Government of Saskatchewan

Hepatitis B – Public Health Follow-Up

PANORAMA

Panorama QA complete: ☐ **Yes** ☐ **No**
Initials:

Panorama Client ID: _____
Panorama Investigation ID: _____

A) CLIENT INFORMATION

LHN ->SUBJECT -> CLIENT DETAILS -> PERSONAL INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	PHN:

B) INVESTIGATION INFORMATION

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

Disease Summary Classification: CASE:	Date	*Classification: CONTACT:*	*Date*	*LAB TEST INFORMATION:*
☐ Lab Confirmed	YYYY / MM / DD	☐ *Contact*	*YYYY / MM / DD*	*Date specimen collected:*
☐ Suspect	YYYY / MM / DD	☐ *Not a Contact*	*YYYY / MM / DD*	*YYYY / MM / DD*
☐ Person Under Investigation	YYYY / MM / DD	☐ *Person Under Investigation*	*YYYY / MM / DD*	

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	YYYY / MM / DD
☐ Incomplete – Unable to locate	YYYY / MM / DD	(Specify where)	YYYY / MM / DD

C) 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 ☐ Previous responder/Previous history of immunity ☐ Date Of Birth

D) INTERVENTION

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

Intervention Type and Sub Type:

Assessment:
- ☐ Assessed for contacts Investigator name YYYY/ MM /DD
- ☐ Client aware of diagnosis Investigator name YYYY/ MM /DD

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

Communication:
- ☐ Phone call (morning) Investigator name YYYY/ MM /DD
- ☐ Phone call (afternoon) Investigator name YYYY/ MM /DD
- ☐ Phone call (evening) Investigator name YYYY/ MM /DD
- ☐ Text Message sent Investigator name YYYY/ MM /DD
- ☐ E-mail Investigator name YYYY/ MM /DD
- ☐ Home visit Investigator name YYYY/ MM /DD
- ☐ Letter Sent Investigator name YYYY/ MM /DD
- ☐ Ordering practitioner contacted Investigator name YYYY/ MM /DD
- ☐ Letter (See Document Management) YYYY/ MM /DD
- ☐ Other communication (See Investigator Notes YYYY/ MM /DD

Environmental health:
- ☐ Personal Service Facility inspection YYYY/ MM /DD
  Investigator name

Referral:
- ☐ Canadian Blood Services YYYY/ MM /DD
- ☐ Child Protective Services YYYY/ MM /DD
- ☐ Harm Reduction Services YYYY/ MM /DD
- ☐ Infectious Disease Specialist YYYY/ MM /DD
- ☐ Primary Care Provider YYYY/ MM /DD
- ☐ Saskatchewan Transplant Program YYYY/ MM /DD
- ☐ Consultation with MHO YYYY/ MM /DD
  Investigator name

General: Investigator name
- ☐ Disease-Info/Prev-Control YYYY/ MM / DD
- ☐ Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD

Testing: Investigator name
- ☐ Post-immunization testing recommended YYYY/ MM /DD
- ☐ Pre-immunization testing recommended YYYY/ MM /DD
- ☐ Laboratory testing recommended YYYY/ MM /DD
- ☐ STBBI Testing recommended (specify) YYYY/ MM /DD

Education/counselling:
- ☐ Prevention/Control measures Investigator name YYYY/ MM /DD
- ☐ Disease information provided Investigator name YYYY/ MM /DD
- ☐ Other (See Investigator Notes) Investigator name YYYY/ MM / DD

Other Investigation Findings
- ☐ Investigator Notes YYYY/ MM /DD
- ☐ See Document Management YYYY/ MM /DD

Date	Intervention subtype	Comments	Next follow-up Date	Initials
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	

Hepatitis B – Public Health Follow-Up

Panorama Client ID: _____
Panorama Investigation ID: _____

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	

E) 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)

F) Transmission Event LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY

Transmission Event ID (system-generated can be documented below)	Exposure Name	Setting type Important: (Select the most appropriate setting for the TE; if >1 select multiple settings)	Date/Time (include the earliest transmission date to the latest date)	# of contacts
	Hep B Contacts-Inv ID #__	☐ Sexual Exposure ☐ Public facilities ☐ Multiple settings ☐ Household ☐ Type of community contact (includes IDU)		

G) Total number of contacts

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK -> UNKNOWN/ANONYMOUS CONTACTS

_____ (total number of *unknown* and *known* contacts)

Initial Report completed by:		**Date initial report completed:** YYYY / MMM / DD

H) CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____ HSN: _____	Gender: ☐ Male ☐ Female ☐ Unknown ☐ Other	
Phone #: ☐ Primary Home: ☐ Workplace: ☐ Mobile contact: ☐ alternate phone: Relationship:	**e-mail Address:**	
Place of Employment/School:	**Is contact pregnant?** ☐ Yes ☐ No ☐ Unknown **Is contact Hep B positive?** ☐ Yes ☐ No ☐ Unknown	
Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ 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**: ☐ Sexual ☐ Household ☐ Sharing Injection/ Non-injection Drug Equipment		
Will the testing Physician/Nurse **follow-up** this contact? ☐ Yes ☐ No If yes, date contact notified: YYYY / MMM / DD Has the contact been vaccinated for Hep B in the past? ☐ Yes ☐ No	**Comments**:	

Complete more contact sheets if needed