Viral Hemorrhagic Fever Data Collection Worksheet

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

LHN-> SUBJECT SUMMARY-> RESPIRATORY AND DIRECT CONTACT ENCOUNTER GROUP->CREATE INVESTIGATION

Disease Summary Classification: CASE	**Date**
☐ Confirmed	YYYY / MM / DD
☐ Does Not Meet Case	YYYY / MM / DD
☐ Person Under Investigation	YYYY / MM / DD
☐ Probable	YYYY / MM / DD
☐ Suspect	YYYY / MM / DD

Classification: CONTACT	***Date***
☐ *Contact*	*YYYY / MM / DD*
☐ *Not a Contact*	*YYYY / MM / DD*
☐ *Person Under Investigation*	*YYYY / MM / DD*

LAB TEST INFORMATION:
Date specimen collected:
YYYY / MM / DD
Specimen type:
☐ *Blood*
☐ *Urine*
☐ *Throat*
☐ *Tissue*
☐ *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		

Responsible Organization

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) IMMIGRATION INFORMATION

SUBJECT -> CLIENT DETAILS -> PERSONAL INFORMATION->IMMIGRATION INFORMATION

Country Born in: _____
Country Emigrated from: _____ Arrival Date: YYYY / MMM / DD OR Arrival Year_____

Government of Saskatchewan
Ministry of Health

Viral Hemorrhagic Fever Data Collection Worksheet

Please complete **all** sections

D) SIGNS & SYMPTOMS

INVESTIGATION->SIGNS & SYMPTOMS

Refer to clinical illness criteria outlined in the case definition to select signs and symptoms to support case classification

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Arthralgia		YYYY / MMM / DD	Lab - liver function abnormality		YYYY / MMM / DD
Bleeding – eyes		YYYY / MMM / DD	Lab - platelet count low		YYYY / MMM / DD
Bleeding – gastrointestinal		YYYY / MMM / DD	Lab-proteinuria		YYYY / MMM / DD
Bleeding – gums		YYYY / MMM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD
Bleeding – lungs		YYYY / MMM / DD	Loss of appetite (anorexia)		YYYY / MMM / DD
Bleeding - nose (epistaxis)		YYYY / MMM / DD	Malaise		YYYY / MMM / DD
Bleeding – urine		YYYY / MMM / DD	Myalgia (muscle pain)		YYYY / MMM / DD
Bleeding – uterus		YYYY / MMM / DD	Nausea		YYYY / MMM / DD
Bruising – excessive		YYYY / MMM / DD	Pain – abdominal		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Pain-back		YYYY / MMM / DD
Confusion		YYYY / MMM / DD	Pain – chest		YYYY / MMM / DD
Conjunctiva-inflammation (conjunctivitis)		YYYY / MMM / DD	Pain – groin		YYYY / MMM / DD
Cough		YYYY / MMM / DD	Pain – limbs		YYYY / MMM / DD
Dehydration		YYYY / MMM / DD	Pain - photophobia (sensitivity to light)		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pain - retro-orbital		YYYY / MMM / DD
Diarrhea – bloody		YYYY / MMM / DD	Pharyngitis (sore throat)		YYYY / MMM / DD
Dyspnea (shortness of breath)		YYYY / MMM / DD	Prostration		YYYY / MMM / DD
Edema - face and neck		YYYY / MMM / DD	Rash-maculopapular		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Rash – petechial		YYYY / MMM / DD
Flushing		YYYY / MMM / DD	Rash – purpura		YYYY / MMM / DD
Headache		YYYY / MMM / DD	Seizures		YYYY / MMM / DD
Hemorrhage – unexplained		YYYY / MMM / DD	Shock		YYYY / MMM / DD
Hypotension		YYYY / MMM / DD	Stool – bloody		YYYY / MMM / DD
Jaundice		YYYY / MMM / DD	Vomiting		YYYY / MMM / DD
Lab-leukopenia		YYYY / MMM / DD	Vomiting - bloody (hematemesis)		YYYY / MMM / DD
Other Signs & Symptoms if applicable					

E) INCUBATION AND COMMUNICABILITY

INVESTIGATION->INCUBATION & COMMUNICABILITY

Incubation for Case:

Earliest Possible Exposure Date: YYYY / MMM / DD

Latest Possible Exposure Date: YYYY / MMM / DD

Exposure Calculation details:

Communicability for Case:

