Northwestern Health Unit
www.nwhu.on.ca

Northwestern Health Unit Control of Infectious Diseases
Human Immunodeficiency Virus (HIV) Public Health Case Investigation

Please return this completed form to the Northwestern Health Unit by fax at 807-468-3813

DATE: _____ ☐ **Internal Case**

Client demographics: Please confirm current address, telephone, and email, or affix label	
Name:	Telephone:
Gender:	Email:
DOB (YY/MM/DD):	Address, including postal code:
Health Card #:	

Is client First Nations? No ☐ Yes ☐
If yes, do they live in a First Nations community? No ☐ Yes ☐ Specify which community: _____

Reason For Testing				
☐ Routine	☐ Contact Tracing	☐ Immigration	☐ Symptoms	☐ Blood or organ donation
☐ Insurance	☐ Post-mortem	☐ Prenatal-EDC:		☐ Other:
Has the client tested positive in the past for HIV? ☐ No ☐ Yes				
If YES, when?		If YES, where?		
Disease diagnosed: ☐ HIV ☐ AIDS				
Is patient deceased? ☐ No ☐ Yes, date of death:			☐ Cause:	

Symptoms (select all that apply)	**Start date**
☐ Asymptomatic	N/A
☐ Fever	
☐ Rash	
☐ Lymphadenopathy	
☐ Fatigue/Lethargy	
☐ Sore throat	
☐ Arthralgia/myalgia	
☐ Unexplained weight loss	
☐ Oral hairy leukoplakia	
☐ Other, please specify:	

Other STBBI screening	**Results**
☐ Chlamydia	
☐ Gonorrhea	
☐ Hepatitis B	
☐ Hepatitis C	
☐ Syphilis	
☐ Other:	

Last confirmed HIV negative test	
Date:	Location:

Counselling	
Client is aware of diagnosis: ☐ Yes ☐ No	
Client has been advised of:	
☐ Situations where disclosure of diagnosis would be legally required	☐ Importance of notifying and testing contacts
☐ Modes of HIV transmission (blood, pre-ejaculate/semen, anal/vaginal secretions, breastmilk)	☐ Risk reduction strategies to prevent transmission including use of condoms and harm reduction services
☐ Natural progression of HIV infection and the importance of treatment	☐ Eligibility for publicly funded high-risk vaccines
☐ Inform care team of diagnosis including any provider that may pierce the skin	☐ Do not donate breast milk, semen, organs, blood, or blood products

This information is being collected under the authority of the Health Protection and Promotion Act,Reg. 569
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July 2023

Client Name: _____ DOB: _____

Medical Risk Factors (select all that apply):

- ☐ Received blood or blood products
  When: _____
  Where: _____
- ☐ Co-diagnosis/co-infection with existing STI
  Specify: _____
- ☐ Other: _____
- ☐ Received organ/tissue transplant or donor insemination
  When: _____
  Where: _____
- ☐ Born to an HIV positive parent
- ☐ Repeat STI
- ☐ Invasive surgical/dental/ocular procedure
  When: _____
  Where: _____
- ☐ Pregnant
- ☐ Unknown

Exposure Risk Factors (select all that apply):

- ☐ Bathhouse
- ☐ Blood exposure through shared accident
- ☐ Correctional facility
- ☐ Encounter following major event
  Specify: _____
- ☐ Under-housed/homeless
- ☐ Other: _____
- ☐ Occupational exposure to potentially contaminated body fluids
- ☐ Electrolysis and acupuncture
- ☐ Tattoo and piercing
- ☐ Other personal services setting
  Specify: _____
- ☐ Unknown
- ☐ Other social venue
  Specify: _____
- ☐ Travel outside province/country
  Specify: _____
- ☐ Travel to or lived in country where HIV is endemic
  Specify: _____

Behavioural Risk Factors (select all that apply):

- ☐ Anonymous sex
- ☐ Consumed breastmilk
- ☐ Sex with opposite sex
- ☐ Sex with same sex
- ☐ Sex with transgender person
- ☐ Sex for drugs/food/shelter/survival
- ☐ Fighting/biting/torture/blood brother
- ☐ Strategic positioning
- ☐ Contact lived in or visited country where HIV is endemic
  Specify: _____
- ☐ No condom use
- ☐ Condom breakage
- ☐ Sex trade worker
- ☐ Sex with sex trade worker
- ☐ Contact is HIV positive
- ☐ Serosorting
- ☐ Judgement impaired by drugs/alcohol
  Specify: _____
- ☐ Contact visiting from outside province or country
  Specify: _____
- ☐ New partner in last 2 months
- ☐ More than 1 partner in last 6 months
- ☐ Inhalation drug use
- ☐ Injection drug use
- ☐ Shared needles
- ☐ Shared other drug equipment
- ☐ Shared sex toys
- ☐ Met contact through internet
- ☐ Unknown
- ☐ Other: _____

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In all cases, clients are to be advised to notify all contacts. *Contacts are defined as those who have had intimate sexual contact, shared drug equipment or other risk activity with client from 14 weeks prior to lab slip documentation of a negative HIV result or if no prior HIV testing, it includes all contacts since 1978.*	
☐ **Healthcare provider to notify partner(s)** ☐ **This person is a contact of a case and is being treated.**	☐ **Client has been advised that they will be contacted by public health to discuss contact notification**
LIST PARTNER INFO HERE (NAME & CONTACT INFO)	LIST PARTNER INFO HERE (NAME & CONTACT INFO)
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Physician/NP/Midwife directing care:		
Name:		
Facility:		
Telephone #:	ext:	Fax #:
Medication prescribed:		Date treatment initiated:

Physician/NP/Midwife completing form:		
Name:		
Facility:		
Telephone #:	ext:	Fax #:

Notes:

Thank you for your assistance.

Kit Young Hoon, MBBS, MPH, MSC, FRCPC
Medical Officer of Health

Enter name and designation

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