

Salmonellosis Data Collection Worksheet

Panorama QA complete: Yes No
Initials: _____

Please complete all sections.

Panorama Client ID: _____
Panorama Investigation ID: _____

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 the same:	

B) INVESTIGATION INFORMATION

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

Disease Summary Classification: CASE	Date	Classification: CONTACT	Date	LAB TEST INFORMATION: Date specimen collected:
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	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

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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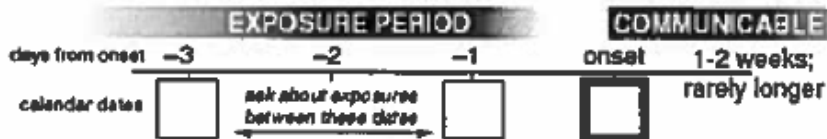
Panorama Client ID: _____
Panorama Investigation ID: _____

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	Headache	YYYY / MM / DD	YYYY / MM / DD
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Myalgia (muscle pain)	YYYY / MM / DD	YYYY / MM / DD
Dehydration	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Diarrhea	YYYY / MM / DD	YYYY / MM / DD	Pain – abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea – bloody	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bacteremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Fever	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Other Signs & Symptoms if applicable					

Exposure period:



NOTE: If Salmonella was isolated from blood or urine, exposure period should be adjusted to reflect most likely onset of initial enteric symptoms.

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	Start date	Add'l Info
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 - Rodents/rodent excreta			YYYY / MM/DD	
Animal Exposure - Wild animals (other than rodents) (Add'l Info)_			YYYY / MM/DD	
Animal Exposure - Other Animal Exposure (Add'l Info)_			YYYY / MM/DD	
Chronic Medical Condition - 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			YYYY / MM/DD	
Occupation - Personal Care Worker	TE		YYYY / MM/DD	
Travel - Outside of Canada (Add'l Info)_	AE		YYYY / MM/DD	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	AE		YYYY / MM/DD	
Water - Bottled water (Add'l Info)			YYYY / MM/DD	
Water - Public water system (Add'l Info)			YYYY / MM/DD	
Water - Private well or system (Add'l Info)			YYYY / MM/DD	
Water - Untreated water (Add'l Info)			YYYY / MM/DD	
Water (Recreational) - Pond, stream, lake, river, ocean			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 -> SALMONELLA FORM

G) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

H) INTERVENTION

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

Intervention Type and Sub Type:				
Assessment: Investigator name <input type="checkbox"/> Assessed for contacts YYYY / MM / DD	Exclusion: 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			
Communication: <input type="checkbox"/> Other communication (See Investigator Notes) YYYY / MM / DD Investigator name <input type="checkbox"/> Letter (See Document Management) YYYY / MM / DD Investigator name	Outbreak Declared YYYY / MM / DD Investigator name			
General: Investigator name <input type="checkbox"/> Disease-Info/Prev-Control YYYY/ MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD	Public Health Order: <input type="checkbox"/> Order (specify) _____ YYYY / MM / DD Investigator name			
Education/counselling: <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided YYYY / MM / DD Investigator name	Referral: <input type="checkbox"/> Canadian food inspection agency YYYY / MM / DD Investigator name			
Environmental Health: YYYY / MM / DD <input type="checkbox"/> Restaurant inspection Investigator name	Testing: Investigator name <input type="checkbox"/> Stool testing recommended (e.g. for follow-up) YYYY / MM / DD <input type="checkbox"/> Laboratory testing recommended YYYY / MM / DD			
Immunization: Investigator name <input type="checkbox"/> Eligible immunizations recommended YYYY / MM / DD	Other Investigation Findings: <input type="checkbox"/> Investigator Notes <input type="checkbox"/> Document Management Notes			
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	

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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

- 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
		<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		
	Salmonella 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