BACTERIAL DISEASES SURVEILLANCE FORM (BDSF) Northwest Territories

Form created 01/99

1) Organism:_____ 2) HCP# _____ 3) NCS Accession #: _____

4) Information Source: ____ 5) Chart Review Status: ____ 6) Case Status: ____

7) Name_____, _____, ____ 8) Birthdate ____/____/_____ 9) Sex: _____(M or F)
(last) (first) (initial) dd mm yyyy

10) Ethnicity: _____ (Code__ __) 11) Town or Village: _____ 12) Postal Code __ __ __

13) Medical Facility:_____ (Code __ __ __) 14) Medical Record #:_____

15) Admitted on _____/_____/_____ 16) Check here if seen only as an outpatient ___ 17) Transferred? ____Yes ____No
dd mm yy

18) Date of transfer (dd/mm/yy)	19) Transfer Facility Name	20) Chart Number
_____/_____/_____		
_____/_____/_____		

21) Final Discharge on (dd/mm/yy) _____/_____/_____

22) Source of Positive Specimen(s) ✔ appropriate box(es)	23) Date Collected (dd/mm /yy)	24) Submitting Lab's Accession Number
G Blood	_____/_____/_____	_____
G CSF	_____/_____/_____	_____
G Other (specify)_____	_____/_____/_____	_____

25) Discharge Diagnoses *(Check (✔) all diagnoses attributed to the organism reported in (1) above)*

___Septicemia ___Meningitis ___Endocarditis ___Pericarditis ___Empyema ___Peritonitis ___Epiglottitis

___Pneumonia ___Septic Arthritis ___Cellulitis ___Amnionitis ___Sepsis,unknown focus

___Other (specify)_____ ___No information available

26) Other Concurrent Infectious Illnesses (*list*):

_____

AIP use only: ICD_____ ICD_____

27) Death during present illness? ___Yes ___No 28) Date of death (dd/mm/yy): ___/___/___

29) Other factors noted from chart(s): *(Check (✔) as many factors as apply to this case)*

___Smoker ___Chronic lung disease ___Asthma ___Pregnancy

___ IDU ___Splenectomy/asplenia ___Diabetes ___Alcohol abuse

___Homelessness ___ On Immunosuppressive Therapy

___ Other risk factor/behavior (specify):

30) Immunization history *(Complete only for the organism reported in (1) above)*:

S. pneumoniae ___No ___Unknown ___Yes Dates (dd/mm/yy) _____/_____/_____ _____/_____/_____

H. influenzae ___No ___Unknown ___Yes Dates (dd/mm/yy) _____/_____/_____ _____/_____/_____

_____/_____/_____ _____/_____/_____

N. meningitidis ___No ___Unknown ___Yes Date (dd/mm/yy) _____/_____/_____

31) Reviewer:_____ 32) Phone # (___)_____ 33)Date completed: (dd/mm/yy) ____/____/____

34) Additional comments? ___No ___Yes (Please write them on the back of this form) 35) Review complete? Y=yes ____

When form is completed, black out the name in field # 7 and fax to ICS Coordinator, Arctic Investigations Program at (907)-729-3429

Please black out the name in #7, then <u>FAX this form to</u> the ICS Co-ordinator at (907)-729-3429 <u>AND MAIL this form to</u> International Surveillance, CDC-Arctic Investigations Program, 4055 Tudor Centre Drive, Anchorage, Alaska, USA 99508.