



## Multi-system Inflammatory Syndrome in Children and Adolescents (MIS-C) Case Report Form

### INSTRUCTIONS

- This form is confidential when completed.
- All SARS-CoV-2 positive laboratory results need to be appended by the physician to this form, when applicable.
- Use the Notes section to include any additional comments that could not be placed in a relevant section.
- Completed forms should be submitted to the health authority pertaining to the residence of the case:  
Vancouver Coastal Health Authority - Fax: (604) 731-2756  
Fraser Health Authority - Fax: (604) 930-5414  
Interior Health Authority - Fax: (250) 549-6310  
Vancouver Island Health Authority - Fax: (250) 519-3441  
Northern Health Authority Central Communicable Disease Hub Fax: (250) 649-7071.
- Any updates as to the Outcome section will be reported by the health authority to BCCDC.
- Only Confirmed MIS-C cases are reportable provincially.

#### HEALTHCARE PROVIDER COLLECTING CASE INFORMATION

Hospital/clinic name:

Physician Name:	Last	First	Middle	Phone Number:	( )	-	ext.
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Email:	Fax Number:	( )	-	ext.
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Date of data collection: \_\_\_\_\_  
  YYYY / MM / DD

#### HEALTH AUTHORITY/PUBLIC HEALTH STAFF REPORTING TO BCCDC

Health Authority:    FHA    FNHA    IHA    NHA    VCH    VIHA

Reporter Name:	Last	First	Middle	Phone Number:	( )	-	ext.
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Email:	Fax Number:	( )	-	ext.
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Date report received by health authority: \_\_\_\_\_  
  YYYY / MM / DD

#### A) CASE PERSONAL INFORMATION

Name:                                      Last                                      First                                      Middle

Date of Birth: _____	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Undifferentiated	<input type="checkbox"/> Unknown
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YYYY / MM / DD

Health Card Number:	Alternate Name(s):
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Address:	Unit #	Street #	Street Name	City
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Postal Code:	Province:	Country of Residence (if not Canada):
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#### B) INDIGENOUS INFORMATION

Do you self-identify as an Indigenous Person?

<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> No	<input type="checkbox"/> Non-BC Resident	<input type="checkbox"/> Yes
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Indigenous Identity:	<input type="checkbox"/> Asked, but unknown	<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> First Nations
<input type="checkbox"/> First Nations and Inuit	<input type="checkbox"/> First Nations and Métis	<input type="checkbox"/> First Nations, Inuit and Métis	<input type="checkbox"/> Inuit
<input type="checkbox"/> Inuit and Métis	<input type="checkbox"/> Métis	<input type="checkbox"/> Not asked	

First Nations Status:	<input type="checkbox"/> Asked, but unknown	<input type="checkbox"/> Asked, not provided	<input type="checkbox"/> Non-Status Indian
	<input type="checkbox"/> Not Asked	<input type="checkbox"/> Status Indian	

Indigenous Organization: \_\_\_\_\_



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### C) COMORBIDITIES / PAST HISTORY

Does the case have a chronic disease or comorbidity?  Yes  No  Not assessed

If yes, specify 1: \_\_\_\_\_

specify 2: \_\_\_\_\_

specify 3: \_\_\_\_\_

### D) PATHOGEN TESTING

Was the case tested for bacterial or viral infections (besides COVID-19)?  Yes  No

specify result:  Positive  Negative  Unknown

If test result was positive, specify pathogen identified: \_\_\_\_\_

type of specimen collected: \_\_\_\_\_

specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

### E) COVID-19 EXPOSURE

Was the case tested by RT-PCR/NAT?  Yes  No

If yes, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

If retest performed, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

comments: \_\_\_\_\_

Was the case tested by antigen test?  Yes  No

If yes, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

If retest performed, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

comments: \_\_\_\_\_

Was the case tested by serology?  Yes  No

If yes, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

If positive, specify type:  Total Ig  IgG

If retest performed, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

If positive, specify type:  Total Ig  IgG

If retest performed, specimen collection date (YYYY/MM/DD): \_\_\_\_/\_\_\_\_/\_\_\_\_

specify result:  Positive  Negative  Indeterminate

If positive, specify type:  Total Ig  IgG

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Was the case in close contact with a laboratory confirmed or probable or epi-linked probable COVID-19 case?  Yes  No  Unknown

