simcoe muskoka DISTRICT HEALTH UNIT
Tel: 705-721-7520
Toll free: 1-877-721-7520
www.simcoemuskokahealth.org
Your Health Connection

HealthFAX

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Infection Prevention and Control Lapse at Orillia Dental Clinic

Attention: Physicians, Emergency Departments, Infection Control Practitioners, Nurse Practitioners, Walk-In Clinics/Urgent Care Clinics, Family Health Teams, Central LHIN, NSM LHIN, Neighbouring Health Units

Date: February 21, 2018

An investigation by the Simcoe Muskoka District Health Unit (SMDHU) has identified that patients who have received dental services at the dental clinic located at 18 Wyandotte Street in Orillia under the business name of Joe Philip and Associates, between January 1, 2012 and December 18, 2017, may have been exposed to improperly cleaned and sterilized instruments used for procedures.

Following a risk assessment by SMDHU, it was determined that the risk of disease transmission is very low in this situation. However, as a precaution, the SMDHU is recommending that you consider testing exposed patients for hepatitis B, hepatitis C and Human Immunodeficiency Virus (HIV). To date, we have received no reports of any patients becoming infected as a result of this IPAC lapse. If a patient was recently exposed, follow-up testing should also occur at least three months after the date of the patient's last procedure to take into account the testing window periods.

The following tests are recommended:

- Hepatitis B surface antigen (HBsAg)
- Hepatitis B core IgM antibody (anti-HBc IgM)
- Hepatitis C screen (anti-HCV)
- HIV screen

The patient should also receive counseling regarding risk reduction during the evaluation period including discussion to reduce sharing of articles such as clippers, razors, toothbrushes, as well as the use of condoms during sexual activity.

Clinician resources including prefilled lab requisitions for this situation are included in this communication and are available at our website specific for this situation www.smdhu.org/ipac or on our Health Professionals Portal www.smdhu.org/hpportal

If you have any further questions please call the Simcoe Muskoka District Health Unit's Communicable Disease Program at 705-721-7520 or 1-877-751-7520 Ext. 8809 Monday to Friday between 8:30 am to 4:30 pm.

Ontario | **Ministry of Health and Long-Term Care**

Laboratory Requisition

Requisitioning Clinician / Practitioner

Name

Address

Laboratory Use Only

Clinician/Practitioner's Contact Number for Urgent Results ( )

Service Date yyyy mm dd

Clinician/Practitioner Number | CPSO / Registration No.

Health Number | Version | Sex ☐M ☐F | Date of Birth yyyy mm dd

Check (✓) one: ☐ **OHIP/Insured** ☐ **Third Party / Uninsured** ☐ **WSIB**

Province | Other Provincial Registration Number | Patient's Telephone Contact Number ( )

Additional Clinical Information *(e.g. diagnosis)*

Exposure to improperly sterilized dental equipment

Patient's Last Name *(as per OHIP Card)*

Patient's First & Middle Names *(as per OHIP Card)*

☐ Copy to: Clinician/Practitioner

Last Name First Name

Address

Patient's Address *(including Postal Code)*

Note: Separate requisitions are required for cytology, histology / pathology and tests performed by Public Health Laboratory

x	Biochemistry
	Glucose ☐Random ☐Fasting
	HbA1C
	Creatinine (eGFR)
	Uric Acid
	Sodium
	Potassium
	ALT
	Alk. Phosphatase
	Bilirubin
	Albumin
	Lipid Assessment (includes Cholesterol, HDL-C, Triglycerides, calculated LDL-C & Chol/HDL-C ratio; individual lipid tests may be ordered in the "Other Tests" section of this form)
	Albumin / Creatinine Ratio, Urine
	Urinalysis (Chemical)
	Neonatal Bilirubin:
	Child's Age: days hours
	Clinician/Practitioner's tel. no. ( )
	Patient's 24 hr telephone no. ( )
	Therapeutic Drug Monitoring:
	Name of Drug #1
	Name of Drug #2
	Time Collected #1 hr. #2 hr.
	Time of Last Dose #1 hr. #2 hr.
	Time of Next Dose #1 hr. #2 hr.

x	Hematology
	CBC
	Prothrombin Time (INR)
	Immunology
	Pregnancy Test (Urine)
	Mononucleosis Screen
	Rubella
	Prenatal: ABO, RhD, Antibody Screen (titre and ident. if positive)
	Repeat Prenatal Antibodies
	Microbiology ID & Sensitivities (if warranted)
	Cervical
	Vaginal
	Vaginal / Rectal – Group B Strep
	Chlamydia *(specify source)*:
	GC *(specify source)*:
	Sputum
	Throat
	Wound *(specify source)*:
	Urine
	Stool Culture
	Stool Ova & Parasites
	Other Swabs / Pus *(specify source)*:

x	Viral Hepatitis *(check one only)*
	Acute Hepatitis
	Chronic Hepatitis
	Immune Status / Previous Exposure *Specify*: ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C

or order individual hepatitis tests in the "Other Tests" section below

Prostate Specific Antigen (PSA)

