

Mumps 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 -> RESPIRATORY & DIRECT CONTACT ENCOUNTER GROUP -> CREATE INVESTIGATION

Disease Summary Classification:	Date	Classification:	Date	LAB TEST INFORMATION:
CASE		CONTACT		<i>Date specimen collected:</i>
<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	<i>Specimen type:</i>
<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:				
<i>FOLLOW UP:</i>				
<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 _____				

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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
Abortion - spontaneous (miscarriage)		YYYY / MM / DD	Lab - platelet count low		YYYY / MM / DD
Coryza or rhinitis		YYYY / MM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MM / DD
Cough		YYYY / MM / DD	Meningitis - aseptic		YYYY / MM / DD
Encephalitis		YYYY / MM / DD	Orchitis (inflamed testicle)		YYYY / MM / DD
Hearing loss		YYYY / MM / DD	Pain - salivary glands		YYYY / MM / DD
Infection - upper respiratory tract		YYYY / MM / DD	Parotid gland - inflammation (parotitis)		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	Start date Yes	N, NA, U	Add'l Info
Contact - At risk population (international travellers or immigrants)	YYYY / MM/DD		
Contact to a known case (Add'l Info)	YYYY / MM/DD		
Immunocompromised - Related to underlying disease or treatment			
Occupation - Health Care Worker - IOM Risk Factor	TE		
Risk Behaviour - Sharing personal items (cigarettes, water bottles)	TE		
Special Population - Attends childcare	TE		
Special Population - Attends school	TE		
Special Population - Lives in a communal setting	TE		
Special Population - Post secondary education institution	TE		
Special Population - Pregnancy			
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		

F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

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

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I) Acquisition Event

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

Acquisition Event ID: _____

Exposure Name: _____

Acquisition Start YYYY / MM / DD to **Acquisition End:** YYYY / MM / DD

Location Name: _____

Setting Type

Travel
 Health care setting
 Public facilities
 Recreational facilities
 Most likely source

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	YYYY / MM / DD to YYYY / MM / DD	
		<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	YYYY / MM / DD to YYYY / MM / DD	
		<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	YYYY / MM / DD to YYYY / MM / DD	
		<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	YYYY / MM / DD to YYYY / MM / DD	
		<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	YYYY / MM / DD to YYYY / MM / DD	
		<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	YYYY / MM / DD to YYYY / MM / DD	
	Mumps 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])

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