# Appendix 1: Ontario's Severe Acute Respiratory Infection Case Report Form

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<tr>
<th>iPHIS Case ID: _________________</th>
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</table>

## CLIENT RECORD

- **Last name:** ______________________________________
- **First name:** _____________________________________
- **Usual residential address:** __________________________
  _________________________________________________
- **City:** ________________ **Province/Territory:** _______
- **Postal code:** _________
- **Responsible Health Unit:** _____________
- **Branch office:** _____________
- **Diagnosing Health Unit:** _____________
- **Phone number(s):** (_____) ______ - ____________
  (_____) ______ - ____________
- **Date of Birth ____/____/________ (dd/mm/yyyy)**

## PROXY Information

- **Is respondent a proxy?** (e.g., for deceased patient, child)
  - □ No
  - □ Yes (complete information below)

- **Last name:** ______________________________________
- **First name:** ______________________________________
- **Relationship to case:** ______________________________
- **Phone number(s):** (_____) ______ - ____________
  (_____) ______ - ____________
  __________________

## Contact information for health unit person reporting

- **Name:** ______________________________________
- **Telephone #:** (____) ______ - ________
- **Email:** ______________________________________
Emerging Pathogens and Severe Acute Respiratory Infection (SARI) Case Report Form

### (2) ADMINISTRATIVE INFORMATION
- **□ Initial Report**  **□ Updated Report**  
  - **Report Date:** ____/____/_______ (dd/mm/yyyy)

#### OUTBREAK OR CLUSTER RELATED?
- □ Yes  □ No
  - **If yes, local Outbreak #:________**

#### NUMBER OF ILL PERSONS ASSOCIATED WITH THE OUTBREAK:
- _____

### (3) CASE DETAILS: DISEASE / AETIOLOGIC AGENT / SUBTYPE
- □ Severe Acute Respiratory Infection
- □ Middle East respiratory syndrome coronavirus (MERS-CoV)
- □ COVID-19, Wuhan, China
- □ Other Novel Respiratory Pathogen
  - **Specify:** ______________________________________

### (4) CASE DETAILS: CASE CLASSIFICATION
- (please refer to Ontario case definitions)
- □ Confirmed  □ Presumptive Confirmed  □ Probable

### (5) CLIENT RECORD: DEMOGRAPHIC INFORMATION
- **Gender:** □ Male  □ Female  □ Unk  □ Other (sp):
  - **Age:** _____ years  **If under 2 years**  
    - _____months  □ Unk

#### DOES THE CASE IDENTIFY AS ABORIGINAL?
- □ Yes  □ No  □ Refused to answer  □ Unk

#### DOES THE CASE RESIDE ON A FIRST NATIONS RESERVE MOST OF THE TIME?
- □ Yes  □ No  □ Refused to answer  □ Unk

### (6) SYMPTOMS (check all that apply)
- **Date of onset of first symptom(s):** ____/____/_______ (dd/mm/yyyy)

#### □ Fever (≥38°C)
- □ Swollen lymph nodes
- □ Sneezing
- □ Conjunctivitis
- □ Otitis
- □ Fatigue/prostration
- □ Malaise/chills
- □ Myalgia/muscle pain
- □ Arthralgia/joint pain
- □ Shortness of breath/difficulty breathing
- □ Chest pain
- □ Anorexia/decreased appetite
- □ Nausea
- □ Vomiting
- □ Diarrhea
- □ Abdominal pain
- □ Nose bleed
- □ Rash
- □ Seizures
- □ Dizziness
- □ Other, specify:
  - __________________________

#### □ Feverish (temp. not taken)

#### □ Cough

#### □ Sputum production

#### □ Headache

#### □ Rhinorrhea/nasal congestion

#### □ Sore throat

### (7) SYMPTOMS, INTERVENTIONS, and OUTCOME
**Date of first presentation to medical care:** ___/___/_______ (dd/mm/yyyy)

### Clinical Evaluations (check all that apply)
- [ ] Altered mental status
- [ ] Arrhythmia
- [ ] Clinical or radiological evidence of pneumonia
- [ ] Diagnosed with Acute Respiratory Distress Syndrome
- [ ] Encephalitis
- [ ] Hypotension
- [ ] Meningismus/neck rigidity
- [ ] O2 saturation ≤95%
- [ ] Other (specify): _______

### Case Hospitalized?
- [ ] Yes
- [ ] No
- [ ] Unk
- **Diagnosis at time of admission:**

### Case admitted to Intensive Care Unit (ICU)
- [ ] Yes
- [ ] No
- [ ] Unk
- **ICU Admission Date:** ___/___/_______ (dd/mm/yyyy)
- **ICU Discharge Date:** ___/___/_______ (dd/mm/yyyy)

