

HIV – 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) INTERVENTIONS

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

Intervention Type and Sub Type:				
Assessment: <input type="checkbox"/> Assessed for contacts Investigator name YYYY / MM / DD <input type="checkbox"/> Client aware of diagnosis Investigator name YYYY / MM / DD	Immunization: Investigator name <input type="checkbox"/> Eligible Immunization recommended YYYY / MM / DD <input type="checkbox"/> Immunization nurse notified YYYY / MM / DD			
Communication: <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) YYYY/MM/DD Investigator name <input type="checkbox"/> Ordering practitioner contacted YYYY/MM/DD Investigator name <input type="checkbox"/> Other communication (See Investigator Notes) YYYY/MM/DD Investigator name	Environmental health: <input type="checkbox"/> Personal Service Facility inspection YYYY / MM / DD Investigator name Referral: 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"/> HIV Case Management 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 Other: <input type="checkbox"/> Other (specify) _____ YYYY / MM / DD			
General: 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	Other Investigation Findings <input type="checkbox"/> Investigator Notes YYYY/ MM /DD <input type="checkbox"/> See Document Management YYYY/ MM /DD			
Education/counselling: <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 (See Investigator Notes) YYYY / MM / DD	Testing: <input type="checkbox"/> Laboratory testing recommended YYYY / MM / DD <input type="checkbox"/> STBBI Testing recommended -See Investigator Notes 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	

HIV Public Health Follow-up

Please complete all sections.

Panorama QA complete: Yes No
Initials:

D) OUTCOMES (Optional except for severe influenza)

LHN-> INVESTIGATION-> OUTCOMES

<input type="checkbox"/> Hospitalization YYYY/MM/DD	<input type="checkbox"/> ICU/intensive medical care: YYYY/MM/DD	<input type="checkbox"/> Intubation/Ventilation YYYY/MM/DD	<input type="checkbox"/> Unknown YYYY/MM/DD
<input type="checkbox"/> Other _____	YYYY/MM/DD		
<input type="checkbox"/> Fatal _____	YYYY/MM/DD	Cause of Death: (if Fatal was selected) _____	

E) Transmission Events

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

Transmission Event ID <small>(system-generated can be documented below)</small>	Exposure Name	Setting type Important: <small>(Select the most appropriate setting for the TE; if >1 select multiple settings)</small>	Date/Time <small>(included the earliest transmission date to the latest date)</small>	# of contacts
	HIV Contact – Inv ID #	<input type="checkbox"/> Sexual Exposure <input type="checkbox"/> Type of community contact (IDU) <input type="checkbox"/> Public facilities <input type="checkbox"/> Multiple Settings		

F) Total number of contacts

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

_____ (Total number of <i>unknown</i> and <i>known</i> contacts)
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Initial Report completed by:		Date initial report completed: YYYY / MMM / DD
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CONTACTS

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MMM / DD Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	
HSN: _____		
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Workplace: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> alternate phone: Relationship:	e-mail Address:	
Online Names: Site/Service: _____ User Name: _____		
Place of Employment/School:	Is contact pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Is contact HIV positive <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown If yes, did they inform case? <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 / MMM / DD to YYYY / MMM / DD		
Exposure Type: <input type="checkbox"/> Heterosexual <input type="checkbox"/> Sharing Injection Drug Equipment <input type="checkbox"/> MSM		
Comments:	INTERVENTION Testing <input type="checkbox"/> Advised <input type="checkbox"/> Received <input type="checkbox"/> Referral (Specify)	

Complete more contact sheets if needed