

Panorama QA complete: Yes No
Initials:

A) PERSON REPORTING – HEALTH CARE PROVIDER INFORMATION

Clinic Name: Location: Attending Physician or Nurse: Address: Phone number:	FOR PUBLIC HEALTH OFFICE USE ONLY: Service Area: Date Received: Panorama Client ID: Panorama Investigation ID:
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B) CLIENT INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	Phone : <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace: <input type="checkbox"/> Alt Contact: Name: _____ Relationship: _____
Health Card Province: _____ Health Card Number (PHN):	<u>Gender Identity:</u> <input type="checkbox"/> Transgender Male-to-female <input type="checkbox"/> Transgender Female-to-male <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Other (specify)	Preferred Communication Method: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> E-mail <input type="checkbox"/> Text
Place of Employment/School:	Email Address:	
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):		

C) IMMIGRATION INFORMATION

Country Born In: _____
Country Emigrated from: _____ Arrival Date: YYYY / MM / DD OR Arrival Year YYYY

D) DISEASE EVENT HISTORY

Staging: <input type="checkbox"/> Acute <input type="checkbox"/> Chronic <input type="checkbox"/> Unknown
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E) SIGNS & SYMPTOMS

Description	No	Yes Date of onset	Description	No	Yes Date of onset
Arthralgia			Nausea		
Asymptomatic			Pain - Abdominal		
Fever			Rash		
Jaundice			Stool – light		
Lethargy (fatigue, drowsiness, weakness, etc)			Urine – dark		
Loss of appetite (anorexia)			Vomiting		
Malaise			Weight loss		
Myalgia (muscle pain)			Other – specify		

Hepatitis B Notification Form

Panorama Client ID: _____
Panorama Investigation ID: _____

F) RISK FACTORS (Please complete all Risk Factors –specify dates as needed) – Legend: N – No, NA – Not asked, U – Unknown

DESCRIPTION	Yes Start Date	N, NA, U	Add'l Info
Contact – Hepatitis B	YYYY / MM/DD		
Exposure – Blood and body fluids (not otherwise listed) (Add'l Info)	YYYY / MM/DD		
Exposure - Invasive body art (e.g. tattoo, body piercing, scarification)	YYYY / MM/DD		
Occupation – Health Care Worker – IOM Risk Factor			
Risk Behavior – Sharing injection drug equipment	TE		
Risk Behavior – Sharing non-injection drug equipment	TE		
Sexual Behaviour – More than 2 sexual partners in past 3 months	TE		
Sexual Behaviour – MSM	TE		
Sexual Behaviour – Sex with a known case (Add'l Info)	YYYY / MM/DD		
Sexual Behavior – Sex with person from endemic country (Add'l Info)			
Sexual Behavior – Sex with person who injects drugs	TE		
Special Populations – Correctional Facility resident			
Special Population – From or residence in an endemic country			
Special Population – Infant born to infected mom			
Special Population – Pregnancy			
Special Population – Self-reported indigenous			
Substance Use – Alcohol			
Substance Use – Injection Drug Use (including Steroids)			
Substance Use – Illicit non-injection drug use			
Travel – Outside of Canada (Add'l Info)	YYYY / MM/DD		
Other risk factor (Add'l Info)			
Medical Treatment - Blood, blood product or tissue recipient (Add'l Info)	YYYY / MM/DD INTERVENTION		
Medical Treatment Other (transplant, surgery, dental, oscopy, artificial insemination etc.) (Add'l Info)	YYYY / MM/DD INTERVENTION		
<i>Blood, blood product, tissue or transplant donor</i>	<i>Document referral in interventions and complete Appendix K – Referral to CBS, and upload into Document Management</i>		

G) UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts: _____ (number of contacts that the individual cannot name)

Include known contacts on the following pages

Hepatitis B – Contacts

Please complete **all** sections.

Please include information on additional contacts on a separate sheet

A) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> alternate phone: Relationship:	e-mail Address:	
Place of Employment/School:	Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is contact Hep B positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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):		
Exposure Dates: 1st YYYY / MM / DD to YYYY / MM / DD Exposure Type: <input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Sharing Injection/ Non-injection Drug Equipment		
Will the testing Physician/Nurse follow-up this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date contact notified: YYYY / MMM / DD Has the contact been vaccinated for Hep B in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		Comments:

B) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> alternate phone: Relationship:	e-mail Address:	
Place of Employment/School:	Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is contact Hep B positive? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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):		
Exposure Dates: 1st YYYY / MM / DD to YYYY / MM / DD Exposure Type: <input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> Sharing Injection/ Non-injection Drug Equipment		
Will the testing Physician/Nurse follow-up this contact? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, date contact notified: YYYY / MMM / DD Has the contact been vaccinated for Hep B in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No		Comments: