

### Campylobacteriosis Data Collection Worksheet

Panorama QA complete:  Yes  No

Please complete all sections

Panorama Client ID: \_\_\_\_\_

Initials: \_\_\_\_\_

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: _____		Preferred Communication Method: (specify - i.e. home phone, text):	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace:		Health Card Number (PHN): _____		Email Address: <input type="checkbox"/> Work <input type="checkbox"/> Personal	
Place of Employment/School:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____		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):  Address at time of infection if not same:			

#### B) INVESTIGATION INFORMATION

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

Disease Summary Classification:	Date	Classification:	Date	LAB TEST INFORMATION:
<b>CASE</b>		<b>CONTACT</b>		<i>Date specimen collected:</i>
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	YYYY / MM / DD
<input type="checkbox"/> Does Not Meet Case	YYYY / MM / DD	<input type="checkbox"/> Not a Contact	YYYY / MM / DD	<i>Specimen type:</i> <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Stool
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	
<input type="checkbox"/> Probable	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)	

<b>REPORTING NOTIFICATION</b>		Location:
Name of Attending Physician or Nurse:		
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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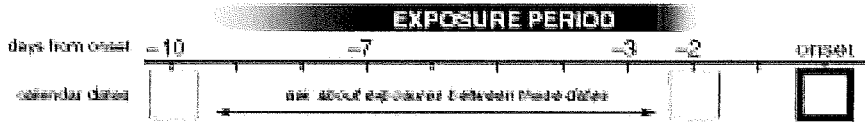
Panorama Client ID: \_\_\_\_\_  
Panorama Investigation ID: \_\_\_\_\_

### C) SIGNS & SYMPTOMS

INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - bloody	YYYY / MM / DD	YYYY / MM / DD	Pain – abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - mucousy	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bactremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - watery	YYYY / MM / DD	YYYY / MM / DD	Stool - bloody	YYYY / MM / DD	YYYY / MM / DD
Headache	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Malaise	YYYY / MM / DD	YYYY / MM / DD		YYYY / MM / DD	YYYY / MM / DD
Other Signs & Symptoms if applicable					

Enter onset date in heavy box  
Count back to figure the  
probable exposure period



### D) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

<b>Incubation for Case (period for acquisition):</b>	
Earliest Possible Exposure Date: YYYY / MM / DD	Latest Possible Exposure Date: YYYY / MM / DD
<i>Exposure Calculation details:</i>	
<b>Communicability for Case (period for transmission):</b>	
Earliest Possible Communicability Date: YYYY / MM / DD	Latest Possible Communicability Date: YYYY / MM / DD
<i>Communicability Calculation Details:</i>	

### E) RISK FACTORS

N – NO, NA – Not Asked, U – Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Add'l Info
Animal Exposure – Farms (Add'l Info)			
Animal Exposure – Other (Add'l Info)			
Animal Exposure – Pet treats and raw food (Add'l Info)			
Animal Exposure – Pets (including reptiles) (Add'l Info)			
Animal Exposure – Rodents/rodent excreta			
Animal Exposure – Wild animals (other than rodents) (Add'l Info)			
Behaviour – Camping/hiking	YYYY / MM/DD		
Contact – Persons with diarrhea/vomiting	YYYY / MM/DD		
Contact to a known case (Add'l Info)	YYYY / MM/DD		
Immunocompromised – Related to underlying disease or treatment			
Occupation – Child Care Worker	TE		
Occupation – Farmer			
Occupation – Food Handler	TE		
Occupation – Health Care Worker – IOM Risk Factor	TE		

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Panorama Client ID: \_\_\_\_\_  
Panorama Investigation ID: \_\_\_\_\_

DESCRIPTION	Yes	N, NA, U	Add'l Info
Occupation – Veterinarian or related worker			
Travel – Outside of Canada (Add'l Info)	YYYY / MM/DD AE		
Travel – Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM/DD AE		
Water – Bottled water (Add'l Info)			
Water – Private well or system (Add'l Info)			
Water – Public water system (Add'l Info)			
Water – Untreated water (Add'l Info)	AE		
Water (Recreational) – Pond, stream, lake, river, ocean (Add'l Info)	AE		
Water (Recreational) – Private (swimming pool/whirl pool)	TE		
Water (Recreational) – Public (swimming/paddling pool/whirl pool)			
Other risk factor (Add'l Info)			

F) USER DEFINED FORM (SEE ATTACHED)      LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> CAMPYLOBACTERIOSIS FORM

G) TREATMENT      LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (to intercept transmission)Panorama = Other Meds) : _____
Prescribed by: _____      Started on: YYYY / MM / DD

