Government of Saskatchewan

Shigellosis Data Collection Worksheet

Please complete **all** sections.

PANORAMA

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

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: 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:* ☐ *Blood* ☐ *Urine* ☐ *Stool*
☐ 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_____

C) DISEASE EVENT HISTORY

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

Staging: ☐ Acute ☐ Carrier

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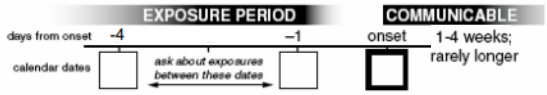
D) SIGNS & SYMPTOMS

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	Hemolytic uremic syndrome (HUS)	YYYY / MM / DD	YYYY / MM / DD
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Dehydration	YYYY / MM / DD	YYYY / MM / DD	Pain - abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea	YYYY / MM / DD	YYYY / MM / DD	Seizures	YYYY / MM / DD	YYYY / MM / DD
Diarrhea – bloody	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bactremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea – mucousy	YYYY / MM / DD	YYYY / MM / DD	Tenesmus	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	Arthritis	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.



Note: Exposure period for *S. dysenteriae* is up to one week.

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
Contact - Daycare			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 disease or treatment	TE		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	
Sexual Behaviour – Oral-anal				
Special Population – Homeless				
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			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			YYYY / MM/DD	
Water (Recreational) - Private (swimming pool/whirl pool)			YYYY / MM/DD	
Water (Recreational) - Public (swimming/paddling pool/whirl pool)			YYYY / MM/DD	

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Panorama Client ID: _____
Panorama Investigation ID: _____

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Other risk factor (Add'l Info)			YYYY / MM/DD	

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Panorama Investigation ID: _____

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

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

Medication *(Panorama = Other Meds) :* _____

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

I) INTERVENTIONS INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

Intervention Type and Sub Type:

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

Outbreak Declared 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

Public Health Order:
☐ Other (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

Other Investigation Findings:
☐ Investigator Notes
☐ Document Management

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

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

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

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

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

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J) 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) _____

K) 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-> ESPOSURE 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)		
	Shigella Contacts – Inv ID# _____	☐ Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

L) 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