Government of Saskatchewan

Giardiasis Data Collection Worksheet

PANORAMA

Please complete **all** sections.

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

Panorama Client ID: _____
Panorama Investigation ID: _____

A) CLIENT INFORMATION

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: CASE	**Date**	***Classification: CONTACT***	***Date***	***LAB TEST INFORMATION:***
☐ Confirmed	YYYY / MM / DD	☐ *Contact*	YYYY / MM / DD	*Date specimen collected:*
☐ Does Not Meet Case Definition	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			☐ *Fluid* ☐ *Biopsy* ☐ *Stool*

Disposition:
FOLLOW UP:

☐ In progress	YYYY / MMM / DD	☐ Complete	YYYY / MMM / DD
☐ Incomplete - Declined	YYYY / MMM / DD	☐ Not required	YYYY / MMM / DD
☐ Incomplete – Lost contact	YYYY / MMM / DD	☐ Referred – Out of province (Specify where)	YYYY / MMM / DD
☐ Incomplete – Unable to locate	YYYY / MMM / DD		YYYY / MMM / DD

REPORTING NOTIFICATION Name of Attending Physician or Nurse**:**	Location:
Provider's Phone number:	Date Received (Public Health): YYYY / MMM / DD
Type of Reporting Source: ☐ Health Care Facility ☐ Lab Report ☐ Nurse Practitioner ☐ Physician ☐ Other_____	

C) DISEASE EVENT HISTORY

LHN->INVESTIGATION->DISEASE SUMMARY (UPDATE)->DISEASE EVENT HISTORY

Staging: ☐ Acute ☐ Chronic ☐ Carrier

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Please complete **all** sections

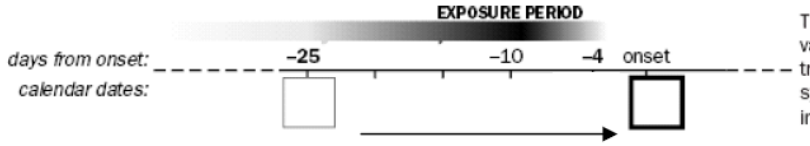
D) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic		YYYY / MMM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD
Abdominal - bloating or distension		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Abdominal - cramping		YYYY / MMM / DD	Stool - steatorrhea (pale and greasy)		YYYY / MMM / DD
Constipation		YYYY / MMM / DD	Weight loss		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

Exposure Period

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



The communicable period is quite variable—weeks to months without treatment. Infected persons without symptoms are more likely to be infectious than those who are sick.

E) 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:

F) 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 - Other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pets (including reptiles) (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Rodents/rodent excreta			YYYY / MM/DD	
Animal Exposure - Wild animals (other than rodents) (Add'l Info)				
Behaviour – Camping/hiking				
Contact – Daycare				
Contact – Persons with diarrhea/vomiting			YYYY / MM/DD	
Contact to a known case (Add'l Info)			YYYY / MM/DD	
Exposure – Diaper changing				
Immunocompromised - Related to underlying disease or treatment			YYYY / MM/DD	
Occupation - Child Care Worker	TE		YYYY / MM/DD	
Occupation - Food Handler	TE		YYYY / MM/DD	
Occupation - Health Care Worker - IOM Risk Factor	TE		YYYY / MM/DD	
Occupation – Personal Care Worker				
Other risk factor (Add'l Info)			YYYY / MM/DD	
Special Population - Attends childcare	TE		YYYY / MM/DD	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Special Population - Attends school	TE		YYYY / MM/DD	
Travel - Outside of Canada (Add'l Info)	AE		YYYY / MM/DD	
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	AE		YYYY / MM/DD	
Water – Bottled water (Add'l Info)			YYYY / MM/DD	
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/paddling pool/whirl pool) (Add'l Info)			YYYY / MM/DD	

G) USER DEFINED FORM (SEE ATTACHED) LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> GIARDIASIS FORM

H) COMPLICATIONS LHN-> INVESTIGATION->COMPLICATIONS

Description	Yes Date of onset	Description	Yes Date of onset
Arthritis - reactive (Reiter's syndrome)	YYYY / MMM / DD	Malabsorption of fats	YYYY / MMM / DD
Other complications			

I) TREATMENT LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (Antibiotics are contraindicated – refer to physician if on Rx)
(Panorama = Other Meds) : _____

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

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

Intervention Type and Sub Type:

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

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

Other Investigation Findings:
☐ Investigator Notes
☐ Document Management

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

Referral: Investigator name
☐ Canadian food inspection agency YYYY/ MM/DD
☐ Primary care provider YYYY/ MM/DD

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

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

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

Immunization:
☐ Eligible Immunization recommended YYYY/ MM/DD
Investigator name

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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	

K) 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) _____

L) 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 ☐ Household Exposure		
		☐ Health Care setting ☐ Household Exposure		
		☐ Health Care setting ☐ Household Exposure		
		☐ Health Care setting ☐ Household Exposure		
	Giardia Contacts – Inv ID# _____	☐ Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

M) 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