

Legionellosis 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: _____ 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

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

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

C) DISEASE EVENT HISTORY

LHN->INVESTIGATION->DISEASE SUMMARY (UPDATE)->DISEASE EVENT HISTORY

Site Description:	☐ Legionnaires' disease	☐ Pontiac fever	☐ Other
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Panorama Investigation ID: _____

D) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Loss of appetite (anorexia)		YYYY / MMM / DD	Headache		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Malaise		YYYY / MMM / DD
Confusion			Myalgia (muscle pain)		
Cough		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pneumonia		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Respiratory distress		YYYY / MMM / DD

E) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

Incubation for Case(Period for acquisition):	
Earliest Possible Exposure Date: YYYY / MM / DD	Latest Possible Exposure Date: YYYY / MM / DD
<i>Exposure Calculation details:</i>	

F) RISK FACTORS N—No, NA—Not asked, U—Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Chronic Medical Condition - Malignancies/Cancer+			
Immunocompromised - Related to underlying disease or treatment			
Immunocompromised - Transplant Candidate or Recipient - Solid Organ/Tissue+			
Travel - Outside of within Canada (Add'l Info)	YYYY / MM/DD AE		
Travel - Outside of Saskatchewan, but within Canada (add'l info)	YYYY / MM/DD AE		
Water - Aerosol - Air conditioning unit	YYYY / MM/DD		
Water - Aerosol - Other (add'l info)	YYYY / MM/DD		
Water - Aerosol - Room/central humidifier	YYYY / MM/DD		
Water - Aerosol - Shower head	YYYY / MM/DD		

G) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (Panorama = Other Meds) : _____	
Prescribed by: _____	Started on: YYYY / MMM / DD

H) INTERVENTION

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

Intervention Type and Sub Type:			
Assessment: Investigator name ☐ Assessed for contacts (individuals exposed to same source)		Immunization: Investigator name ☐ Eligible immunizations recommended	
Communication: ☐ Other communication (See Investigator Notes) Investigator name ☐ Letter (See Document Management) Investigator name		Referral: ☐ Infection Prevention and Control Investigator name ☐ Consultation with MHO Investigator name	
General: Investigator name ☐ Disease-Info/Prev-Control ☐ Disease-Info/Prev-Cont/Assess'd for Contacts		Other Investigation Findings: ☐ Investigator Notes ☐ Document Management Notes	
Education/counselling: ☐ Prevention/Control measures ☐ Disease information provided Investigator name			

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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	

I) 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 | ☐ Other YYYY / MM / DD |
| ☐ Fatal YYYY / MM / DD | ☐ Unknown _____ | |

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

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