

Campylobacteriosis Data Collection Worksheet

Panorama QA complete: ☐ Yes ☐ No

Please complete all sections

Panorama Client ID: _____

Panorama Investigation ID: _____

Initials: _____

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 same:	

B) INVESTIGATION INFORMATION

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

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

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 _____

Campylobacteriosis Data Collection Worksheet

Please complete all sections

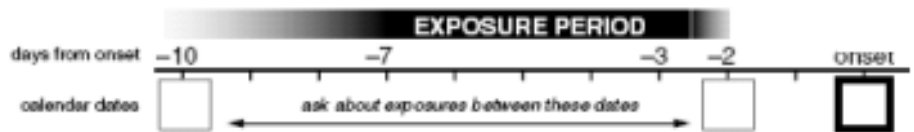
Panorama Client ID: _____
Panorama Investigation ID: _____

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	Cardiac- myocarditis	YYYY / MM / DD	YYYY / MM / DD
Arthritis	YYYY / MM / DD	YYYY / MM / DD	Cardiac-pericarditis	YYYY / MM / DD	YYYY / MM / DD
Guillain-Barre Syndrome	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

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>	
Communicability for Case (period for transmission): 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		

Campylobacteriosis Data Collection Worksheet

Please complete all sections

Panorama Client ID: _____
Panorama Investigation ID: _____

DESCRIPTION	Yes	N, NA, U	Add'l Info
Occupation – Health Care Worker – IOM Risk Factor	TE		
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 (<i>to intercept transmission</i>)Panorama = Other Meds) : _____	
Prescribed by: _____	Started on: YYYY / MM / DD

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

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

Campylobacteriosis Data Collection Worksheet

Please complete all sections

Panorama Client ID: _____
Panorama Investigation ID: _____

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	☐ Unknown	YYYY / MM / DD
☐ Fatal	YYYY / MM / DD	☐ 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
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
	Campy 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 exposed)

Initial Report completed by:		Date initial report completed: YYYY / MM / DD
------------------------------	--	--