If yes:

Name <i>Last, First</i>	PHN	First Contact Date or Sustained Contact YYYY / MM / DD	Last Contact Date YYYY / MM / DD	Contact Setting (e.g., household)
		<input type="checkbox"/> Sustained contact		
		<input type="checkbox"/> Sustained contact		
		<input type="checkbox"/> Sustained contact		

### F) SIGNS AND SYMPTOMS

Onset of earliest symptom: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
  YYYY                                MM                                DD

Clinical picture	Yes	No	Unknown	Not Assessed
Fever If yes, total duration of fever: _____ days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Features of hypotension or shock</b>				
Shock (hypotension, tachycardia, prolonged capillary refill time, pale/mottled skin, cold extremities, or urinary output <2 mL/kg/hr)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Cutaneous and mucocutaneous</b>				
Skin rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis (bilateral, non-purulent)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral mucosal inflammation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peripheral signs of inflammation (e.g. erythema and edema or peeling of hands and/or feet)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Gastrointestinal</b>				
Acute abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b>				
<i>specify</i> 1: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>specify</i> 2: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>specify</i> 3: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>specify</i> 4: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### G) LABORATORY TESTS

Abnormal test result	Yes	No	Unknown	Not Assessed
Elevated ESR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated C-reactive protein	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated procalcitonin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated PT/PTT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated D-dimers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Elevated troponin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated BNP or NT-proBNP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Elevated Ferritin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 1: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 2: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 3: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 4: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>H) CARDIAC IMAGING</b>				
<b>Abnormal echocardiogram finding</b>	<b>Yes</b>	<b>No</b>	<b>Unknown</b>	<b>Not Assessed</b>
Features of myocardial dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Features of pericarditis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Features of valvulitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify 1: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>I) HOSPITALIZATION</b>				
Admitted to hospital: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed				
If yes, name of hospital: _____				
Admission date (YYYY / MM / DD): ____/____/____ Discharge date (YYYY / MM / DD): ____/____/____				
Admitted to intensive care unit: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed				
Admission date (YYYY / MM / DD): ____/____/____ Discharge date (YYYY / MM / DD): ____/____/____				
<b>J) OUTCOME</b>				
<input type="checkbox"/> Fully recovered				
<input type="checkbox"/> Not yet recovered/recovering				
<input type="checkbox"/> Fatal <i>If died, date of death (YYYY / MM / DD):</i> ____/____/____				
<i>If died, specify cause of death:</i> _____				
<input type="checkbox"/> Permanent disability, specify: _____				
<input type="checkbox"/> Other, specify: _____				
<input type="checkbox"/> Unknown				
<b>K) CLASSIFICATION</b>				
<input type="checkbox"/> Person under investigation (non-reportable) <input type="checkbox"/> Confirmed				
<b>L) NOTES</b>				



