Government of Saskatchewan

Streptococcal Invasive Disease (group A) Data Collection Worksheet

PANORAMA

Please complete **all** sections.

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 (Goes by):
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN): _____	Preferred Communication Method: (specify - i.e. home phone, text): Email Address: ☐ Work ☐ Personal
Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:		
Place of Employment/School:	Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown	
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____	Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home): Address at time of infection (if not the same):	

B) INVESTIGATION INFORMATION

SUBJECT SUMMARY->RESPIRATORY & DIRECT CONTACT ENCOUNTER GROUP->CREATE INVESTIGATION

Disease Summary Classification: CASE	**Date**	***Classification: CONTACT***	***Date***	***LAB TEST INFORMATION:***
☐ Confirmed	YYYY / MM / DD	☐ *Contact*	*YYYY / MM / DD*	*Date specimen collected:*
☐ Does Not Meet Case Definition	YYYY / MM / DD	☐ *Not a Contact*	*YYYY / MM / DD*	*YYYY / MM / DD*
☐ Person Under Investigation	YYYY / MM / DD	☐ *Person Under Investigation*	*YYYY / MM / DD*	*Specimen type:*
☐ Probable	YYYY / MM / DD			☐ *Blood* ☐ *CSF* ☐ *Other*

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

REPORTING NOTIFICATION Name of Attending Physician or Nurse**:**	Location:
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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C) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Acute respiratory distress syndrome (ARDS) - CXR/CT*		YYYY / MM / DD	**Muscle inflammation (myositis)**		YYYY / MM / DD
Arthritis - septic		YYYY / MM / DD	Necrosis - skin and tissue		YYYY / MM / DD
Cardiac - myocardial infarction		YYYY / MM / DD	**Necrotizing fasciitis**		YYYY / MM / DD
Cellulitis		YYYY / MM / DD	Confusion		YYYY / MM / DD
Chills		YYYY / MM / DD	Pain - severe		YYYY / MM / DD
Fever		YYYY / MM / DD	Cardiac - pericarditis		YYYY / MM / DD
Gangrene		YYYY / MM / DD	Pharyngitis (sore throat)		YYYY / MM / DD
Hypotension*		YYYY / MM / DD	Pneumonia		YYYY / MM / DD
Infection - soft tissue		YYYY / MM / DD	**Rash - erythematous macular ***		YYYY / MM / DD
Infection - wound		YYYY / MM / DD	**Renal impairment *** (refer to CDC Manual for parameters)		YYYY / MM / DD
Lab - liver function abnormality* (refer to CDC Manual for parameters)		YYYY / MM / DD	**Sepsis (e.g. bacteremia, septicemia, etc.)**		YYYY / MM / DD
Lab - platelet count low* (refer to CDC Manual for parameters)		YYYY / MM / DD	Skin - pain and swelling		YYYY / MM / DD
Meningitis		YYYY / MM / DD	**Streptococcal toxic shock syndrome (STSS)** Includes hypotension and 2 or more of the S/S with an *		YYYY / MM / DD
Other s/s					

D) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

Communicability for Case (period for transmission):
Earliest Possible Communicability Date: YYYY / MM / DD **Latest Possible Communicability Date**: YYYY / MM / DD

Communicability Calculation Details:

E) RISK FACTORS (RF followed by + impact the Immunization Forecaster)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	YES	N – No NA – not asked U - Unknown	DESCRIPTION	YES	N – No NA – not asked U - Unknown
Chronic Medical Condition - Cardiac Disease +			**Medical Risk Factor** - Varicella	YYYY / MM / DD	
Chronic Medical Condition - Diabetes Mellitus +			**Medical Treatment** - Surgery/surgical wound	YYYY / MM / DD	
Chronic Medical Condition - Liver disease +			**Setting** - Crowded living conditions (>1 person per room excluding bathrooms)		
Chronic Medical Condition - Lung disease +			**Special Population** – Homeless +		
Chronic Medical Condition - Renal disease +			**Special Population** - Lives in a communal setting		
Contact to a known case (Add'l Info)	YYYY / MM / DD		**Special Population** - LTC Facility +		

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DESCRIPTION	YES	N – No NA – not asked U - Unknown	DESCRIPTION	YES	N – No NA – not asked U - Unknown
Immunocompromised - HIV +			**Special Population** - Self-reported Indigenous identity		
Immunocompromised - Related to underlying disease or treatment			**Substance Use** - Alcohol		
Medical Risk Factor - Postpartum			**Substance Use** - Injection drug use (including steroids) +		
Medical Risk Factor History of injury (Add'l Info)	YYYY / MM / DD		Travel - Outside of Canada (Add'l Info)	YYYY / MM / DD	
Medical Risk Factor - Skin infection or dermatological condition	YYYY / MM / DD		Travel -Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM / DD	

F) TREATMENT

INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds) :* _____

Prescribed by:_____ Started on: YYYY / MM / DD

G) INTERVENTIONS

INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

Intervention Type and Sub Type:

Assessment:
☐ Assessed for contacts YYYY / MM / DD
Investigator name

Education/counselling: Investigator name
☐ Prevention/Control measures YYYY / MM / DD
☐ Disease information provided YYYY / MM / DD

Communication:
☐ Phone call attempted (day) YYYY / MM / DD
☐ Phone call attempted (evening) YYYY / MM / DD
☐ Home visit attempted YYYY / MM / DD
☐ Letter sent YYYY / MM / DD
☐ Text message sent YYYY / MM / DD
☐ Other communication (See Investigator Notes) YYYY / MM / DD
☐ Letter (See Document Management) YYYY / MM / DD
Investigator name

Immunization:
☐ Eligible Immunization(s) recommended YYYY / MM / DD
Investigator name

Isolation:
☐ Facility isolation YYYY / MM / DD ☐ Home isolation YYYY/MM/ DD
Investigator name

Referral
☐ Consult 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

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

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	
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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H) OUTCOMES

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) _____________________________

I) Transmission Events

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

Transmission Event ID (system-generated can be documented below	**Exposure Name**	**Setting type** (Select the most appropriate setting for the TE; if >1 select multiple settings will be entered into Panorama)	**Date/Time**	**# of contacts**
		☐ Childcare worker/attendee ☐ Health care setting ☐ Household ☐ Sexual exposure ☐ Type of community contact ☐ Congregate/communal living setting		
		☐ Childcare worker/attendee ☐ Health care setting ☐ Household ☐ Sexual exposure ☐ Type of community contact ☐ Congregate/communal living setting		
		☐ Childcare worker/attendee ☐ Health care setting ☐ Household ☐ Sexual exposure ☐ Type of community contact ☐ Congregate/communal living setting		
		☐ Childcare worker/attendee ☐ Health care setting ☐ Household ☐ Sexual exposure ☐ Type of community contact ☐ Congregate/communal living setting		
	iGAS Contacts – Inv ID# _____	☐ Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

J) 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