

Pneumococcal Disease (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: <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

SUBJECT SUMMARY-> RESPIRATORY & DIRECT CONTACT ENCOUNTER GROUP-> CREATE INVESTIGATION

Disease Summary Classification:	Date		LAB TEST INFORMATION:
CASE			Date specimen collected:
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD
<input type="checkbox"/> Does Not Meet Case	YYYY / MM / DD	<input type="checkbox"/> Probable	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)			
REPORTING NOTIFICATION		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) DISEASE EVENT HISTORY

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

Site / Presentation:	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Pneumonia with bacteremia	<input type="checkbox"/> Other
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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
Arthritis - septic		YYYY / MM / DD	Malaise		YYYY / MMM / DD
Cardiac - endocarditis		YYYY / MM / DD	Meningitis		YYYY / MMM / DD
Cardiac - pericarditis		YYYY / MM / DD	Peritonitis		YYYY / MMM / DD
Fever		YYYY / MM / DD	Pneumonia		YYYY / MMM / DD
Osteomyelitis			Sepsis (e.g. bactremia, septicemia, etc.)		

E) RISK FACTORS (RF followed by + impact the Immunization Forecaster)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Chronic Medical Condition - Cardiac Disease+			
Chronic Medical Condition - Diabetes Mellitus+			
Chronic Medical Condition - Liver Disease+			
Chronic Medical Condition - Lung Disease+			
Chronic Medical Condition - Other (Add'l Info)			
Contact to a known case (Add'l Info)	YYYY / MM/DD		
Exposure - Second hand smoke			
Immunocompromised - Related to underlying disease or treatment			
Special Population - Attends childcare			
Special Population – Homeless +			
Special Population - Lives in a communal setting			
Substance Use - Alcohol			
Substance Use - Tobacco			

F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

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

G) TREATMENT

LHN -> INVESTIGATION-> MEDICATIONS-> MEDICATIONS SUMMARY

Medication (<i>Panorama = Other Meds</i>): _____
Prescribed by: _____ Started on: YYYY / MM / DD

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H) INTERVENTION

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

Intervention Type and Sub Type:				
General: Investigator name		Immunization:		
<input type="checkbox"/> Disease-Info/Prev-Control	YYYY / MM / DD	<input type="checkbox"/> Eligible Immunization recommended	YYYY / MM / DD	
Education/counselling: Investigator name		<input type="checkbox"/> Disease-specific immunization recommended	YYYY / MM / DD	
<input type="checkbox"/> Prevention/Control measures	YYYY / MM / DD	<input type="checkbox"/> Disease-specific immunization given	YYYY / MM / DD	
<input type="checkbox"/> Disease information provided		Investigator name		
Other Investigation Findings:		Isolation:		
<input type="checkbox"/> Investigator Notes		<input type="checkbox"/> See Document Management		
		<input type="checkbox"/> Facility isolation	YYYY / MM / DD	Investigator name
		<input type="checkbox"/> Home isolation	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	
YYYY / MM / DD			YYYY / MM / DD	

I) OUTCOMES

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) _____					

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