☐ Total PSA ☐ Free PSA

Specify one below:

☐ Insured – Meets OHIP eligibility criteria

☐ Uninsured – Screening: Patient responsible for payment

Vitamin D (25-Hydroxy)

☐ Insured - Meets OHIP eligibility criteria: osteopenia; osteoporosis; rickets; renal disease; malabsorption syndromes; medications affecting vitamin D metabolism

☐ Uninsured - Patient responsible for payment

Other Tests - one test per line

Hepatitis B surface antigen (HBsAg)
Hepatitis B core IgM antibody (anti-HBc IgM)
Hepatitis C antibody (anti-HCV)

Specimen Collection

Time *24 hour clock* | Date *yyyy/mm/dd*

Fecal Occult Blood Test (FOBT) *(check one)*

☐ FOBT (non CCC) ☐ ColonCancerCheck FOBT (CCC) no other test can be ordered on this form

Laboratory Use Only

I hereby certify the tests ordered are not for registered in or out patients of a hospital.

X

Clinician/Practitioner Signature Date

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7530-4581

Public Health Ontario | Santé publique Ontario

For laboratory use only

Date received: yyyy / mm / dd

PHOL No.

HIV and HTLVI/HTLVII Serology HIV PCR Test Requisition

ALL Sections of this Form MUST be Completed

Submitter

Courier Code

Provide Return Address:
Name
Address
City & Province
Postal code

Submitter lab no. (if applicable):

Clinician Initial / Surname and OHIP / CPSO Number

____

Tel: ____________ Fax: ____________

cc Doctor/Qualified Health Care Provider Information

Name: ____________ Tel: ____________

Lab/Clinic name: ____________

____________ Fax: ____________

CPSO #: ____________

Address: ____________

Postal code:

Specimen Details

Collection date of specimen: yyyy / mm / dd

Type of specimen: ☐ Whole blood ☐ Serum ☐ ACD/EDTA ☐ Plasma ☐ Dried blood spot (HIV PCR only)

Tests requested: ☐ HIV1/HIV2 ☐ HTLVI/HTLVII ☐ HIV PCR (for infant diagnosis ≤18 mos)

Comments:

Reason for Test (check all that apply)

- ☐ Routine
- ☐ Known to be HIV positive (repeat test)
- ☐ Symptoms - acute seroconversion (e.g. flu-like illness, fever, rash)
- ☐ Symptoms - advanced disease/AIDS
- ☐ Sexual assault
- ☐ Visa/immigration requirement
- ☐ Prenatal
- ☐ Pre-exposure prophylaxis
- ☐ Post-exposure prophylaxis
- ☐ Infant diagnosis ≤18 mos
- ☐ Other, specify: ____________

Previous Test Information

Last test result:

- ☐ Negative
- ☐ Positive (in Ontario)
- ☐ Positive (outside Ontario)
- ☐ Unknown
- ☐ Indeterminate
- ☐ Previous PHOL sample no.: (if available)

Patient Information

Health card no.:	Medical record no. (if applicable):
Date of Birth: yyyy / mm / dd	Sex: ☐ F ☐ M ☐ TF* ☐ TM* *TF=transfemale (M to F); TM=transmale (F to M)
Last name: (per health card)	First name: (per health card)
Address:	
City:	Postal code:
PHO study or program no. (if applicable):	
Country of birth:	

Race/Ethnicity:

- ☐ White
- ☐ Black
- ☐ First Nations ☐ Métis ☐ Inuit
- ☐ South Asian (e.g. East Indian, Pakistani, Sri Lankan, Punjabi, Bangladeshi, Nepali)
- ☐ Southeast Asian (e.g. Chinese, Japanese, Vietnamese, Cambodian, Indonesian, Korean, Filipino)
- ☐ Arab/West Asian (e.g. Armenian, Egyptian, Iranian, Lebanese, Moroccan)
- ☐ Latin American (e.g. Mexican, Central/South American)
- ☐ Other - includes mixed ethnicity; specify:

Risk Factors (check all that apply)

- W Sex with women
- M Sex with men
- I Injection drug use
- E Born in an HIV-endemic country (includes countries in sub-Saharan Africa and the Caribbean)
- C Child of HIV+ mother

Sex with a person who was known to be (check all that apply)

- H HIV-positive
- 1 Using injection drugs
- 2 Born in an HIV-endemic country (includes countries in sub-Saharan Africa and the Caribbean)
- 6 A bisexual male

- O Other (e.g. clotting factor, blood transfusion, needle stick/occupational, tattoo, piercing), please specify:

CONFIDENTIAL WHEN COMPLETED

The personal health information is collected under the authority of the Personal Health Information Protection Act, s.36(1)(c)(iii) for the purpose of clinical laboratory testing. If you have questions about the collection of this personal health information please contact the PHO laboratory Manager of Customer Service at 416-235-6556 or toll free 1-877-604-4567.

Form No. F-SD-SCG-1001 (01/18)

Ontario
Agency for Health Protection and Promotion
Agence de protection et de promotion de la santé