Pneumococcal Disease (invasive) 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: ☐ Work ☐ Personal
Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:		
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

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

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

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) DISEASE EVENT HISTORY

INVESTIGATION->DISEASE SUMMARY (UPDATE)->DISEASE EVENT HISTORY

Site / Presentation: ☐ Sepsis ☐ Meningitis ☐ Pneumonia with bacteremia ☐ Other

D) 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	**Malaise**		YYYY / MMM / DD
Cardiac - endocarditis		YYYY / MM / DD	**Meningitis**		YYYY / MMM / DD
Cardiac - pericarditis		YYYY / MM / DD	**Peritonitis**		YYYY / MMM / DD
Fever		YYYY / MM / DD	**Pneumonia**		YYYY / MMM / DD
Osteomyelitis			**Sepsis (e.g. bactremia, septicemia, etc.)**		

E) RISK FACTORS (RF followed by + impact the Immunization Forecaster)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Chronic Medical Condition - Other (Add'l Info))			
Contact to a known case (Add'l Info)	YYYY / MM/DD		
Environmental - Second hand smoke			
Immunocompromised – Acquired Complement Deficiency +			
I**mmunocompromised** – Congenital immunodeficiency +			
Special Population - Attends childcare			
Special Population – Homeless +			
Special Population - Lives in a communal setting			
Substance Use - Tobacco			

F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

Interpretation Date: YYYY / MM / DD

Interpretation of Disease Immunity: ☐ IOM - Fully immunized (for age) ☐ IOM - Partially immunized

☐ IOM – Unimmunized ☐ IOM - Unclear immunization history **Valid doses received**: _____ **Doses needed**: _____

Reason:

☐ IOM – Interpretation of history by investigator

G) TREATMENT

LHN -> INVESTIGATION-> MEDICATIONS-> MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds) :* _____

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

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Please complete **all** sections.

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Panorama Investigation ID: _____

H) INTERVENTION

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

Intervention Type and Sub Type:

General: Investigator name
☐ Disease-Info/Prev-Control YYYY/ MM / DD

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

Immunization:
☐ Eligible Immunization recommended YYYY / MM / DD
☐ Disease-specific immunization recommended YYYY / MM / DD
☐ Disease-specific immunization given YYYY / MM / DD
Investigator name

Other Investigation Findings:
☐ Investigator Notes ☐ See Document Management

Isolation:
☐ Facility isolation YYYY / MM / DD Investigator name
☐ Home isolation 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	
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	

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) _____

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