Government of Saskatchewan

PANORAMA

Listeriosis, invasive 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 same:	

B) INVESTIGATION INFORMATION

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

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

LAB TEST INFORMATION:
Date specimen collected:
YYYY / MMM / DD
Specimen Type

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		

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

Site Description: ☐ Congenital Listeriosis ☐ Meningitis ☐ Sepsis ☐ Other ☐ Unknown

Listeriosis, invasive Data Collection Worksheet

Please complete **all** sections

Panorama Client ID: _____
Panorama Investigation ID: _____

D) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION-> SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Abortion - spontaneous (miscarriage)		YYYY / MMM / DD	**Meningoencephalitis**		YYYY / MMM / DD
Birth of infected infant		YYYY / MMM / DD	Myalgia (muscle pain)		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Neurologic - delerium		YYYY / MMM / DD
Fetal death - stillbirth		YYYY / MMM / DD	Pain - back		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Pneumonia		YYYY / MMM / DD
Gastrointestinal symptoms		YYYY / MMM / DD	Premature delivery (mother)		YYYY / MMM / DD
Headache		YYYY / MMM / DD	Premature labour (may not mean premature delivery)		YYYY / MMM / DD
Meningeal irritation *(severe unrelating headaches, irritability, nausea and vomiting, fever and chills and generalized muscle aches and pains)*		YYYY / MMM / DD	Prematurity (infant)		YYYY / MMM / DD
Meningitis		YYYY / MMM / DD	**Sepsis (e.g. bactremia, septicemia, etc.)**		YYYY / MMM / DD

E) INCUBATION

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

Incubation for Case (period for acquisition):
Earliest Possible Exposure Date: YYYY / MMM / DD **Latest Possible Exposure Date**: YYYY / MMM / DD

Exposure Calculation details:

F) RISK FACTORS (provide a response for ALL Risk Factors)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Add'l Info
Chronic Medical Condition Cardiac Disease			
Chronic Medical Condition Liver disease			
Chronic Medical Condition Lung disease			
Chronic Medical Condition Malignancies/Cancer			
Chronic Medical Condition Other (Add'l Info)			
Chronic Medical Condition Renal disease			
Immunocompromised due to underlying disease or treatment (Add'l Info)			
Special Population Infant born to an infected mother			
Special Population Pregnancy			
Travel – Outside of Canada (Add'l Info)	YYYY / MM/DD		
Travel –Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM/DD		

G) USER DEFINED FORM (SEE ATTACHED)

LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> LISTERIOSIS FORM

Listeriosis, invasive Data Collection Worksheet

Please complete **all** sections

Panorama Client ID: _____
Panorama Investigation ID: _____

H) COMPLICATIONS

LHN-> INVESTIGATION->COMPLICATIONS

Description	Yes Date of onset	Description	Yes Date of onset
Abscesses	YYYY / MMM / DD	Coma	YYYY / MMM / DD
Cardiac - endocarditis	YYYY / MMM / DD	Granulomatosis infantisepticum	YYYY / MMM / DD
Other complications			

I) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds)* : _____

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

J) INTERVENTIONS

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

Intervention Type and Sub Type:

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

Environmental Health: YYYY / MM / DD
☐ Environmental sampling ☐ Restaurant inspection
☐ Food/Water sampling
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 YYYY / MM / DD
☐ Document Management Notes YYYY / MM / DD

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
☐ Consultation with MHO YYYY / MM / DD
☐ Physician YYYY / MM / DD

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

K) 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
☐ Other _____ YYYY / MM / DD
☐ Hospitalization YYYY / MM / DD
☐ Unknown YYYY / MM / DD

Cause of Death: (if Fatal was selected) _____

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