

All Other DOPHS

HEALTH CARE PROVIDER REPORTING FORM

The Health Protection and Promotion Act 1990 (HPPA), R.S.O., 1990, and Ontario Reg. 135/18, outlines the requirements for health care providers and institutions to report **any suspect or confirmed disease of public health significance (DoPHS)** to the Medical Officer of Health.

This form is required to be completed and faxed to the Windsor-Essex County Health Unit (WECHU) – Infectious Disease Prevention Department (fax: 226-783-2132), after-hours (fax: 226-783-2113, phone: 519-973-4510).

Date Reported (YYYY/MM/DD):	Reporting Provider Name	Phone Number () - ext.	
DOPHS Reported:			
SECTION A: PATIENT INFORMATION			
Patient Name:			
(First)	(Middle)	(Last)	
Date of Birth (YYYY/MM/DD):	Age:	Sex:	
Address:			
(Street)	(City)	(Postal Code)	
Home Phone: ()		Alternate Phone: ()	
Parent/Guardian Name (if applicable):			

SECTION B: PRESENTING SIGNS AND SYMPTOMS			
✓ SIGNS & SYMPTOMS	Onset Date (YYYY/MM/DD)	✓ SIGNS & SYMPTOMS	Onset Date (YYYY/MM/DD)
<input type="checkbox"/> Asymptomatic		<input type="checkbox"/> Malaise [general unwell feeling]	
<input type="checkbox"/> Chills		<input type="checkbox"/> Myalgia [muscle pain]	
<input type="checkbox"/> Cough		<input type="checkbox"/> Respiratory distress	
<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Sore throat/hoarseness/difficulty swallowing	
<input type="checkbox"/> Difficulty breathing		<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Fever (> 38° C)		<input type="checkbox"/> Other, <i>specify:</i>	
<input type="checkbox"/> Headache			

SECTION C: LAB INFORMATION	
Specimen type:	Date Collected:

REPORTING HEALTH CARE PROVIDER'S SIGNATURE: _____