

Cyclosporiasis 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-> 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	☐ Biopsy
☐ Probable	YYYY / MM / DD			☐ Intestinal Fluid
				☐ Stool
Disposition: FOLLOW UP: ☐ In progress YYYY / MM / DD ☐ Incomplete - Declined YYYY / MM / DD ☐ Incomplete – Lost contact YYYY / MM / DD ☐ Incomplete – Unable to locate YYYY / MM / DD ☐ Complete YYYY / MM / DD ☐ Not required YYYY / MM / DD ☐ Referred – Out of province 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 _____				

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C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Abdominal - bloating or distension		YYYY / MMM / DD	Fever - low grade		YYYY / MMM / DD
Cardiac - endocarditis		YYYY / MMM / DD	Flatulence		YYYY / MMM / DD
Asymptomatic		YYYY / MMM / DD	Loss of appetite (anorexia)		YYYY / MMM / DD
Constipation		YYYY / MMM / DD	Nausea		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea - watery		YYYY / MMM / DD	Vomiting		YYYY / MMM / DD
Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD	Weight loss		YYYY / MMM / DD
Fever		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

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>	

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Contact - At risk population (international travellers or immigrants)	YYYY / MM/DD		
Contact - Persons with diarrhea/vomiting	YYYY / MM/DD		
Contact to a known case (add'l info)			
Immunocompromised - Related to underlying disease or treatment			
Special Population - From or residence in an endemic country (add'l info)			
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 – Bottled water (specify)			
Water - Private well or system (Add'l Info)			
Water - Public water system (Add'l Info)			
Water - Untreated water (Add'l Info)			
Water (Recreational) - Pond, stream, lake, river, ocean (Add'l Info)	YYYY / MM/DD		
Water (Recreational) - Private (swimming pool/whirl pool) (Add'l Info)	YYYY / MM/DD		
Water (Recreational) - Public (swimming pool/paddling pool/whirl pool) (Add'l Info)	YYYY / MM/DD		

F) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

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G) INTERVENTION

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

Intervention Type and Sub Type:				
Assessment: Investigator name ☐ Assessed for contacts YYYY / MM / DD		Immunization: Investigator name ☐ Eligible immunizations recommended YYYY / MM / DD		
Communication: ☐ Other communication (See Investigator Notes) YYYY / MM / DD Investigator name ☐ Letter (See Document Management) YYYY / MM / DD Investigator name		Public Health Order: ☐ Order (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		Referral: ☐ Canadian food inspection agency YYYY / MM / DD Investigator name ☐ Primary care provider YYYY / MM / DD Investigator name ☐ Consultation with MHO YYYY / MM / DD Investigator name		
Education/counselling: ☐ Prevention/Control measures YYYY / MM / DD ☐ Disease information provided YYYY / MM / DD Investigator name		Testing: Investigator name ☐ Stool testing recommended (e.g. contacts) YYYY / MM / DD ☐ Laboratory testing recommended (contacts) YYYY / MM / DD		
Exclusion: Investigator name ☐ Daycare YYYY / MM / DD ☐ Preschool YYYY / MM / DD ☐ School YYYY / MM / DD ☐ Work YYYY / MM / DD		Other Investigation Findings: ☐ Investigator Notes ☐ Document Management Notes		
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	

H) OUTCOMES

LHN-> INVESTIGATION-> OUTCOMES

☐ Not yet recovered/recovering YYYY / MM / DD ☐ Recovered YYYY / MM / DD ☐ Fatal YYYY / MM / DD	☐ ICU/intensive medical care YYYY / MM / DD ☐ Intubation /ventilation YYYY / MM / DD ☐ Unknown _____	☐ Hospitalization YYYY / MM / DD ☐ Other YYYY / MM / DD
Cause of Death: (if Fatal was selected) _____		

I) EXPOSURES

LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> ACQUISITION QUICK ENTRY

Acquisition Event 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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