type="checkbox"/> Snakes/ reptiles <input type="checkbox"/> Wild game (eg. Deer) <input type="checkbox"/> Bats <input type="checkbox"/> Other: _____		<input checked="" type="checkbox"/>		
<p>If yes, specify date of last direct contact:</p>			(dd/mm/yyyy)		YYYY-MM-DD to YYYY-MM-DD		
<p>Did the animal display any symptoms of illness or was the animal dead?</p>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
<p>If yes, where</p>	<input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> During travel <input type="checkbox"/> Live animal market		<input type="checkbox"/> Home <input type="checkbox"/> Work (fill in occupational section) <input type="checkbox"/> Agricultural fair or event/petting zoo <input type="checkbox"/> Outdoor work/recreation (camping, hiking, hunting etc.) <input type="checkbox"/> Other: _____				
<p>Specify city</p>	<input checked="" type="checkbox"/>						
<p>In the 14 days prior to symptom onset, did the case have indirect contact with animals?</p>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
<p>If yes, specify date of last indirect contact</p>			(dd/mm/yyyy)				
<p>Where did the indirect contact occur?</p>			<input type="checkbox"/> Home <input type="checkbox"/> Work (fill in occupational section) <input type="checkbox"/> Agricultural fair or event/petting zoo <input type="checkbox"/> Outdoor work / recreation (camping, hiking, hunting, etc.) <input type="checkbox"/> Market where animals, meats and/or animal products are sold <input type="checkbox"/> Other: _____				
<p>Total number of contacts identified for this case</p>	integer			<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<p>unknown</p>	<input type="checkbox"/> Unknown			<input type="checkbox"/> Unknown	<input checked="" type="checkbox"/>		
<p>In the 14 days prior to symptom onset, did the case have indirect contact with animals?</p>			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
<p>If yes, specify date of last indirect contact</p>			(dd/mm/yyyy)				
<p>Where did the indirect contact occur?</p>			<input type="checkbox"/> Home <input type="checkbox"/> Work (fill in occupational section) <input type="checkbox"/> Agricultural fair or event/petting zoo <input type="checkbox"/> Outdoor work / recreation (camping, hiking, hunting, etc.) <input type="checkbox"/> Market where animals, meats and/or animal products are sold <input type="checkbox"/> Other: _____				
<p>Was there an event or location at which this client may have exposed 25 or more contacts?</p>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	<input checked="" type="checkbox"/>		
<p>if yes, event name</p>				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<p>Event date</p>				yyyy/mm/dd	<input checked="" type="checkbox"/>		
<p>Event Location</p>				<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>		
<p>Close contact with a person with acute respiratory illness/group exposure in last 14 days</p>				<i>Yes? Does have equivalent for confirmed covid-19 case and for group exposure event.</i>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
<p>Lab exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID (SARS-CoV-2)</p>				<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed		<input checked="" type="checkbox"/>	
<p>If the case has not traveled, has not had contact with a confirmed case, is not associated with an outbreak</p>							
<p>During the 14 days preceding the symptoms, the case frequented environments where he would have been in contact with symptomatic people</p>		<input type="checkbox"/> Yes (Suspected circles) <input type="checkbox"/> No (No source of acquisition suspected)					

