Government of Saskatchewan

PANORAMA

Verotoxigenic Escherichia Coli Infection Data Collection Worksheet

Please complete **all** sections.

Panorama Client ID: ___________
Panorama Investigation ID: ___________

Panorama QA complete: ☐ **Yes** ☐ **No**
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: _______ Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:	Health Card Province: ________ Health Card Number (PHN): ____________________________________	Preferred Communication Method: (specify - i.e. home phone, text): Email Address: ☐Work ☐Personal
Place of Employment/School:	Gender: ☐ Male ☐ Female ☐Other ☐ Unknown	
Alternate Contact: _______________________________ Relationship: __________________________ Alt. Contact phone: _____________________________	Address Type: ☐No fixed ☐Postal Address ☐ Primary Home ☐Temporary ☐Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home): Address at time of infection if not the same:	

B) INVESTIGATION INFORMATION

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

Disease Summary Classification: **CASE**	**Date**	***Classification:*** ***CONTACT***	***Date***	***LAB TEST INFORMATION:***
☐ Confirmed	YYYY / MM / DD	☐*Contact*	*YYYY / MM / DD*	*Date specimen collected:* *YYYY / MM / DD*
☐ Does Not Meet Case	YYYY / MM / DD	☐ *Not a Contact*	*YYYY / MM / DD*	*Specimen type:*
☐ Person Under Investigation	YYYY / MM / DD	☐ *Person Under Investigation*	*YYYY / MM / DD*	☐ *Blood* ☐ *Urine*
☐ Probable	YYYY / MM / DD			☐ *Stool*

Disposition:
FOLLOW UP:

☐ In progress	YYYY / MM / DD	☐ Complete	YYYY / MM / DD
☐ Incomplete - Declined	YYYY / MM / DD	☐ Not required	YYYY / MM / DD
☐ Incomplete – Lost contact	YYYY / MM / DD	☐ Referred – Out of province (specify where)	YYYY / MM / DD
☐ Incomplete – Unable to locate	YYYY / MM / DD		

REPORTING NOTIFICATION Name of Attending Physician or Nurse:	Location:
Physician/Nurse Phone number:	Date Received (Public Health): YYYY / MM / DD

Type of Reporting Source: ☐ Health Care Facility ☐Lab Report ☐ Nurse Practitioner ☐Physician ☐Other________________________

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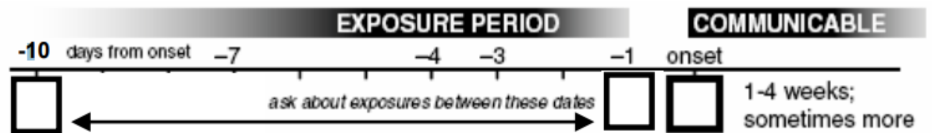
C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Abdominal - cramping	YYYY / MM / DD	YYYY / MM / DD	Hemolytic uremic syndrome (HUS)	YYYY / MM / DD	YYYY / MM / DD
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Pain - abdominal	YYYY / MM / DD	YYYY / MM / DD
Dehydration	YYYY / MM / DD	YYYY / MM / DD	Stool - bloody	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - bloody	YYYY / MM / DD	YYYY / MM / DD	Thrombotic thrombocytopenic purpura (TTP)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - watery	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Fever	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

Exposure Calculation details:

Communicability for Case (period for transmission):
Earliest Possible Communicability Date: YYYY / MM / DD **Latest Possible Communicability Date**: YYYY / MM / DD

Communicability Calculation Details:

E) RISK FACTORS N—No, NA–Not asked, U–Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Animal Exposure - Farms (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pet treats and raw food (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pets (including reptiles) (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Petting zoos/zoos/special events/other (Add'l Info)			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			YYYY / MM/DD	
Occupation - Child Care Worker	TE		YYYY / MM/DD	
Occupation - Food Handler	TE		YYYY / MM/DD	
Occupation - Health Care Worker - IOM Risk Factor	TE		YYYY / MM/DD	
Other risk factor (Add'l Info)			YYYY / MM/DD	
Special Population - Attends childcare	TE		YYYY / MM/DD	
Special Population - Attends school	TE		YYYY / MM/DD	
Travel - Outside of Canada (Add'l Info)	AE		YYYY / MM/DD	
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	AE		YYYY / MM/DD	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Water – Bottled water (Add'l Info)			YYYY / MM/DD	
Water - Private well or system (Add'l Info)			YYYY / MM/DD	
Water - Public water system (Add'l Info)			YYYY / MM/DD	
Water - Untreated water (Add'l Info)			YYYY / MM/DD	
Water (Recreational) - Pond, stream, lake, river, ocean (Add'l Info)			YYYY / MM/DD	
Water (Recreational) - Private (swimming pool/whirl pool)			YYYY / MM/DD	
Water (Recreational) - Public (swimming/paddling pool/whirl pool)			YYYY / MM/DD	

F) USER DEFINED FORM (SEE ATTACHED) LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> VEROTOXIGENIC E. COLI FORM

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

Medication (Antibiotics are contraindicated – refer to physician if on Rx)
(Panorama = Other Meds) : ____

Prescribed by:______________________________ Started on: YYYY / MM / DD

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

Intervention Type and Sub Type:

Assessment:
☐ Assessed for contacts YYYY/ MM/DD
Investigator name

Outbreak Declared YYYY / MM / DD
Investigator name

Communication:
☐ Other communication (See Investigator Notes) YYYY / MM / DD
Investigator name
☐ Letter (See Document Management) YYYY / MM / DD
Investigator name

Public Health Order:
☐ Other (specify) YYYY/ MM/DD
Investigator name

General: Investigator name
☐ Disease-Info/Prev-Control YYYY/ MM / DD
☐ Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD

Other Investigation Findings:
☐ Investigator Notes
☐ Document Management

Education/counselling: Investigator name
☐ Prevention/Control measures YYYY/ MM/DD
☐ Disease information provided YYYY/ MM/DD

Referral: Investigator name
☐ Canadian food inspection agency YYYY/ MM/DD
☐ Primary care provider YYYY/ MM/DD

Exclusion: Investigator name
☐ Daycare YYYY/ MM/DD ☐ Preschool YYYY/ MM/DD
☐ School YYYY/ MM/DD ☐ Work YYYY/ MM/DD

Testing: Investigator name
☐ Stool testing recommended (e.g. for follow-up) YYYY/ MM/DD

Immunization:
☐ Eligible Immunization recommended YYYY/ MM/DD
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	

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I) OUTCOMES *(optional except for severe influenza,*

LHN-> INVESTIGATION-> OUTCOMES

☐ Not yet recovered/recovering YYYY / MM / DD ☐ ICU/intensive medical care YYYY / MM / DD ☐ Hospitalization YYYY / MM / DD
☐ Recovered YYYY / MM / DD ☐ Intubation /ventilation YYYY / MM / DD ☐ Unknown YYYY / MM / DD
☐ Fatal YYYY / MM / DD ☐ 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

☐ Travel ☐ Exposure or consumption of potentially contaminated food or water ☐ 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
		☐ Food service establishment ☐ Public facilities	☐ Health Care setting ☐ Household Exposure		
		☐ Food service establishment ☐ Public facilities	☐ Health Care setting ☐ Household Exposure		
		☐ Food service establishment ☐ Public facilities	☐ Health Care setting ☐ Household Exposure		
		☐ Food service establishment ☐ Public facilities	☐ Health Care setting ☐ Household Exposure		
	VTEC Contacts – Inv ID# _____	☐ 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