

Haemophilus influenzae infection (invasive) Data Collection Worksheet

Please complete all sections.

Panorama QA complete: Yes No

Panorama Client ID: _____

Initials: _____

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: _____		Preferred Communication Method: (specify - i.e. home phone, text):	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace:		Health Card Number (PHN): _____		Email Address: <input type="checkbox"/> Work <input type="checkbox"/> Personal	
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 investigation if not the same:			

B) INVESTIGATION INFORMATION

LHN-> SUBJECT SUMMARY-> RESPIRATORY & DIRECT CONTACT ENCOUNTER GROUP-> CREATE INVESTIGATION

Disease Summary Classification:	Date	Classification:	Date	LAB TEST INFORMATION:
CASE		CONTACT		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"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Blood
<input type="checkbox"/> Probable	YYYY / MM / DD			<input type="checkbox"/> Urine
				<input type="checkbox"/> Stool

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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C) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Arthritis - septic		YYYY / MM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MM / DD
Bulging fontanelle		YYYY / MM / DD	Meningitis		
Cardiac - pericarditis		YYYY / MM / DD	Neck stiffness (nuchal rigidity)		YYYY / MM / DD
Cellulitis		YYYY / MM / DD	Confusion		YYYY / MM / DD
Dyspnea (shortness of breath)		YYYY / MM / DD	Pneumonia		YYYY / MM / DD
Epiglottitis		YYYY / MM / DD	Respiratory compromise		YYYY / MM / DD
Fever		YYYY / MM / DD	Sepsis (e.g. bactremia, septicemia, etc.)		YYYY / MM / DD
Infection - empyema		YYYY / MM / DD			
Other s/s					

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start Date	N, NA, U	Add'l Info
Contact - Daycare	YYYY / MM / DD TE		
Contact to a known case (Add'l Info)	YYYY / MM / DD AE		
Special population – Attends Childcare	YYYY / MM / DD TE		
Special population – Attends school	YYYY / MM / DD TE		
Travel - Outside of Canada (Add'l Info)	YYYY / MM / DD TE		
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM / DD TE		

F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

Interpretation Date: YYYY / MM / DD	
Interpretation of Disease Immunity:	<input type="checkbox"/> IOM - Fully immunized (for age) <input type="checkbox"/> IOM - Partially immunized
<input type="checkbox"/> IOM – Unimmunized <input type="checkbox"/> IOM - Unclear immunization history	Valid doses received: _____ Doses needed: _____
Reason: <input type="checkbox"/> IIOM – Interpretation of history by investigator	

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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) Transmission Events

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

Transmission Event ID	Exposure Name	Setting type (Consider the following settings for TE; if >1 select "multiple settings" in Panorama)	Date/Time	# of contacts
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities (e.g daycare)		
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		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities (e.g daycare)		
	Hib 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 [including groups that 1:1 follow-up is not required or is not feasible])