### Patient isolated in hospital?
- [ ] Yes
- [ ] No
- [ ] Unk
- If yes, specify type of isolation (e.g., respiratory droplet precaution, negative pressure):

### Supplemental oxygen therapy
- [ ] Yes
- [ ] No
- [ ] Unk
- **Mechanical ventilation**
  - [ ] Yes
  - [ ] No
  - [ ] Unk
  - If yes, number of days on ventilation______

### Case Discharged from Hospital
- [ ] Yes
- [ ] No
- [ ] Unk
- **Discharge Date 1:** ___/___/_______ (dd/mm/yyyy)
- **Discharge Date 2:** ___/___/_______ (dd/mm/yyyy)
- **Transfer Date:** ___/___/_______ (dd/mm/yyyy)

### Current Disposition
- [ ] Recovered
- [ ] Stable
- [ ] Deteriorating
- [ ] Deceased
  - **If deceased, is post-mortem:**
    - [ ] Performed
    - [ ] Pending
    - [ ] None
    - [ ] Unk
  - Respiratory illness contributed to the cause of death?
    - [ ] Yes
    - [ ] No
    - [ ] Unk
  - Respiratory illness was the underlying cause of death?
    - [ ] Yes
    - [ ] No
    - [ ] Unk
  - **Cause of death (as listed on death certificate):**

### (8) RISK FACTORS (check all that apply)

- [ ] None identified
- **Cardiac Disease**
  - If yes, please specify:
  - [ ] Yes
  - [ ] No
  - [ ] Unk
- **Hemoglobinopathy/Ane mia**
  - If yes, please specify:
  - [ ] Yes
  - [ ] No
  - [ ] Unk

- **Hepatic Disease**
  - If yes, please specify:
  - [ ] Yes
  - [ ] No
  - [ ] Unk
- **Receiving immunosuppressing medications**
  - If yes, please specify:
  - [ ] Yes
  - [ ] No
  - [ ] Unk

- **Metabolic Disease**
  - If yes, please specify:
    - [ ] Diabetes
    - [ ] Yes
    - [ ] No
    - [ ] Unk
- **Substance use**
  - If yes, please specify:
    - [ ] Smoker (current)
    - [ ] Yes
    - [ ] No
    - [ ] Unk
<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>Unk</th>
<th>Other:________</th>
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</thead>
<tbody>
<tr>
<td>Obese (BMI &gt; 30)</td>
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<tr>
<td>Alcohol abuse</td>
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<td>Injection drug use</td>
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<tr>
<td>Renal Disease</td>
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<tr>
<td>Malignancy</td>
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<tr>
<td>Respiratory Disease</td>
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<td>Asthma</td>
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<td>Tuberculosis</td>
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<td>Other Chronic Conditions</td>
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<tr>
<td>Neurologic Disorder</td>
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<tr>
<td>Neuromuscular Disorder</td>
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<td>Epilepsy</td>
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<tr>
<td>Pregnancy</td>
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<tr>
<td>Immunodeficiency disease / condition</td>
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<tr>
<td>Post-Partum (≤6 weeks)</td>
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<tr>
<td>Treatment</td>
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<td>Did the case receive prescribed prophylaxis prior to symptom onset?</td>
<td>Yes</td>
<td>No</td>
<td>Unk</td>
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<tr>
<td>Specify name:____________________</td>
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<tr>
<td>date of first dose:</td>
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<td>date of last dose:</td>
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<td>In the treatment of this infection, is the case taking:</td>
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<td>Antiviral medication</td>
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<td>Antibiotic/antifungal medication</td>
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<td>Immunosuppressant/immunomodulating medication</td>
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<td>Unknown</td>
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<td>None</td>
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<tr>
<td>Other</td>
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<td>Interventions: Immunizations</td>
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<tr>
<td>Did the case receive the current year's seasonal influenza vaccine?</td>
<td>Yes</td>
<td>No</td>
<td>Unk</td>
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<td>If yes, date of vaccination:</td>
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<td>Did the case receive the previous year's seasonal influenza vaccine?</td>
<td>Yes</td>
<td>No</td>
<td>Unk</td>
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<td>Did the case receive pneumococcal vaccine in the past?</td>
<td>Yes</td>
<td>No</td>
<td>Unk</td>
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<td>If yes, year of most recent dose:</td>
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If yes, type ☐ polysaccharide or ☐ conjugate: 7 or 13

(11) LABORATORY INFORMATION

Microbiology / Virology / Serology (complete if applicable)