Earliest Possible Communicability Date: YYYY / MMM / DD

Latest Possible Communicability Date: YYYY / MMM / DD

Communicability Calculation Details:

F) RISK FACTORS

INVESTIGATION-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	START DATE	END DATE	ADD'L INFO
Animal Exposure-Bats					
Animal Exposure- Wild animals (other than rodents) (Add'l Info)					

Government of Saskatchewan
Ministry of Health

Viral Hemorrhagic Fever Data Collection Worksheet

Please complete **all** sections

Animal Exposure-Other (Add'l Info)					
Behaviour - Lack of personal protective measures					
Contact - Contact to a known case (Add'l Info)			YYYY / MM/DD	YYYY / MM/DD	Include INV ID # if known in add'l info Create an AE with details
Contact - Persons with similar symptoms			YYYY / MM/DD	YYYY / MM/DD	Create an AE with details
Occupation-Health Care Worker					Create an AE with details
Occupation-Laboratory					Create an AE with details
Travel - Outside of Canada (Add'l Info)			YYYY / MM/DD	YYYY / MM/DD	Include name of country in add'l info
Other Risk Factor (Add'l Info)			YYYY / MM/DD	YYYY / MM/DD	

G) TREATMENT

INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds)* : _____

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

H) INTERVENTIONS

INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

Intervention Type and Sub Type:

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

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

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

Exclusion: Investigator name
☐ Work YYYY / MM / DD ☐ Preschool YYYY / MM / DD
☐ School YYYY / MM / DD ☐ Daycare YYYY / MM / DD

General:
☐ Disease-Info/Prev-Control YYYY/ MM / DD
☐ Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD
Investigator name

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

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

Public Health Order
☐ Order (see Document Management) YYYY / MM / DD
☐ Order to report to Public Health YYYY / MM / DD

Quarantine
☐ Home YYYY/ MM /DD
☐ Designated facility YYYY/ MM /DD

Referral:
☐ Consultation with MHO YYYY / MM / DD
☐ Infectious Disease Specialist YYYY / MM / DD
☐ Infection Prevention and Control YYYY / MM / DD
☐ Other/Multiple (see Investigator Notes) YYYY / MM / DD
Investigator name

Symptom Monitoring
☐ Direct ☐ Indirect, active ☐ Indirect , passive

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

Treatment
☐ Treatment 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	

Government of Saskatchewan
Ministry of Health

Viral Hemorrhagic Fever Data Collection Worksheet

Please complete **all** sections

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	

I) OUTCOMES (if applicable)

INVESTIGATION->OUTCOMES

☐ Not yet recovered/recovering ☐ ICU/intensive medical care: ☐ Hospitalization
☐ Recovered ☐ Unknown ☐ Intubation/ventilation
☐ Fatal ☐ Other _____

Cause of Death: (if Fatal was selected) _____

J) EXPOSURES – CONSIDER THE MODE OF TRANSMISSION

Acquisition Event

LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> MULTIPLE AE ENTRY

Exposure Name (use the most appropriate and most specific Key Descriptor check box as the name)	**Location City/Town**	**Setting type** (Consider the following settings for TE; if >1 select "multiple settings" in Panorama)	**Start/End Date**	**Most likely source**
☐ Contact to a case		☐ Household exposures ☐ Private Function ☐ Type of community contact	YYYY / MM / DD to YYYY / MM / DD	☐
☐ EMS ☐ Hospital ☐ Integrated Facility ☐ Laboratory ☐ Physician Office		☐ Health care setting	YYYY / MM / DD to YYYY / MM / DD	☐
City, Province OR City, Country		☐ Travel	YYYY / MM / DD to YYYY / MM / DD	☐

Transmission Events

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

Exposure Name (use the most appropriate Key Descriptor as per the RF/AE Quick Reference as the name)	**Location City/Town**	**Setting type** (Consider the following settings for TE; if >1 select "multiple settings" in Panorama)	**Date/Time**
Use key descriptor or the name of the setting	City, name of facility	☐ Educational institution ☐ Health care setting ☐ Household ☐ Private Function ☐ Recreational Facility ☐ Workplace	YYYY / MM / DD to YYYY / MM / DD
☐ Daycare/day home		☐ Public Facilities	YYYY / MM / DD to YYYY / MM / DD
City, Province OR City, Country		☐ Travel	YYYY / MM / DD to YYYY / MM / DD
☐ Close non-household ☐ Visiting friends and relatives		☐ Type of Community Contact	

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