Ontario

Ministry of Health and Long-Term Care

Form 3 – Notification of New Active – Leprosy (Hansen's Disease)

Health Protection and Promotion Act

Patient Information

Last name	First name	Middle initial

Sex	Marital status	Date of birth (yyyy/mm/dd)
☐M ☐F ☐Other	☐Single ☐Married / C.L. ☐Separated ☐Widowed ☐Divorced	

Country of birth	Permanent residence

Occupation	Telephone (Home)	Telephone (Business)

Date of arrival in Canada (yyyy/mm/dd)	Country in which infection acquired

Date of residence in that country (yyyy/mm/dd)	Date of first symptoms (yyyy/mm/dd)	Date of first diagnosis (yyyy/mm/dd)

First diagnosis made in

☐Canada ☐Other country (Specify)

Diagnosis	Tuberculoid	Borderline Tuberculoid	Mid-borderline	Borderline Lepromatous	Lepromatous	Indeterminate
Clinical Diagnosis	☐(TT)	☐(BT)	☐(BB)	☐(BL)	☐(LL)	☐(IND)
Histopathological Diagnosis	☐(TT)	☐(BT)	☐(BB)	☐(BL)	☐(LL)	☐(IND)

Slit Skin Smears (For BB, BL, LL)

Date (yyyy/mm/dd)

	Nose - Blow	EarEar		ElbowElbow		HandHand		KneeKnee		Other
		R	L	R	L	R	L	R	L	
(0-6 +) BI										
(%) MI										

Treatment Information

Date treatment first commenced (yyyy/mm/dd)	Planned duration of the first treatment	Actual duration of the first treatment

Date current treatment commenced (yyyy/mm/dd)

Treatment	Medication Rifampin	Medication Dapsone	Medication Clofazimine	Medication Ofloxacin	Medication Clarithromycin	Medication Other (name and dosage)
Previous Treatment	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
Current Treatment	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	

d - daily, w - weekly, m - monthly

Contact follow-up by	Number of household contacts	Consultant Leprologist

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Chemoprophylaxis for household contacts ☐Yes ☐No

If **Yes**: list recipients, medications and duration in the table below

Household contact	Medication	Medication	**Medication**	Medication
Name and date chemoprophylaxis commenced	Rifampin	Ofloxacin	Minocycline	Other medication (name and dosage)
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	
	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	mg ☐d ☐w ☐m	

Pathologist

Last name			First name	Middle initial
Unit number	Street number	Street name		PO Box
City/Town			Province	Postal code

Physician

Last name			First name	Middle initial
Unit number	Street number	Street name		PO Box
City/Town			Province	Postal code
Signature			Date (yyyy/mm/dd)	Telephone

Health Unit

Medical Officer of Health	Date of this notification (yyyy/mm/dd)

Name of Health Unit

Unit number	Street number	Street name	PO Box

City/Town	Province	Postal code