

Notifiable Disease and Notification Form

The **PUBLIC HEALTH PROTECTION AND PROMOTION ACT** requires the following communicable diseases to be reported to Communicable Disease Control, within the appropriate timeframes identified below.

Timely reporting is essential to control the spread of communicable disease.

Report by telephone to the appropriate region noted below as soon as disease is SUSPECTED.
Following reporting via telephone, a written report is required within 24 hours.

<input type="checkbox"/> Anthrax <input type="checkbox"/> Botulism <input type="checkbox"/> Creutzfeldt-Jakob Disease (CJD) <input type="checkbox"/> Diphtheria <input type="checkbox"/> Group A Streptococcal Disease, Invasive (IGAS) <input type="checkbox"/> Haemophilus Influenza type B Disease, Invasive (HIB) <input type="checkbox"/> Measles <input type="checkbox"/> Meningococcal Disease, Invasive <input type="checkbox"/> Plague	<input type="checkbox"/> Rabies (includes animal bites from species known to carry Rabies, e.g. bats, cats, dogs, farm and wild animals) <input type="checkbox"/> Severe Acute Respiratory Illness (SARI) <input type="checkbox"/> Smallpox <input type="checkbox"/> Tetanus <input type="checkbox"/> Tularemia <input type="checkbox"/> Viral Hemorrhagic Fevers (e.g. Ebola, Lassa, Marburg, Yellow Fever) <input type="checkbox"/> All disease outbreaks, unusual disease clusters and unusual disease occurrences or features should be reported immediately
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Report in writing within 24 hours of laboratory or clinical diagnosis

<input type="checkbox"/> Acute Flaccid Paralysis <input type="checkbox"/> Antimicrobial Resistant Organisms <input type="checkbox"/> Arbovirus (e.g. La Crosse, West Nile, Zika virus) <input type="checkbox"/> Brucellosis <input type="checkbox"/> Clostridium Difficile <input type="checkbox"/> COVID-19 <input type="checkbox"/> Chlamydia <input type="checkbox"/> Food and Waterborne Illness (e.g. Amoebiasis, <i>Campylobacter</i> , <i>Cryptosporidium</i> , <i>E. coli</i> , <i>Giardia</i> , <i>Listeria</i> , <i>Salmonella</i>) <input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Group B Streptococcal Disease of the Newborn <input type="checkbox"/> Haemophilus Influenza Non-B Disease, Invasive <input type="checkbox"/> Hantavirus Pulmonary Syndrome <input type="checkbox"/> Hepatitis A, B, C, and Unspecified Hepatitis <input type="checkbox"/> Human Immunodeficiency Virus (HIV) <input type="checkbox"/> Influenza (laboratory-confirmed only) <input type="checkbox"/> Legionellosis <input type="checkbox"/> Leprosy <input type="checkbox"/> Louse or Tickborne Diseases (e.g. Babesiosis, Lyme, Powassan)	<input type="checkbox"/> Malaria <input type="checkbox"/> Mpox <input type="checkbox"/> Multisystem Inflammatory Syndrome in Children (MIS-C) <input type="checkbox"/> Mumps <input type="checkbox"/> Pertussis <input type="checkbox"/> Poliomyelitis <input type="checkbox"/> Q fever <input type="checkbox"/> Rubella (including Congenital Rubella Syndrome) <input type="checkbox"/> Syphilis (including Congenital Syphilis) <input type="checkbox"/> Tuberculosis
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Report in writing within 7 days of laboratory or clinical diagnosis

<input type="checkbox"/> Chancroid	<input type="checkbox"/> Pneumococcal Disease, Invasive	<input type="checkbox"/> Varicella
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Contact Information by Zone (Monday – Friday 8:30am – 4:30pm)

If corresponding via email, please only send via secure email with encryption

Eastern Zone Telephone: 709-752-4358 Fax: 709-752-4873 Email: cdcprogram@easternhealth.ca	Central Zone Telephone: 709-571-2183 or 709-422-1740 Fax: 709-651-6483 Email: CZ-communicable.disease@nlhealthservices.ca
Western Zone Telephone: 709-643-1830 Fax: 709-643-8541 Email: cdc@westernhealth.nl.ca	Labrador-Grenfell Zone Telephone: 709-897-3110 or 709-456-2401 ext 6247 Fax: 709-896-4393 Email: cdcconsult@lghealth.ca

URGENT AFTER HOURS AND WEEKENDS CONTACT: 709-777-6300

Surveillance may be conducted on other diseases in conjunction with the Public Health Laboratory.

Documentation of client information

Client Information	
Name	
Address	
MCP/HCN	
Phone Number	Phone (Home): Phone (Cell):
DOB (dd/mm/yyyy)	
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse <input type="checkbox"/> Unknown
Pregnancy Status	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Applicable

Disease Details	
How was the disease identified?	<input type="checkbox"/> Clinical presentation <input type="checkbox"/> Contact Tracing Follow-up <input type="checkbox"/> Screening
Is the client hospitalized? If yes, specify hospital and unit	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

Reporting Health Care Provider Details	
Name	
Clinic Name	
Phone Number	
Date (dd/mm/yyyy)	

Additional Comments	