

Chlamydia and Gonorrhea Data Collection Worksheet –

Panorama QA complete: Yes No
 Initials: _____

Public Health – Follow-Up

Panorama Client ID: _____
 Panorama Investigation ID: _____

A) CLIENT INFORMATION

LHN -> SUBJECT -> CLIENT DETAILS -> PERSONAL INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name:
DOB: YYYY / MM / DD Age: _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Unknown <input type="checkbox"/> Other	PHN:

B) INVESTIGATION INFORMATION

LHN -> SUBJECT SUMMARY-> STBBI ENCOUNTER GROUP-> CREATE INVESTIGATION

Disease Summary Classification: CASE:	Date	Classification: CONTACT:	Date	LAB TEST INFORMATION:
<input type="checkbox"/> Lab Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	Date specimen collected: YYYY / MM / DD
<input type="checkbox"/> Suspect	YYYY / MM / DD	<input type="checkbox"/> Not a Contact	YYYY / MM / DD	
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	

Disposition: FOLLOW UP:			
<input type="checkbox"/> In progress	YYYY / MM / DD	<input type="checkbox"/> Complete	YYYY / MM / DD
<input type="checkbox"/> Incomplete - Declined	YYYY / MM / DD	<input type="checkbox"/> Not required	YYYY / MM / DD
<input type="checkbox"/> Incomplete – Lost contact	YYYY / MM / DD	<input type="checkbox"/> Referred – Out of province	YYYY / MM / DD
<input type="checkbox"/> Incomplete – Unable to locate	YYYY / MM / DD	(Specify where)	YYYY / MM / DD

C) INTERVENTIONS

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

Intervention Type and Sub Type:	
Assessment: <input type="checkbox"/> Assessed for contacts Investigator name YYYY/ MM/ DD <input type="checkbox"/> Client aware of diagnosis Investigator name YYYY/ MM/ DD	Immunization: <input type="checkbox"/> Eligible Immunization recommended: YYYY/ MM/ DD Investigator name
Communication: <input type="checkbox"/> Phone call (morning) Investigator name YYYY/ MM/ DD <input type="checkbox"/> Phone call (afternoon) Investigator name YYYY/ MM/ DD <input type="checkbox"/> Phone call (evening) Investigator name YYYY/ MM/ DD <input type="checkbox"/> Text Message sent Investigator name YYYY/ MM/ DD <input type="checkbox"/> E-mail Investigator name YYYY/ MM/ DD <input type="checkbox"/> Home visit Investigator name YYYY/ MM/ DD <input type="checkbox"/> Letter Sent Investigator name YYYY/ MM/ DD <input type="checkbox"/> Letter (See Document Management) YYYY/ MM/ DD Investigator name <input type="checkbox"/> Ordering practitioner contacted YYYY/ MM/ DD Investigator name <input type="checkbox"/> Other communication (See Investigator Notes) YYYY/ MM/ DD Investigator name	Other: <input type="checkbox"/> Other (See Investigator Notes)
General: Investigator name <input type="checkbox"/> Disease-Info/Prev-Control YYYY/ MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD	Referral: <input type="checkbox"/> Child Protective Services YYYY / MM / DD <input type="checkbox"/> Harm Reduction Services YYYY / MM / DD <input type="checkbox"/> Infectious Disease Specialist YYYY / MM / DD <input type="checkbox"/> Primary Care Provider YYYY / MM / DD <input type="checkbox"/> Consultation with MHO YYYY / MM / DD Investigator name Testing: Investigator name <input type="checkbox"/> Laboratory testing recommended: YYYY / MM / DD <input type="checkbox"/> STBBI Testing recommended YYYY / MM / DD <input type="checkbox"/> Test of Cure Recommended: YYYY / MM / DD
Education/counseling: <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD Investigator name <input type="checkbox"/> Disease information provided YYYY / MM / DD Investigator name <input type="checkbox"/> Other (See Investigator Notes) YYYY / MM / DD Investigator name	Other Investigation Findings: <input type="checkbox"/> Investigator Notes YYYY / MM / DD <input type="checkbox"/> See Document Management YYYY / MM / DD
NOTE TO PUBLIC HEALTH: Ensure a Data Collection Worksheet/Notification Form has been completed and entered directly into Panorama.	

Chlamydia and Gonorrhea Data Collection Worksheet –**Public Health – Follow-Up**

Panorama Client ID: _____

Panorama Investigation ID: _____

Please complete all sections.

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	
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YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	

D) OUTCOMES (optional except for severe influenza)**LHN-> INVESTIGATION-> OUTCOMES**

<input type="checkbox"/> Not yet recovered/recovering	YYYY / MM / DD	<input type="checkbox"/> ICU/intensive medical care	YYYY / MM / DD	<input type="checkbox"/> Hospitalization	YYYY / MM / DD
<input type="checkbox"/> Recovered	YYYY / MM / DD	<input type="checkbox"/> Intubation /ventilation	YYYY / MM / DD	<input type="checkbox"/> Other	YYYY / MM / DD
<input type="checkbox"/> Fatal	YYYY / MM / DD	<input type="checkbox"/> Unknown	_____		

Cause of Death: (if Fatal was selected) _____

E) TRANSMISSION EVENT**LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY**

Transmission Event ID (system-generated can be documented below)	Exposure Name (enter the most appropriate exposure)	Setting type Important: (Select the most appropriate setting for the TE; if >1 select multiple settings)	Date (include the earliest date for contact tracing – transmission end date is not required)
	CT Contacts – Inv ID# GC Contacts – Inv ID# CT/GC Contacts – InvID#	<input type="checkbox"/> Sexual Exposure <input type="checkbox"/> Public facilities <input type="checkbox"/> Multiple settings <input type="checkbox"/> Household <input type="checkbox"/> Type of community contact (includes IDU)	

F) Total number of contacts**LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK**

_____ (total number of <i>unknown</i> and <i>known</i> contacts)
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Initial Report completed by:		Date initial report completed: YYYY / MMM / DD
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