

## Hepatitis C – Public Health Follow-Up

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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	PHN:

### B) INVESTIGATION INFORMATION

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

Disease Summary Classification: CASE:	Date	Classification: CONTACT:	Date	LAB TEST INFORMATION:
<input type="checkbox"/> Lab Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	Date specimen collected: YYYY / MM / DD
<input type="checkbox"/> Suspect	YYYY / MM / DD	<input type="checkbox"/> Not a Contact	YYYY / MM / DD	
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	

**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)	YYYY / MM / DD

### C) INTERVENTION

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

Intervention Type and Sub Type:				
<b>Assessment:</b> <input type="checkbox"/> Assessed for contacts    Investigator name    YYYY/ MM /DD <input type="checkbox"/> Client aware of diagnosis    Investigator name    YYYY/ MM /DD	<b>Immunization:</b> <input type="checkbox"/> Eligible Immunization recommended    YYYY/ MM /DD <input type="checkbox"/> Immunization nurse notified    YYYY/ MM /DD Investigator name			
<b>Communication:</b> <input type="checkbox"/> Phone call (morning)    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Phone call (afternoon)    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Phone call (evening)    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Text Message sent    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> E-mail    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Home visit    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Letter Sent    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Letter (See Document Management)    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Ordering practitioner contacted    Investigator name    YYYY/ MM/ DD <input type="checkbox"/> Other communication (See Investigator Notes)    Investigator name    YYYY/ MM/ DD	<b>Environmental health:</b> <input type="checkbox"/> Personal Service Facility inspection    YYYY/ MM /DD Investigator name <b>Referral:</b> Investigator name <input type="checkbox"/> Canadian Blood Services    YYYY/ MM /DD <input type="checkbox"/> Child Protective Services    YYYY/ MM /DD <input type="checkbox"/> Harm Reduction Services    YYYY/ MM /DD <input type="checkbox"/> Infectious Disease Specialist    YYYY/ MM /DD <input type="checkbox"/> Primary Care Provider    YYYY/ MM /DD <input type="checkbox"/> Saskatchewan Transplant Program    YYYY/ MM /DD <input type="checkbox"/> Consultation with MHO    YYYY/ MM /DD <b>Other:</b> <input type="checkbox"/> Other (specify)    YYYY/ MM /DD Investigator name <b>Other Investigation Findings</b> <input type="checkbox"/> Investigator Notes    YYYY/ MM /DD <input type="checkbox"/> See Document Management    YYYY/ MM /DD			
<b>General:</b> Investigator name <input type="checkbox"/> Disease-Info/Prev-Control    YYYY/ MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts    YYYY/ MM / DD	<b>Testing:</b> <input type="checkbox"/> Laboratory testing recommended    YYYY/ MM /DD <input type="checkbox"/> STBBI Testing recommended (specify)    YYYY/ MM /DD Investigator name			
<b>Education/counselling:</b> <input type="checkbox"/> Prevention/Control measures    Investigator name    YYYY/ MM /DD <input type="checkbox"/> Disease information provided    Investigator name    YYYY/ MM /DD <input type="checkbox"/> Other (specify)    YYYY/ MM /DD				
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	