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if yes, Social Circles		<div><input type="checkbox"/> Care environment, Hospital centre</div> <div><input type="checkbox"/> Care environment, Residential and long-term care centre</div> <div><input type="checkbox"/> Care environment,</div> <div><input type="checkbox"/> Work environment</div> <div><input type="checkbox"/> School environment</div> <div><input type="checkbox"/> Childcare</div> <div><input type="checkbox"/> Public transport</div> <div><input type="checkbox"/> Other</div>					
Further information on suspected cases		<div>In Response to each: <input type="checkbox"/> Yes, <input type="checkbox"/> No, <input type="checkbox"/> Unknown, Details (middle name)</div>					
LABORATORY INFORMATION (microbiology / virology / serology) (complete if applicable) (REPEATABLE)							
Lab ID	<div><input checked="" type="checkbox"/></div>	Analysis Laboratory Name	<div><input checked="" type="checkbox"/></div>	<div><input checked="" type="checkbox"/></div>			
Specimen Collection Date	(mm/dd/yyyy)	<div><input checked="" type="checkbox"/></div>	<div><input checked="" type="checkbox"/></div>	(yyyy/mm/dd)		(yyyy/mo/dd)	YYYY/MMM/DD
Time						<div><input checked="" type="checkbox"/></div>	
Collected By		Sampling Center Name and RSS				<div><input checked="" type="checkbox"/></div>	
Specimen Type & Source	<div><input checked="" type="checkbox"/></div>		<div><input checked="" type="checkbox"/></div>	<div><input type="checkbox"/> Upper respiratory (e.g., Nasopharyngeal or oropharyngeal swab)</div> <div><input type="checkbox"/> Lower respiratory (e.g., sputum, tracheal aspirate, BAL, pleural fluid)</div> <div><input type="checkbox"/> Other, Specify:</div>		<div>Sample source:</div> <div><input type="checkbox"/> Throat</div> <div><input type="checkbox"/> Nasopharyngeal</div> <div><input type="checkbox"/> Other</div>	<div><input type="checkbox"/> NP swab</div> <div><input type="checkbox"/> Throat swab</div> <div><input type="checkbox"/> Sputum</div> <div><input type="checkbox"/> Other (e.g. BAL), specify:</div>
Sentinal Site						<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div> <div>Specify:</div> <div><input type="checkbox"/> Admission</div> <div><input type="checkbox"/> ED</div>	
Contact case						<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div>	
Test of Cure						<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div>	
Test Method	<div><input checked="" type="checkbox"/></div>		<div><input checked="" type="checkbox"/></div>				
Test Result	<div><input type="checkbox"/> positive</div> <div><input type="checkbox"/> negative</div> <div><input type="checkbox"/> inconclusive</div> <div><input type="checkbox"/> pending</div>	<div><input type="checkbox"/> Confirmed Case* <i>Is it's own field, not the answer to a specified "test result" field</i></div> <div>-----</div> <div><input type="checkbox"/> Positive</div> <div><input type="checkbox"/> Ambiguous</div>	<div><input checked="" type="checkbox"/></div>	<div><input type="checkbox"/> Positive</div> <div><input type="checkbox"/> Negative</div> <div><input type="checkbox"/> Indeterminate</div> <div><input type="checkbox"/> Pending</div>			
Has another respiratory organism been identified?				<div><input type="checkbox"/> Yes</div> <div><input type="checkbox"/> No</div> <div><input type="checkbox"/> Unknown</div>			
if yes, specify the organism				<div><input checked="" type="checkbox"/></div>			
Test Date	(mm/dd/yyyy)		<div><input checked="" type="checkbox"/></div>				
Result Date		YYYY-MM-DD					
Results of National Microbiology Laboratory confirmatory testing:	<div><input type="checkbox"/> Not submitted</div> <div><input type="checkbox"/> Positive</div> <div><input type="checkbox"/> Negative</div> <div><input type="checkbox"/> Inconclusive</div> <div><input type="checkbox"/> Pending</div>						
Date of NML confirmation:	(mm/dd/yyyy)						
ADDITIONAL DETAILS/COMMENTS	<div><input checked="" type="checkbox"/></div>			<div><input checked="" type="checkbox"/></div>			
Ordering Provider						<div><input checked="" type="checkbox"/></div>	

