Government of Saskatchewan

PANORAMA

Typhoid/Paratyphoid Data Collection Worksheet

Please complete **all** sections.

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	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			☐ *Blood* ☐ *Urine* ☐ *Stool*

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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Panorama Investigation ID: _____

C) DISEASE EVENT HISTORY

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

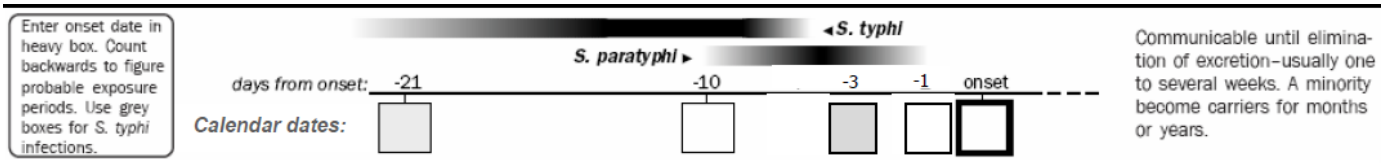
Site / Presentation: ☐ Enteric fever ☐ Gastroenteritis ☐ Other

Staging: ☐ Acute ☐ Carrier

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
Dactylitis (swollen digit)		YYYY / MMM / DD	**Loss of appetite (anorexia)**		YYYY / MMM / DD
Dehydration		YYYY / MMM / DD	**Malaise**		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Neurologic - delerium		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Fever - insidious onset		YYYY / MMM / DD	Parotid gland - inflammation (parotitis)		YYYY / MMM / DD
Headache		YYYY / MMM / DD	Rash - rose spots on trunk		YYYY / MMM / DD
Hearing loss			Sepsis (e.g. bactremia, septicemia, etc.)		
Hepatomegaly		YYYY / MMM / DD	**Splenomegaly**		YYYY / MMM / DD
Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD			YYYY / MMM / DD



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
Chronic Medical condition - Biliary tract disease			YYYY / MM/DD	
Chronic medical condition - Liver disease			YYYY / MM/DD	
Chronic Medical Condition - Schistosomiasis			YYYY / MM/DD	
Contact - At risk population (international travellers or immigrants)			YYYY / MM/DD	
Contact - Carrier			YYYY / MM/DD	
Contact - Persons with similar symptoms			YYYY / MM/DD	
Contact to a known case (Add'l Info)			YYYY / MM/DD	
Immunocompromised - Related to underlying disease or treatment (Add'l Info)			YYYY / MM/DD	
Occupation - Child Care Worker			YYYY / MM/DD	

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Panorama Investigation ID: _____

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Occupation - Food Handler			YYYY / MM/DD	
Occupation – Health Care Worker IOM Risk Factor			YYYY / MM/DD	
Travel - Outside of Canada (Add'l Info)			YYYY / MM/DD	
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)			YYYY / MM/DD	
Water - Bottled water (Add'l Info)			YYYY / MM/DD	
Water – Public water system (Add'l Info)			YYYY / MM/DD	
Water - Private well or 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 -> TYPHOID FORM

H) COMPLICATIONS LHN-> INVESTIGATION->COMPLICATIONS

Description	Yes Date of onset	Description	Yes Date of onset
Biliary tract abnormalities	YYYY / MMM / DD	Kidney stones	YYYY / MMM / DD
Cardiac - endocarditis	YYYY / MMM / DD	Meningitis	YYYY / MMM / DD
Encephalitis	YYYY / MMM / DD	Pancreatitis	YYYY / MMM / DD
Gallstones	YYYY / MMM / DD	Perforation - intestinal	YYYY / MMM / DD
Hemorrhage - intestinal	YYYY / MMM / DD	Schistosome infections	YYYY / MMM / DD
Other complications			

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

Medication *(Panorama = Other Meds)* : _____

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

J) 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

Outbreak Declared 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

Public Health Order:
☐ Order (specify)_____ YYYY / MM / DD
Investigator name

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

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

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Panorama Investigation ID: _____

Environmental Health: YYYY / MM / DD ☐ Restaurant inspection Investigator name	**Testing:** Investigator name ☐ Stool testing recommended (e.g. for follow-up) YYYY / MM / DD ☐ Laboratory testing recommended YYYY / MM / DD
Immunization: Investigator name ☐ Eligible immunizations recommended 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	

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
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
	Typhoid/paratyphoid 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