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

Intervention Type and Sub Type:				
<b>Assessment:</b>			<b>Exclusion (recommended):</b> Investigator name	
<input type="checkbox"/> Assessed for contacts      YYYY/ MM / DD			<input type="checkbox"/> Daycare      YYYY/ MM / DD	<input type="checkbox"/> Preschool      YYYY/ MM / DD
Investigator name			<input type="checkbox"/> School      YYYY/ MM / DD	<input type="checkbox"/> Work      YYYY/ MM / DD
<b>General:</b> Investigator name			<b>Public Health Order:</b>	
<input type="checkbox"/> Disease-Info/Prev-Control      YYYY/ MM / DD			<input type="checkbox"/> Other (specify)      YYYY/ MM / DD	
<input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts      YYYY/ MM / DD			Investigator name	
<b>Communication:</b>			<b>Referral:</b> Investigator name	
<input type="checkbox"/> Other communication (See Investigator Notes)      YYYY/ MM / DD	Investigator name		<input type="checkbox"/> Canadian Food Inspection Agency      YYYY/ MM / DD	<input type="checkbox"/> Primary Care Provider      YYYY/ MM / DD
<input type="checkbox"/> Letter See Document Management      YYYY/ MM / DD	Investigator name		<input type="checkbox"/> Saskatchewan Water Security Agency      YYYY/ MM / DD	
<b>Education/counselling:</b> Investigator name			<b>Other Investigation Findings:</b>	
<input type="checkbox"/> Prevention/Control measures      YYYY/ MM / DD			<input type="checkbox"/> Investigator Notes	
<input type="checkbox"/> Disease information provided      YYYY/ MM / DD			<input type="checkbox"/> Document Management	
<b>Environmental health:</b> YYYY/ MM / DD				
<input type="checkbox"/> Restaurant Inspection <input type="checkbox"/> Facility Inspection				
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	

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Panorama Client ID: \_\_\_\_\_  
Panorama Investigation ID: \_\_\_\_\_

### I) OUTCOMES (optional except for severe influenza)

LHN-> INVESTIGATION-> OUTCOMES

- |   |                |   |                |  |                |
|---|----------------|---|----------------|--|----------------|
| <input type="checkbox"/> Not yet recovered/recovering | YYYY / MM / DD | <input type="checkbox"/> ICU/intensive medical care | YYYY / MM / DD | <input type="checkbox"/> Hospitalization | YYYY / MM / DD |
| <input type="checkbox"/> Recovered                    | YYYY / MM / DD | <input type="checkbox"/> Intubation /ventilation    | YYYY / MM / DD | <input type="checkbox"/> Unknown         | YYYY / MM / DD |
| <input type="checkbox"/> Fatal                        | YYYY / MM / DD | <input type="checkbox"/> Other _____                | YYYY / MM / DD |  |                |

Cause of Death: (if Fatal was selected) \_\_\_\_\_

### J) EXPOSURES

Acquisition Event

LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> ACQUISITION QUICK ENTRY

Acquisition Event ID: \_\_\_\_\_

- Exposure Name: \_\_\_\_\_
- Acquisition Start YYYY / MM / DD to Acquisition End: YYYY / MM / DD
- Location Name: \_\_\_\_\_
- Setting Type**
- Travel       Exposure or consumption of potentially contaminated food or water       Most likely source

### Transmission Events

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

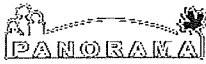
Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
	Campy Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

### K) TOTAL NUMBER OF CONTACTS

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

Anonymous contacts: \_\_\_\_\_ (total number of individuals exposed)

Initial Report completed by:		Date initial report completed: YYYY / MM / DD
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Campylobacteriosis Food Exposure Questionnaire



Loading...

Record type: Investigation  
Record ID: 146  
Record Name: UDF Investigation

In this form the answers (Yes, Probably, No, and Don't know) are from the perspective of the person being interviewed. "Probably" can be used if the client thinks he/she may have eaten this food or usually eats this food, but is unsure if it was eaten during the period in question.

**Diet and Allergies** Show/Hide

Are you a vegetarian?

Yes  
 No  
 Don't know  
 Not asked

Do you have any food Allergies / avoidances / special diet?

Yes  
 No  
 Don't know  
 Not asked

If yes, specify details

**Food Exposures** Show/Hide

In the 10 days prior to onset did you eat...

Any chicken meat?

Yes  
 Probably  
 No  
 Don't know  
 None of the Above

If yes, was the chicken undercooked?

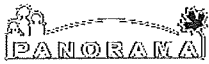
Yes  
 Probably  
 No  
 Don't know  
 None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any eggs or food contain eggs (from any bird species)?

Yes  
 Probably  
 No  
 Don't know  
 None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)



Any pork?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any beef?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any fish?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any raw vegetables?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

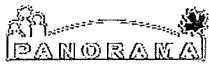
Any raw fruits?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any Unpasteurized dairy (e.g. milk, cheese)?

- Yes
- Probably
- No
- Don't know



None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

**Social Functions** [Show/Hide](#)

In the 10 days prior to onset did you attend any social functions (e.g. parties, weddings, showers, potlucks, community events)?

Yes  
 No  
 Don't know  
 Not asked

Click the Add button to add social event/function details

Add

**Restaurants** [Show/Hide](#)

In the 10 days prior to onset did you attend any restaurants (including take-out, cafeteria, bakery, deli, kiosk)?

Yes  
 No  
 Don't know  
 Not asked

Click the Add button to add restaurant details

Add

**Grocery Stores** [Show/Hide](#)

In the 10 days prior to onset did you attend any grocery stores for food consumed during the incubation period?

Yes  
 No  
 Don't know  
 Not asked

Click the Add button to add grocery store details

Add

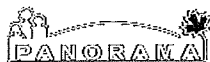
**Loyalty card/store issued card (for outbreak investigation only)** [Show/Hide](#)

This section is only for use in some specific outbreak situations, with client consent. It is not a routine question for sporadic cases.

Has the client given consent (written or verbal)?

Yes  
 No  
 Not applicable

Loyalty card details (names and numbers)



Interviewer Details and Notes		<a href="#">Show/Hide</a>
Interviewer Name	<input type="text"/>	
Interview date	<input type="text" value="8/22/2018"/>	
Any special notes regarding this interview	<input type="text"/>	

Save as Draft      Submit      Clear

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