Government of Saskatchewan

PANORAMA

Pertussis Data Collection Worksheet

Panorama QA complete: ☐ **Yes** ☐ **No**
Initials:

Please complete **all** sections.

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

LHN-> 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	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			☐ *Nasopharyngeal*
☐ Suspect	YYYY / MM / DD			☐ *Throat*

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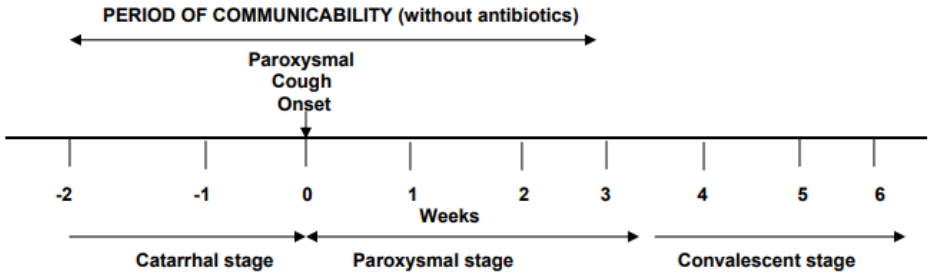
C) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes - Date of onset	Description	No	Yes - Date of onset
Apnea		YYYY / MM / DD	**Cough – paroxysmal**		YYYY / MM / DD
Coryza or rhinitis		YYYY / MM / DD	**Cough – with whoop**		YYYY / MM / DD
Cough		YYYY / MM / DD	**Cough > 2 weeks**		YYYY / MM / DD
Cough – with apnea		YYYY / MM / DD	**Gagging - infant**		YYYY / MM / DD
Cough – with vomiting		YYYY / MM / DD	**Gasping - infant**		YYYY / MM / DD



D) 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

Exposure Calculation details:

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
Special Population - Pregnancy	YYYY / MM / DD		**Setting** - Crowded living conditions (>1 person per room excluding bathrooms)		
Contact - Persons with similar symptoms	YYYY / MM / DD		**Special Population** - Lives in a communal setting		
Contact to a known case (Add'l Info)	YYYY / MM / DD		**Travel** - Outside of Canada (Add'l Info)	AE/TE YYYY / MM / DD	
Immunocompromised - Related to underlying disease or treatment			**Travel** - Outside of Saskatchewan, but within Canada (Add'l Info)	AE/TE YYYY / MM / DD	
Maternal Tdap not received between 27 weeks and 2 weeks prior to delivery *(For infant cases <1 year)*	YYYY / MM / DD				

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F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

Interpretation Date: YYYY / MM / DD

Interpretation of Disease Immunity: ☐ IOM - Fully immunized (for age) ☐ IOM - Partially immunized

☐ IOM – Unimmunized ☐ IOM - Unclear immunization history **Valid doses received**: _____ **Doses needed**: _____

Reason: ☐ IOM - Interpretation of history by investigator

G) TREATMENT

LHN -> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds)* : _____

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

H) INTERVENTION

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

Intervention Type and Sub Type:

Assessment:
☐ Assessed for contacts YYYY / MM / DD
(especially pregnant or < 1 year of age)
Investigator name

Other Investigation Findings:
☐ Investigator Notes ☐ See Document Management

Immunization:
☐ Eligible immunizations recommended YYYY / MM / DD
☐ Disease-specific immunization recommended YYYY / MM / DD
☐ Disease-specific immunization given YYYY / MM / DD
Investigator name

Communication:
☐ Other communication (see Investigator Notes) YYYY / MM / DD
Investigator name
☐ Letter (See Document Management) YYYY / MM / DD
Investigator name

Referral:
☐ Other (specify)_____ 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

Testing:
☐ Laboratory testing recommended YYYY / MM / DD
Investigator name

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

Treatment:
☐ Treatment not recommended YYYY / MM / DD
Investigator name

Exclusion: Investigator name
☐ Daycare YYYY / MM / DD ☐ Preschool YYYY / MM / DD
☐ School YYYY / MM / DD ☐ Work 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	
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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I) OUTCOMES (required for infants <12 months) 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) _____

J) Transmission Events LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY

Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		☐Congregate/Communal living ☐Health Care setting ☐Type of community contact ☐ Household Exposure		
		☐Congregate/Communal living ☐Health Care setting ☐Type of community contact ☐ Household Exposure		
		☐Congregate/Communal living ☐Health Care setting ☐Type of community contact ☐ Household Exposure		
	Pertussis Contacts – Inv ID# _____	☐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 [including groups that do not require 1:1 follow-up])

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