

Campylobacteriosis Data Collection Worksheet

Panorama QA complete: Yes No

Please complete all sections

Panorama Client ID: _____

Panorama Investigation ID: _____

Initials: _____

A) CLIENT INFORMATION

LHN -> SUBJECT -> CLIENT DETAILS -> PERSONAL INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name (Goes by):
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN): _____	Preferred Communication Method: (specify - i.e. home phone, text): Email Address: <input type="checkbox"/> Work <input type="checkbox"/> Personal
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace:		
Place of Employment/School:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____	Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home): Address at time of infection if not same:	

B) INVESTIGATION INFORMATION

LHN-> SUBJECT SUMMARY-> ENTERIC ENCOUNTER GROUP->CREATE INVESTIGATION

Disease Summary Classification: CASE	Date	Classification: CONTACT	Date	LAB TEST INFORMATION:
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	Date specimen collected: YYYY / MM / DD
<input type="checkbox"/> Does Not Meet Case	YYYY / MM / DD	<input type="checkbox"/> Not a Contact	YYYY / MM / DD	Specimen type: <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Stool
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	
<input type="checkbox"/> Probable	YYYY / MM / DD			
Disposition:				
FOLLOW UP:				
<input type="checkbox"/> In progress	YYYY / MM / DD	<input type="checkbox"/> Complete	YYYY / MM / DD	
<input type="checkbox"/> Incomplete – Declined	YYYY / MM / DD	<input type="checkbox"/> Not required	YYYY / MM / DD	
<input type="checkbox"/> Incomplete – Lost contact	YYYY / MM / DD	<input type="checkbox"/> Referred – Out of province	YYYY / MM / DD	
<input type="checkbox"/> Incomplete – Unable to locate	YYYY / MM / DD	(specify where)		
REPORTING NOTIFICATION		Location:		
Name of Attending Physician or Nurse:				
Physician/Nurse Phone number:		Date Received (Public Health): YYYY / MM / DD		
Type of Reporting Source: <input type="checkbox"/> Health Care Facility <input type="checkbox"/> Lab Report <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Other _____				

Campylobacteriosis Data Collection Worksheet

Please complete all sections

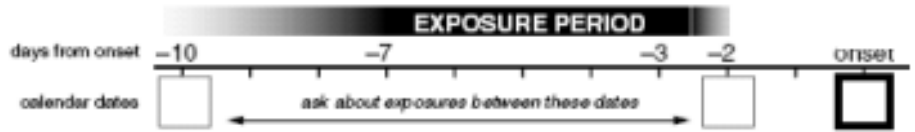
Panorama Client ID: _____
Panorama Investigation ID: _____

C) SIGNS & SYMPTOMS

INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - bloody	YYYY / MM / DD	YYYY / MM / DD	Pain – abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - mucousy	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bactremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - watery	YYYY / MM / DD	YYYY / MM / DD	Stool - bloody	YYYY / MM / DD	YYYY / MM / DD
Headache	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Malaise	YYYY / MM / DD	YYYY / MM / DD		YYYY / MM / DD	YYYY / MM / DD
Other Signs & Symptoms if applicable					

Enter onset date in heavy box.
Count back to figure the
probable exposure period.



D) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

Incubation for Case (period for acquisition):	
Earliest Possible Exposure Date: YYYY / MM / DD	Latest Possible Exposure Date: YYYY / MM / DD
<i>Exposure Calculation details:</i>	
Communicability for Case (period for transmission):	
Earliest Possible Communicability Date: YYYY / MM / DD	Latest Possible Communicability Date: YYYY / MM / DD
<i>Communicability Calculation Details:</i>	

E) RISK FACTORS

N – NO, NA – Not Asked, U – Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Add'l Info
Animal Exposure – Farms (Add'l Info)			
Animal Exposure – Other (Add'l Info)			
Animal Exposure – Pet treats and raw food (Add'l Info)			
Animal Exposure – Pets (including reptiles) (Add'l Info)			
Animal Exposure – Rodents/rodent excreta			
Animal Exposure – Wild animals (other than rodents) (Add'l Info)			
Behaviour – Camping/hiking	YYYY / MM/DD		
Contact – Persons with diarrhea/vomiting	YYYY / MM/DD		
Contact to a known case (Add'l Info)	YYYY / MM/DD		
Immunocompromised – Related to underlying disease or treatment			
Occupation – Child Care Worker	TE		
Occupation – Farmer			
Occupation – Food Handler	TE		
Occupation – Health Care Worker – IOM Risk Factor	TE		

