BC Contact Exclusion Form

Associated Lab Confirmed Case

Patient Surname: First Name: PHN:

Lab Report Date: (e.g. 15/Dec/07):

Associated Case Diagnosis

☐ S. Typhi ☐ S. Paratyphi ☐ Shigella ☐ E. coli

☐ Other: _____

Contact Demographic Information

Contact Surname:		First Name:	PHN:
Birthdate: (E.g. 15/Dec/07)	Sex: F ☐ M ☐	Parent or Guardian: ☐ Respondent is case	
Address: (street, city, postal code) E-mail:		Home phone: _____ Work: _____ Cell: _____	
Physician:		Physician Phone:	

Clinical Information

Onset of Earliest Symptom (E.g. 15/Dec/07) Time: am/pm ☐ Asymptomatic (E. coli/Shigella/S. Tyhpi)	Earliest Symptom:	Hospitalized: ☐Y ☐N ☐DK	Name of Hospital:
Other Symptoms: ☐ Fever ☐ Headache ☐ Nausea ☐ Malaise ☐ Diarrhea ☐ Abdominal cramps ☐ Vomiting Other: _____		Date of Admission (E.g. 15/Dec/07)	Date of Discharge (E.g. 15/Dec/07):
		Deceased: ☐Y ☐N ☐DK	Antibiotic Use: ☐Y ☐N ☐DK

Nature of Contact with Case

☐ Household ☐ Sexual contact ☐ Other: _____ _____	Details of contact:

Occupation and Exclusion

Occupation: Facility name:

Sensitive Setting (check if applicable):

- ☐ Work/volunteer or attend day care
- ☐ Work/volunteer in a health care setting
- ☐ Work/volunteer as a food handler
- ☐ Other (e.g. pool): _____

Excluded ☐Y ☐N

Effective date (e.g. 15/Dec/07):

Details:

Symptom end date (e.g. 15/Dec/07):

Exclusion lifted: (e.g. 15/Dec/07):

MHO:

Contact Exclusion Worksheet†

Antibiotic Use: ☐Y ☐N ☐DK Length of treatment: _____ days

Date of Discontinuation (e.g. 15/Dec/07):

Sample Number	Sample type	Date (E.G. 15/DEC/07)	Result
1	☐ Stool ☐ Urine		☐ Pos ☐ Neg
2	☐ Stool ☐ Urine		☐ Pos ☐ Neg
3	☐ Stool ☐ Urine		☐ Pos ☐ Neg
4	☐ Stool ☐ Urine		☐ Pos ☐ Neg

† Refer to CD Control Guidelines on Exclusion of Enteric Cases and their Contacts from High Risk Settings