 **Perinatally Acquired Notifiable Disease Enhanced Report**

**Fax Completed Form to: 780-415-9609**

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|  | [ ] Unable to contact[ ] Lost to follow-up | **Lives on Reserve** [ ] No [ ] Yes 🡪 If Yes, name of reserve: Enter Name  |
| **SECTION 1: MATERNAL** |
| **1a. Personal Identifiers** |
| **Identifier Code:** ID Code  | **PHN/Other Identifier** Enter PHN  | **Birth Date:** Select Date  | **Ethnic Group:**  [ ] Caucasian [ ] Black [ ] Asian (East/SE) [ ] Other Asian[ ] Middle East/Arab [ ] Latin American [ ] First Nations [ ] Inuit [ ] Métis [ ] Unknown [ ] Other, Specify: Specify Other  |
| **Name:** Last Last Name First First Name Middle Middle Name  | **Alias:** Last Last Name First First Name  |
| **Address:** Enter Address  | **Municipality:**  Enter Municipality  | **Province:** Select Province  | **Country:** Enter Country  | **Postal Code:** Enter Postal Code  |
| **1b. Clinical Details - Prenatal/Delivery** |
| **Was disease diagnosed/screened for during pregnancy?** [ ] No [ ] Yes [ ] Unknown  |
| **If yes** 🡪 **Date:** Select Date  | **Screening Reason:** Select Reason Other, specify: Specify Other  | **Gestational age at time of screen:** Enter Age  |
| **Screening Result:** Enter Result  | **Treatment/Prophylaxis provided?** [ ] Yes 🡪 Date: Select Date Agent: Enter Agent [ ] No 🡪 Reason not provided: Enter Reason  |
| **Pregnancy Outcome:** Select Outcome  | **Gestational age at outcome:** Enter Age  | **Outcome Date:** Select Date  | **Outcome Related to Disease?**[ ] No [ ] Yes [ ] Unknown |
| **1c. Immunization – Varicella only** |
| **History of disease prior to pregnancy?**[ ] No [ ] Yes [ ] Unknown | **History of immunization prior to pregnancy?**[ ] No [ ] Yes [ ] Unknown | **Immunization Records Available?**[ ] No [ ] Yes |
| **Vaccine Code** | **Antigen Count** | **Date Received** |
|  Enter Vaccine Code  |  Enter Antigen Count  |  Select Date  |
|  Enter Vaccine Code  |  Enter Antigen Count  |  Select Date  |
| **SECTION 2: INFANT** |
| **2a. Personal Identifiers** |
| **Identifier Code** ID Code  | **PHN/Other Identifier** Enter PHN  | **Birth Date** Select Date  | **Gender** [ ] Male [ ] Female [ ] Other [ ] Unknown  | **Birth Weight (grams):** Enter Weight  |
| **Name:** Last Last Name First First Name Middle Middle Name  | **Alias:** Last Last Name First First Name  |
| **Address:** Enter Address  | **Municipality:** Enter Municipality  | **Province:**  Select Province  | **Country:**  Enter Country  | **Postal Code:**  Enter Postal Code  |
| **2b. Laboratory Test Details** |
| **Disease name:** Enter Disease  | **ICD Code:** Enter Code  | **Diagnosis (as per case definition)** [ ] Confirmed [ ] Probable |
| **Diagnosis Date:** Select Date  | **Specimen Collection Date:** Select Date  |
| **Type of Specimen** [ ] Blood [ ] CSF [ ] Eye Swab [ ] Fluid [ ] Lesion [ ] Nasopharyngeal [ ] Stool [ ] Sputum [ ] Throat Swab[ ] Tissue [ ] Urine [ ] Vesicular Scraping [ ] Other: Specify Other  |
| **2c. Clinical Details – Live Birth only** |
| **Delivery method:** Select Method  | **CMV Only: Breastfed?**  [ ] No [ ] Yes |
| **Hospitalized**[ ] No[ ] Yes[ ] Unknown | **Fatal** 🡪 Death Date: Select Date  | [ ] Died from disease[ ] Disease contributed to death (secondary cause)  | [ ] Died other causes[ ] Died cause unknown |
| **Autopsy Performed?**  [ ] No [ ] Yes [ ] Unknown |
| **Prior to symptom onset, was the infant given** **Post Exposure Prophylaxis?** [ ] No [ ] Yes [ ] Unknown | **If Yes, Agent Received:** Enter Agent  | **Date Received:** Select Date  |
| **After symptom onset, was the infant given treatment?**  [ ] No [ ] Yes | **If Yes, Agent Received:** Enter Agent  | **Date Received:** Select Date  |
| **2d. Manifestations - Select All That Apply for Disease being reported** |
| **Chlamydia** [ ] Ophthalmia Neonatorum [ ] Pneumonia [ ] Other, specify: Specify Other  |
| **Congenital Cytomegalovirus** [ ] Brain Damage [ ] Hepatosplenomegaly [ ] Intracerebral calcifications [ ] Intrauterine growth retardation[ ] Jaundice [ ] Microcephaly [ ] Purpura [ ] Retinitis [ ] Sensorineural hearing loss [ ] Other, specify: Specify Other  |
| **Congenital Toxoplasmosis** [ ] Chorioretinitis [ ] Diarrhea [ ] Encephalitis [ ] Hydrocephalus [ ] Hypothermia [ ] Intracranial calcification [ ] Jaundice [ ] Mental retardation [ ] Microcephaly [ ] Pneumonitis [ ] Psychomotor impairment [ ] Rash [ ] Seizure Disorder [ ] Strabismus [ ] Thrombocytopenia [ ] Other, specify: Specify Other  |
| **Gonorrhea** [ ] Arthritis [ ] Bacteremia [ ] Meningitis [ ] Ophthalmia Neonatorum [ ] Scalp abscess [ ] Vaginitis[ ] Other, specify: Specify Other  |
| **Neonatal Herpes Simplex** [ ] Disseminated infection [ ] Localized CNS infection [ ] Infection of skin, eyes or mouth [ ]  Other, specify: Specify Other  |
| **Varicella (Chickenpox), Congenital and Neonatal** [ ] Cardiovascular anomalies [ ] Eye disorders [ ] Genitourinary anomalies[ ] Intrauterine growth retardation [ ] Limb hypoplasia and other skeletal anomalies [ ] Neurologic defects [ ] Skin lesions[ ] Other, specify: Specify Other  |
| **SECTION 3: ADDITIONAL INFORMATION / REPORTING** |
| **Comments:** Add Comments  |
| **Submitter:** Enter Name  | **Telephone number:** Enter Number  | **Date Reported to Alberta Health:** Select Date  |