

## Mumps 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: <input type="checkbox"/> Work <input type="checkbox"/> Personal
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace:		
Place of Employment/School:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____	Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> 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 -> RESPIRATORY & DIRECT CONTACT ENCOUNTER GROUP -> CREATE INVESTIGATION

Disease Summary Classification:	Date	Classification:	Date	LAB TEST INFORMATION:
<b>CASE</b>		<b>CONTACT</b>		<i>Date specimen collected:</i>
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	YYYY / MM / DD
<input type="checkbox"/> Does Not Meet Case	YYYY / MM / DD	<input type="checkbox"/> Not a Contact	YYYY / MM / DD	<i>Specimen type:</i>
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Blood
<input type="checkbox"/> Probable	YYYY / MM / DD			<input type="checkbox"/> Urine
				<input type="checkbox"/> Stool
<b>Disposition:</b>				
<i>FOLLOW UP:</i>				
<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)		
<b>REPORTING NOTIFICATION</b>		Location:		
Name of Attending Physician or Nurse:				
Physician/Nurse Phone number:		Date Received (Public Health): YYYY / MM / DD		
Type of Reporting Source: <input type="checkbox"/> Health Care Facility <input type="checkbox"/> Lab Report <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Other _____				

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### C) 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 / MM / DD	Lab - platelet count low		YYYY / MM / DD
Coryza or rhinitis		YYYY / MM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MM / DD
Cough		YYYY / MM / DD	Meningitis - aseptic		YYYY / MM / DD
Encephalitis		YYYY / MM / DD	Orchitis (inflamed testicle)		YYYY / MM / DD
Hearing loss		YYYY / MM / DD	<b>Pain - salivary glands</b>		YYYY / MM / DD
Infection - upper respiratory tract		YYYY / MM / DD	<b>Parotid gland - inflammation (parotitis)</b>		YYYY / MM / DD
Other S/S					

### D) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

<b>Incubation for Case (period for acquisition):</b>	
<b>Earliest Possible Exposure Date:</b> YYYY / MM / DD	<b>Latest Possible Exposure Date:</b> YYYY / MM / DD
<i>Exposure Calculation details:</i>	
<b>Communicability for Case (period for transmission):</b>	
<b>Earliest Possible Communicability Date:</b> YYYY / MM / DD	<b>Latest Possible Communicability Date:</b> YYYY / MM / DD
<i>Communicability Calculation Details:</i>	

### E) RISK FACTORS

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Start date Yes	N, NA, U	Add'l Info
<b>Contact</b> - At risk population (international travellers or immigrants)	YYYY / MM/DD		
<b>Contact</b> to a known case (Add'l Info)	YYYY / MM/DD		
<b>Immunocompromised</b> - Related to underlying disease or treatment			
<b>Occupation</b> - Health Care Worker - IOM Risk Factor	TE		
<b>Risk Behaviour</b> - Sharing personal items (cigarettes, water bottles)	TE		
<b>Special Population</b> - Attends childcare	TE		
<b>Special Population</b> - Attends school	TE		
<b>Special Population</b> - Lives in a communal setting	TE		
<b>Special Population</b> - Post secondary education institution	TE		
<b>Special Population</b> - Pregnancy			
<b>Travel</b> - Outside of Canada (Add'l Info)	YYYY / MM/DD AE		
<b>Travel</b> - Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM/DD AE		

### F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

<b>Interpretation Date:</b> YYYY / MM / DD	
<b>Interpretation of Disease Immunity:</b>	<input type="checkbox"/> Disease Case - Fully immunized (for age) <input type="checkbox"/> Disease Case - Partially immunized <input type="checkbox"/> Disease Case – Unimmunized <input type="checkbox"/> Disease Case - Unclear immunization history <b>Valid doses received:</b> _____ <b>Doses needed:</b> _____
<b>Reason:</b>	<input type="checkbox"/> Previous disease <input type="checkbox"/> Previous responder/Previous history of immunity <input type="checkbox"/> Date Of Birth <input type="checkbox"/> Interpretation of history by investigator

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Please complete all sections.

Panorama Client ID: \_\_\_\_\_  
Panorama Investigation ID: \_\_\_\_\_

## G) INTERVENTION

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

Intervention Type and Sub Type:				
<b>Assessment:</b> <input type="checkbox"/> Assessed for contacts      YYYY / MM / DD Investigator name		<b>Exclusion:</b> Investigator name <input type="checkbox"/> Work      YYYY / MM / DD <input type="checkbox"/> Preschool      YYYY / MM / DD <input type="checkbox"/> School      YYYY / MM / DD <input type="checkbox"/> Daycare      YYYY / MM / DD		
<b>Other Investigation Findings:</b> <input type="checkbox"/> Investigator Notes      YYYY / MM / DD <input type="checkbox"/> See document management      YYYY / MM / DD		<b>Immunization:</b> Investigator name <input type="checkbox"/> Eligible Immunization recommended      YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization recommended      YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization given      YYYY / MM / DD		
<b>Communication:</b> <input type="checkbox"/> Other communication (see Investigator Notes)      YYYY / MM / DD Investigator name <input type="checkbox"/> Letter (See Document Management)      YYYY / MM / DD Investigator name		<b>Isolation:</b> <input type="checkbox"/> Facility isolation      YYYY / MM / DD      Investigator name <input type="checkbox"/> Home isolation      YYYY / MM / DD      Investigator name		
<b>General:</b> 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		<b>Quarantine:</b> <input type="checkbox"/> Quarantine      YYYY / MM / DD Investigator name		
<b>Education/counseling:</b> Investigator name <input type="checkbox"/> Prevention/Control measures      YYYY / MM / DD <input type="checkbox"/> Disease information provided      YYYY / MM / DD		<b>Testing:</b> <input type="checkbox"/> Lab testing 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	
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YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	

## H) 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"/> Unknown      YYYY / MM / DD
<input type="checkbox"/> Fatal      YYYY / MM / DD	<input type="checkbox"/> Other _____ YYYY / MM / DD	
Cause of Death: (if Fatal was selected) _____		

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### I) Acquisition Event

LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> ACQUISITION EVENT SUMMARY -> QUICK ENTRY

Acquisition Event ID: \_\_\_\_\_

Exposure Name: \_\_\_\_\_

**Acquisition Start** YYYY / MM / DD **to Acquisition End:** YYYY / MM / DD

Location Name: \_\_\_\_\_

**Setting Type**

Travel       Health care setting       Public facilities       Recreational facilities       Most likely source

### J) Transmission Events

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY

Transmission Event ID	Exposure Name	Setting type (Consider the following settings for TE; if >1 select "multiple settings" in Panorama)	Date/Time	# of contacts
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities	YYYY / MM / DD to YYYY / MM / DD	
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities	YYYY / MM / DD to YYYY / MM / DD	
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities	YYYY / MM / DD to YYYY / MM / DD	
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities	YYYY / MM / DD to YYYY / MM / DD	
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities	YYYY / MM / DD to YYYY / MM / DD	
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure <input type="checkbox"/> Public facilities	YYYY / MM / DD to YYYY / MM / DD	
	Mumps Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

### K) TOTAL NUMBER OF CONTACTS

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK -> UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts: \_\_\_\_\_ (total number of individuals [including groups that 1:1 follow-up is not required or is not feasible])

<b>Initial Report completed by:</b>		<b>Date initial report completed:</b> YYYY / MM / DD
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