Campylobacteriosis Data Collection Worksheet

Please complete all sections

Panorama Client ID: _____
Panorama Investigation ID: _____

DESCRIPTION	Yes	N, NA, U	Add'l Info
Occupation – Veterinarian or related worker			
Travel – Outside of Canada (Add'l Info)	YYYY / MM/DD AE		
Travel – Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM/DD AE		
Water – Bottled water (Add'l Info)			
Water – Private well or system (Add'l Info)			
Water – Public water system (Add'l Info)			
Water – Untreated water (Add'l Info)	AE		
Water (Recreational) – Pond, stream, lake, river, ocean (Add'l Info)	AE		
Water (Recreational) – Private (swimming pool/whirl pool)	TE		
Water (Recreational) – Public (swimming/paddling pool/whirl pool)			
Other risk factor (Add'l Info)			

F) USER DEFINED FORM (SEE ATTACHED) LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> CAMPYLOBACTERIOSIS FORM

G) TREATMENT LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (<i>to intercept transmission</i>)Panorama = Other Meds) : _____ Prescribed by: _____ Started on: YYYY / MM / DD
--

H) INTERVENTIONS LHN-> INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

Intervention Type and Sub Type:				
Assessment:				
<input type="checkbox"/> Assessed for contacts	YYYY/ MM / DD	Exclusion (recommended):	Investigator name	
Investigator name		<input type="checkbox"/> Daycare	YYYY/ MM / DD	<input type="checkbox"/> Preschool YYYY/ MM / DD
		<input type="checkbox"/> School	YYYY/ MM / DD	<input type="checkbox"/> Work YYYY/ MM / DD
General: Investigator name		Public Health Order:		
<input type="checkbox"/> Disease-Info/Prev-Control	YYYY/ MM / DD	<input type="checkbox"/> Other (specify)	YYYY/ MM / DD	
<input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts	YYYY/ MM / DD	Investigator name		
Communication:		Referral: Investigator name		
<input type="checkbox"/> Other communication (See Investigator Notes)	YYYY/ MM / DD	<input type="checkbox"/> Canadian Food Inspection Agency	YYYY/ MM / DD	
Investigator name		<input type="checkbox"/> Primary Care Provider	YYYY/ MM / DD	
<input type="checkbox"/> Letter See Document Management	YYYY/ MM / DD	<input type="checkbox"/> Saskatchewan Water Security Agency	YYYY/ MM / DD	
Investigator name				
Education/counselling: Investigator name		Other Investigation Findings:		
<input type="checkbox"/> Prevention/Control measures	YYYY/ MM / DD	<input type="checkbox"/> Investigator Notes		
<input type="checkbox"/> Disease information provided	YYYY/ MM / DD	<input type="checkbox"/> Document Management		
Environmental health: YYYY/ MM / DD				
<input type="checkbox"/> Restaurant Inspection		<input type="checkbox"/> Facility Inspection		
Investigator name				
Date	Intervention subtype	Comments	Next follow-up Date	Initials
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	

Campylobacteriosis Data Collection Worksheet

Please complete all sections

Panorama Client ID: _____
Panorama Investigation ID: _____

I) OUTCOMES (optional except for severe influenza)

LHN-> INVESTIGATION-> OUTCOMES

<input type="checkbox"/> Not yet recovered/recovering YYYY / MM / DD	<input type="checkbox"/> ICU/intensive medical care YYYY / MM / DD	<input type="checkbox"/> Hospitalization YYYY / MM / DD
<input type="checkbox"/> Recovered YYYY / MM / DD	<input type="checkbox"/> Intubation /ventilation YYYY / MM / DD	<input type="checkbox"/> Unknown YYYY / MM / DD
<input type="checkbox"/> Fatal YYYY / MM / DD	<input type="checkbox"/> Other _____ YYYY / MM / DD	

Cause of Death: (if Fatal was selected) _____

J) EXPOSURES

Acquisition Event

LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> ACQUISITION QUICK ENTRY

Acquisition Event ID: _____

Exposure Name: _____		
Acquisition Start YYYY / MM / DD to Acquisition End: YYYY / MM / DD		
Location Name: _____		
Setting Type		
<input type="checkbox"/> Travel	<input type="checkbox"/> Exposure or consumption of potentially contaminated food or water	<input type="checkbox"/> Most likely source

Transmission Events

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY

Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
	Campy Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

K) TOTAL NUMBER OF CONTACTS

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK -> UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts: _____ (total number of individuals exposed)

Initial Report completed by:		Date initial report completed: YYYY / MM / DD
-------------------------------------	--	---