Government of Saskatchewan

Cryptosporidiosis Data Collection Worksheet

PANORAMA

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: _____	Preferred Communication Method: (specify - i.e. home phone, text):
Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:	Health Card Number (PHN): _____	Email Address: ☐ Work ☐ Personal
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: CASE	**Date**	**Classification: CONTACT**	**Date**	**LAB TEST INFORMATION:**
☐ Confirmed	YYYY / MM / DD	☐ Contact	YYYY / MM / DD	Date specimen collected: YYYY / MM / DD
☐ Does Not Meet Case Definition	YYYY / MM / DD	☐ Not a Contact	YYYY / MM / DD	Specimen type: ☐ Intestinal Fluid ☐ Stool
☐ Person Under Investigation	YYYY / MM / DD	☐ Person Under Investigation	YYYY / MM / DD	
☐ Probable	YYYY / MM / DD			

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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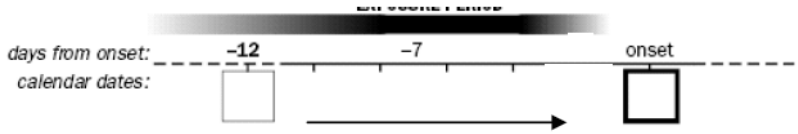
C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Abdominal - cramping	YYYY / MM / DD	YYYY / MM / DD	Loss of appetite (anorexia)	YYYY / MM / DD	YYYY / MM / DD
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Malaise	YYYY / MM / DD	YYYY / MM / DD
Diarrhea	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - profuse	YYYY / MM / DD	YYYY / MM / DD	Pain - abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - watery	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Fever	YYYY / MM / DD	YYYY / MM / DD		YYYY / MM / DD	YYYY / MM / DD
Other Signs & Symptoms if applicable					

Exposure Period

Enter onset date in heavy box. Count backwards to figure probable exposure period.



Most persons shed infectious oocysts in stool during the period of diarrhea. Shedding may continue in some patients for several days—possibly longer.

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 N—No, NA–Not asked, U–Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Animal Exposure - Farms (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pet treats and raw food (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pets (including reptiles) (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Petting zoos/zoos/ special events/ other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Rodents/rodent excreta			YYYY / MM/DD	
Animal Exposure - Wild animals (other than rodents) (Add'l Info)			YYYY / MM/DD	
Behaviour - Camping/hiking			YYYY / MM/DD	
Contact - Daycare			YYYY / MM/DD	
Contact - Persons with diarrhea/vomiting			YYYY / MM/DD	
Exposure – Diaper changing			YYYY / MM/DD	
Occupation - Child Care Worker			YYYY / MM/DD	
Occupation - Health Care Worker - IOM Risk Factor			YYYY / MM/DD	
Occupation - Personal Care Worker			YYYY / MM/DD	
Sexual Behaviour – MSM +			YYYY / MM/DD	
Sexual Behaviour - Oral-anal			YYYY / MM/DD	
Travel - Outside of within Canada (Add'l Info)			YYYY / MM/DD	
Travel - Outside of Saskatchewan, but within Canada (add'l info)				
Water – Bottled water (specify)			YYYY / MM/DD	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Water - Private well or system (Add'l Info)			YYYY / MM/DD	
Water - Public water system (Add'l Info)			YYYY / MM/DD	
Water - Untreated water (Add'l Info)			YYYY / MM/DD	
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) USER DEFINED FORM (SEE ATTACHED) LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> CRYPTOSPORIDOSIS FORM

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 YYYY / MM / DD

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

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

Testing: Investigator name
☐ Stool testing recommended (e.g. for follow-up) YYYY / MM / DD
☐ Laboratory testing recommended YYYY / MM / DD

Environmental health: YYYY/ MM / DD
☐ Restaurant Inspection ☐ Water system inspection
☐ Food/Water sampling ☐ Environmental sampling
Investigator name

Other Investigation Findings:
☐ Investigator Notes
☐ Document Management Notes

Immunization: Investigator name
☐ Eligible immunizations recommended 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	

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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

Transmission Events

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

Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		☐Health care setting ☐ Food service establishment ☐ Household ☐Private Function (Food prep)		
		☐Health care setting ☐ Food service establishment ☐ Household ☐Private Function (Food prep)		
		☐Health care setting ☐ Food service establishment ☐ Household ☐Private Function (Food prep)		
		☐Health care setting ☐ Food service establishment ☐ Household ☐Private Function (Food prep)		
	Crypto 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 / MMM / DD