Notification of Fatal Outcome of COVID-19 or Influenza

Please complete all fields

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Attending Physician or Nurse:	***FOR PUBLIC HEALTH OFFICE USE ONLY:***
Phone number:	**Service Area:**
Hospital Name and Unit (if applicable):	**Date Received:**
Location:	**Panorama Client ID:**
	Panorama Investigation ID:
	Panorama QA complete: ☐ **Yes** ☐ **No**

B) CLIENT INFORMATION (please complete or affix patient label in the table below)

Last Name:	First Name: and Middle Name:	Alternate Name (Goes by):
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN):	Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown
Next of Kin: _____ Relationship: _____ Contact phone: _____	Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home):	

C) DISEASE and LABORATORY DETAILS

Disease being reported:	☐ COVID-19	☐ Influenza
LAB TEST INFORMATION:		
Test Type: ☐ **PCR**	**Date specimen collected:** YYYY / MM / DD	☐ **Antigen** **Date specimen collected:** YYYY / MM / DD

D) RISK FACTORS (check all that apply)

Chronic Medical Condition [1] - Other (Add'l Info) **Please Specify**	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	
Pregnancy	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	
Special Population - Self-reported Indigenous identity	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	
Special Population –Long Term Care Facility Resident Include the name of the facility	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	
Special Population – Personal Care Home Resident Include the name of the facility	☐ **Yes**	☐ No ☐ Not asked ☐ Unknown	

[1] Chronic medical conditions associated with severity include: cardiac disease, lung disease, diabetes, cancer, renal disease, immunosuppression, morbid obesity, transplant candidate or recipient

E) OUTCOMES

Fatal – Date of Death YYYY / MM / DD

How was the reported disease Related to Cause of Death?
☐ Underlying cause of death
☐ Contributed to but was not underlying cause of death
☐ Unrelated to cause of death

Report completed by:		**Date report completed:** YYYY / MM / DD

Please save a copy for your file and fax to the local public health office.