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Label specimen as follows						<div>• PHPR - PH Priority Referral</div> <div>• HCP - Direct Care Healthcare Professional</div> <div>• HCW - Healthcare Worker/Staff</div> <div>• LTC/CORR/SHELTER/DAYCARE</div> <div>• HOSP - Hospitalized patient</div> <div>• INDIGENOUS – Member from Indigenous community</div>	
Specimen Type & Source							
Name of Antimicrobial			<div>✓</div>				
Specimen Type & Source			<div>✓</div>				
Test Method			<div>✓</div>				
Test Result			<div>✓</div>				
Test Date			<div>✓</div>				
TO BE COMPLETED BY: The Public Health Agency of Canada							
Date Received	(mm/dd/yyyy)						
PHAC Case ID	<div>✓</div>						
If applicable, national outbreak ID	<div>✓</div>						
*Check Priority Group if Applicable						<div><div><input type="checkbox"/> 1. Person Under Investigation by Public Health</div><div><input type="checkbox"/> 2. Symptomatic healthcare professional with direct patient care/contact (MD, NP, nurse, pharmacist etc.)</div><div><input type="checkbox"/> 3. Symptomatic staff in hospitals, nursing homes, childcare centres and other institutional or group living settings with direct patient care/contact</div><div><input type="checkbox"/> 4. Symptomatic patients/residents in institutional and group living settings with vulnerable populations (NH, corrections, shelter, etc.)</div><div><input type="checkbox"/> 5. Hospitalized patients with respiratory symptoms (new or exacerbated) and no alternative laboratory-based diagnosis</div><div><input type="checkbox"/> 6. Symptomatic members of Indigenous Communities</div></div>	
TREATMENT							
Did the case receive prescribed prophylaxis prior to symptom onset?			<div><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</div>				
Specify name			<div>✓</div>				
date of first dose			(dd/mm/yyyy)				
date of last dose			(dd/mm/yyyy)				
			<div><input type="checkbox"/> Antiviral medication</div> <div><input type="checkbox"/> Antibiotic/antifungal medication</div> <div><input type="checkbox"/> Immunosuppressant/immunomodulating medication</div> <div><input type="checkbox"/> Unknown</div> <div><input type="checkbox"/> None</div> <div><input type="checkbox"/> Other</div>				
In the treatment of this infection, is the case taking:							
Specify Name (1)			<div>✓</div>				
date of first dose (1)			(dd/mm/yyyy)				
date of last dose (1)			(dd/mm/yyyy)				
Specify name (2)			<div>✓</div>				
date of first dose (2)			(dd/mm/yyyy)				
date of last dose (2)			(dd/mm/yyyy)				
INTERVENTIONS: IMMUNIZATIONS							
Did the case receive the current year's seasonal influenza vaccine?			<div><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk <input type="checkbox"/> Vaccine not yet available</div>				
If yes, date of vaccination:			(dd/mm/yyyy)				
Did the case receive the previous year's seasonal influenza vaccine?			<div><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk</div>				

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Did the case receive pneumococcal vaccine in the past?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unk				
If yes, year of most recent dose:			(dd/mm/yyyy)				
If yes, type			<input type="checkbox"/> polysaccharide or <input type="checkbox"/> conjugate: 7 or 13				
ADDITIONAL DETAILS/COMMENTS (add as necessary)				<input checked="" type="checkbox"/>			
Routine Activities Prompt Worksheet-Case11 When interviewing a case, ensure that the following activity prompts are considered to identify a possible source of infection within the 14 days prior to the onset of symptoms: work; school; visitors at home; volunteer activities; daycare; religious activities; social activities (restaurants, shopping); sports; visits to acute care settings, long-term care homes, retirement homes, medical labs, dentists, and other health care providers; contact with ill persons; and contact with birds/swine or other animals.							
Date of Onset			(Create an acquisition exposure for each activity)				
Case Last Name			<input checked="" type="checkbox"/>				
Case First Name			<input checked="" type="checkbox"/>				
Date of Birth			<input checked="" type="checkbox"/>				
Gender			<input checked="" type="checkbox"/>				
PHU representative			<input checked="" type="checkbox"/>				
Date/Time (Start and End) (Repeatable)			<input checked="" type="checkbox"/>				
Activities/Contacts (Repeatable)			<input checked="" type="checkbox"/>				
Location of Activity (Repeatable)			<input checked="" type="checkbox"/>				
Contact Person (Name & Tel) (Repeatable)			<input checked="" type="checkbox"/>				
Comments (Repeatable)			<input checked="" type="checkbox"/>				

[1] Asks if resides on first nations community which is not synonymous with a first nations reserve.

[2] Asks if resides on first nations community which is not synonymous with a first nations reserve.

[3] repeat field