<table>
<thead>
<tr>
<th>Lab ID</th>
<th>Date Specimen Collected</th>
<th>Specimen Type &amp; Source</th>
<th>Test Method</th>
<th>Test Result</th>
<th>Test Date</th>
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Antimicrobial Resistance of suspect etiological agent(s) (complete if applicable)

<table>
<thead>
<tr>
<th>Lab ID</th>
<th>Name of Antimicrobial</th>
<th>Specimen Type &amp; Source</th>
<th>Test Method</th>
<th>Test Result</th>
<th>Test Date</th>
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(12) EXPOSURES (add additional details in the comments section as necessary)

Travel

In the 14 days prior to symptom onset, did the case travel outside of their province/territory of residence or outside of Canada? ☐ Yes ☐ No ☐ Unk

If yes, please specify the following (submit additional information on a separate page if required)

<table>
<thead>
<tr>
<th>Country/City Visited</th>
<th>Hotel or Residence</th>
<th>Dates of Travel</th>
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</thead>
<tbody>
<tr>
<td>Trip 1</td>
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<tr>
<td>Trip 2</td>
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</table>

In the 14 days prior to symptom onset, did the case travel on a plane or other public carrier(s)? ☐ Yes ☐ No ☐ Unk

If yes, please specify the following

<table>
<thead>
<tr>
<th>Travel Type</th>
<th>Carrier Name</th>
<th>Flight / Carrier #</th>
<th>Seat #</th>
<th>City of Origin</th>
<th>Dates of Travel</th>
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Human

In the 14 days prior to symptom onset, was the case in close contact (cared for, lived with, spent significant time within enclosed quarters (e.g., co-worker) or had direct contact with respiratory secretions) with:

A confirmed case of the same disease? ☐ Yes ☐ No ☐ Unk

If yes, specify the Case ID:_________

A probable case of the same disease? ☐ Yes ☐ No ☐ Unk

If yes, specify disease:___________ and specify the Case ID:_________
A person who had fever, respiratory symptoms like cough or sore throat, or respiratory illness like pneumonia? □ Yes □ No □ Unk

If yes, specify the type of contact:
- □ Household member
- □ Person who works in a healthcare setting
- □ Person who works in a laboratory
- □ Works with Patients
- □ Person who works with animals
- □ Person who travelled outside of Canada
- □ Other (specify): ______________________

Where did exposure occur?
- □ In a household setting
- □ School/daycare
- □ Farm
- □ Other (please specify)
- □ In a health care setting (e.g., hospital, long-term care home, community provider’s office)
- □ Other institutional setting (dormitory, shelter/group home, prison, etc.)
- □ In means of travel (place, train, etc.)

Occupational / Residential
The case is a:
- □ Health care worker or health care volunteer
- □ Laboratory worker handling biological specimens
- □ School or daycare worker/ attendee
- □ Resident of a retirement residence or long-term care facility
- □ Resident in an institutional facility (dormitory, shelter/group home, prison, etc.)

A. Direct Contact (touch or handle)
In the 14 days prior to symptom onset, did the case have direct contact with any animals or animal products (faeces, bedding/nests, carcass/fresh meat, fur/skins, camel milk, etc.)? □ Yes □ No □ Unk
If yes, specify date of last direct contact: ______/_____/_______ (dd/mm/yyyy)

What type of animals did the case have direct contact with? (check all that apply)
- □ Cat(s)
- □ Dogs
- □ Horses
- □ Cows
- □ Poultry
- □ Sheep / Goat
- □ Wild Birds
- □ Rodents
- □ Swine
- □ Camel
- □ Snakes/ reptiles
- □ Wild game (eg. Deer)
- □ Bats
- □ Other: ______________________

Did the animal display any symptoms of illness or was the animal dead? □ Yes □ No □ Unk

Where did the direct contact occur? (check all that apply)
- □ Home
- □ Work (fill in occupational section)
- □ Agricultural fair or event/ petting zoo
- □ Outdoor work/recreation (camping, hiking, hunting etc.)
- □ Other: ______________________

B. Indirect Contact (e.g., visit or walk through or work in an area where animals are present, etc.)
In the 14 days prior to symptom onset, did the case have indirect contact with animals? □ Yes □ No □ Unk
If yes, specify date of last indirect contact: ______/_____/_______ (dd/mm/yyyy)
Where did the *indirect contact* occur? *(check all that apply)*
- □ Home
- □ Work *(fill in occupational section)*
- □ Agricultural fair or event/petting zoo
- □ Outdoor work / recreation *(camping, hiking, hunting, etc.)*
- □ Market where animals, meats and/or animal products are sold
- □ Other: _____________________________

(13) ADDITIONAL DETAILS/COMMENTS *(add as necessary)*