C:\Users\ann.chung\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.Word\AB-Gov 2Color Sky RGB.JPG **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 | | | | | | | | |