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M) DEFINITIONS	
<b>COVID-19 Confirmed – lab case</b>	<p>A person with confirmation of infection with SARS-CoV-2 documented by:</p> <ul style="list-style-type: none"> <li>The detection of at least one specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory)</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>The detection of at least one specific gene target by a validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing)</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS-CoV-2</li> </ul>
<b>COVID-19 Probable – lab case</b>	<ol style="list-style-type: none"> <li>A person who: <ul style="list-style-type: none"> <li>Has symptoms (see Symptoms* below) compatible with COVID-19</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>Has had a laboratory-based NAAT assay for SARS-CoV-2 and the result is inconclusive</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset</li> </ul> </li> <li>A person who had a POC NAAT or POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive</li> <li>A person who had a validated POC antigen test for SARS-CoV-2 completed and the result is positive</li> </ol> <p><i>*Symptoms compatible with COVID-19 include any 1 or more of the following: Fever or chills; Cough; Loss of sense of smell or taste; Difficulty breathing; Sore throat; Loss of appetite; Extreme fatigue or tiredness; Headache; Body aches; Nausea or vomiting; Diarrhea.</i></p>
<b>COVID-19 Probable – epi-linked case</b>	<ul style="list-style-type: none"> <li>A person who has symptoms (see Symptoms* below) compatible with COVID-19</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>A person who had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19</li> </ul> <p>AND</p> <ul style="list-style-type: none"> <li>A person who has not had a laboratory-based NAAT assay for SARS-CoV-2 completed.</li> </ul> <p>(Note: Cases who had a high-risk exposure with a probable COVID-19 case that had a positive result to validated POC antigen test for SARS-CoV-2 where confirmatory testing was not required (as per the provincial guidelines for POC test in Rural, Remote and Indigenous Communities) should also be considered probable – epi-linked).</p> <p><i>*Symptoms compatible with COVID-19 include any 1 or more of the following: Fever or chills; Cough; Loss of sense of smell or taste; Difficulty breathing; Sore throat; Loss of appetite; Extreme fatigue or tiredness; Headache; Body aches; Nausea or vomiting; Diarrhea.</i></p>
<b>Close contact</b>	<p>A close contact is defined as a person who:</p> <p>provided direct care for the case, including healthcare workers, family members or other caregivers, or who had other similar close physical contact (e.g., intimate partner) without consistent and appropriate use of personal protective equipment, <b>OR</b></p> <p>lived with or otherwise had close face to face contact (within 2 metres) with a probable or confirmed case for more than 15 minutes (may be cumulative, i.e., multiple interactions) up to 48 hours prior to symptom onset, <b>OR</b></p> <p>had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended PPE, <b>OR</b></p> <p>has been identified by the local MHO as a possible contact.</p>
<b>Hospitalization</b>	<p>Any person admitted to a hospital for at least an overnight stay, for reasons directly or indirectly related to their MIS-C, and with no period of complete recovery between illness and admission. If unable to determine whether an admission was related to MIS-C, please report as a hospital admission. Includes persons admitted to hospital but without transfer to a ward/unit.</p>
<b>ICU admission</b>	<p>Any person admitted to an intensive care unit (ICU) for at least an overnight stay, for reasons directly or indirectly related to MIS-C and with no period of complete recovery between illness and admission. If unable to determine whether an admission was related to MIS-C, please report as an ICU admission.</p>
<b>Death</b>	<p>A death occurring in any person with no period of complete recovery between illness and death, unless there is evidence that MIS-C did not contribute to the death (e.g., trauma, poisoning, drug overdose).</p>



# Multi-system Inflammatory Syndrome in Children and Adolescents (MIS-C)

## Case Report Form

**MIS-C confirmed case**

Children 0-19 years of age requiring hospitalization with fever for three days or more and two of the following:

- a) Acute gastrointestinal symptoms (abdominal pain, vomiting, diarrhea);
- b) Rash or bilateral non-purulent conjunctivitis or muco-cutaneous inflammation signs (oral, hands or feet);
- c) Hypotension or shock;
- d) Features of myocardial dysfunction or pericarditis or valvulitis or coronary abnormalities: ECHO findings or elevated troponin/ brain natriuretic peptide (BNP)/ natriuretic peptide tests (NT-proBNP);
- e) Evidence of coagulopathy: Abnormal prothrombin time/ partial thromboplastin time (PT/PTT), elevated d-dimer;

And

Elevated markers of inflammation such as erythrocyte sedimentation rate, C-reactive protein, or procalcitonin;

And

No other obvious microbial cause of inflammation, including bacterial sepsis, staphylococcal or streptococcal shock syndromes, and no alternative plausible obvious diagnosis;

And

Evidence of SARS-CoV-2 infection (positive NAAT test, antigen test and/or serology) or close contact with a confirmed or probable (lab-probable or epi-link probable) COVID-19 case