

Enteric/Food-Borne Diseases

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 physicians, practitioners, and institutions to report **any suspect or confirmed disease of public health significance** to the Medical Officer of Health.

This form is required to be completed and faxed within one working day of the initial patient assessment to the Windsor-Essex County Health Unit (WECHU) – Infectious Disease Prevention Department (fax: 226-783-2132).

Date Reported (YYYY/MM/DD):	Disease Being Reported:		
	<input type="checkbox"/> Amebiasis	<input type="checkbox"/> Food poisoning	<input type="checkbox"/> Shigellosis
	<input type="checkbox"/> Campylobacter	<input type="checkbox"/> Giardiasis	<input type="checkbox"/> Trichinosis
	<input type="checkbox"/> Cryptosporidiosis	<input type="checkbox"/> Listeriosis	<input type="checkbox"/> Yersiniosis
	<input type="checkbox"/> Cyclosporiasis	<input type="checkbox"/> Salmonellosis	<input type="checkbox"/> Other:

Name and Contact Number of Reporting Health Care Provider:

() - ext.

SECTION A: PATIENT INFORMATION

Patient Name:

(First) (Middle) (Last)

Date of Birth (YYYY/MM/DD):	Age:	Sex:
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Address:

(Street) (City) (Postal Code)

Home Phone: ()	Alternate Phone: ()
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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	
<input type="checkbox"/> Abdominal Pain/Cramps		<input type="checkbox"/> Nausea	
<input type="checkbox"/> Abdominal Bloating or Flatulence		<input type="checkbox"/> Vomiting	
<input type="checkbox"/> Anorexia (loss of appetite)		<input type="checkbox"/> Other:	
<input type="checkbox"/> Diarrhea		<input type="checkbox"/> Other:	
<input type="checkbox"/> Fever		<input type="checkbox"/> Other:	

SECTION C: LAB AND TREATMENT INFORMATION (Please attach all lab results)

Specimen type:	Date Collected:
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Was treatment ordered? No Yes If yes, treatment details:

SECTION D: RISK FACTORS		
<input type="checkbox"/> Yes <input type="checkbox"/> No	Travel outside of Ontario	Locations: Date of return (YYYY/MM/DD):
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient works in the food industry	Details:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient works in a daycare	Details:
<input type="checkbox"/> Yes <input type="checkbox"/> No	Patient works in health care	Details:

REPORTING HEALTH CARE PROVIDER'S SIGNATURE: _____

The most current version of the form is available on our website: <https://www.wechu.org/forms>.

For more information: 519-258-2146 ext. 1420

Infectious Disease Prevention

www.wechu.org

MARCH 2022