

## Varicella 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:
CASE		CONTACT		Date specimen collected:
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	YYYY / MM / DD
<input type="checkbox"/> Does Not Meet Case Definition	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	
<input type="checkbox"/> Probable	YYYY / MM / DD			
<input type="checkbox"/> Suspect	YYYY / MM / DD			
<b>Disposition:</b>				
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)		
<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 _____				

### C) DISEASE EVENT HISTORY

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

<b>Site / Presentation:</b> <input type="checkbox"/> Severe <input type="checkbox"/> Neonatal <input type="checkbox"/> Case with high risk contacts
<b>Staging:</b> <input type="checkbox"/> Acute <input type="checkbox"/> Reactivation

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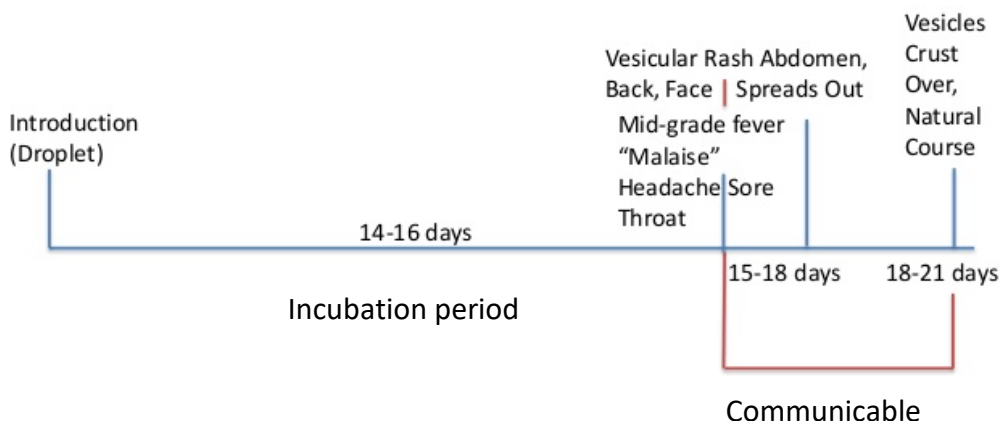
Please complete all sections.

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### D) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Fever		YYYY / MMM / DD	<b>Rash - crusted lesions or scabs</b>		YYYY / MMM / DD
Lesion - less than 50 lesions (Mild)		YYYY / MMM / DD	Rash - herpes zoster (shingles)		YYYY / MMM / DD
Lesion - 50 to 249 lesions (Mild - moderate)		YYYY / MMM / DD	Rash - itchy		YYYY / MMM / DD
Lesion - 250 to 499 lesions (Moderate)		YYYY / MMM / DD	<b>Rash - macules, papules, and vesicles</b>		YYYY / MMM / DD
Lesion - 500 or more lesions (Severe)		YYYY / MMM / DD	Rash - painful		YYYY / MMM / DD
Lesions - conjunctiva		YYYY / MMM / DD	Rash - ulcerated lesions		YYYY / MMM / DD
Lesions - mucous membrane - ulcerated		YYYY / MMM / DD	Rash - unilateral red painful blisters		YYYY / MMM / DD
Malaise		YYYY / MMM / DD	Infection - upper respiratory tract		YYYY / MMM / DD
Other Signs & Symptoms if applicable					



### E) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

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

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	YES	N – No NA – not asked U - Unknown	DESCRIPTION	YES	N – No NA – not asked U - Unknown
<b>Contact</b> to a known case (Add'l Info)	YYYY / MM / DD AE		<b>Special Population</b> - Pregnancy	YYYY / MM / DD	
<b>Immunocompromised</b> - Related to underlying disease or treatment			<b>Travel</b> - Outside of Canada (specify)		
<b>Occupation</b> - Health Care Worker - IOM Risk Factor	TE		<b>Travel</b> - Outside of Saskatchewan, but within Canada (specify)		
<b>Special Population</b> - Infant born to an infected mother	YYYY / MM / DD				

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### G) 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"/> IOM - Fully immunized (for age) <span style="margin-left: 200px;"><input type="checkbox"/> IOM - Partially immunized</span>
<input type="checkbox"/> IOM – Unimmunized <span style="margin-left: 100px;"><input type="checkbox"/> IOM - Unclear immunization history</span>	<b>Valid doses received:</b> ____ <b>Doses needed:</b> ____
<b>Reason:</b>	<input type="checkbox"/> IOM - Interpretation of history by investigator

### H) TREATMENT

LHN -> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

### I) INTERVENTION

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

<b>Intervention Type and Sub Type:</b>				
<b>Assessment:</b>		<b>Immunization:</b>		
<input type="checkbox"/> Assessed for contacts (especially pregnant or < 1 year of age) YYYY / MM / DD Investigator name		<input type="checkbox"/> Eligible immunizations recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization given YYYY / MM / DD Investigator name		
<b>Other Investigation Findings:</b>		<b>Referral:</b>		
<input type="checkbox"/> Investigator Notes <span style="margin-left: 50px;"><input type="checkbox"/> See Document Management</span>		<input type="checkbox"/> Other (specify) _____ YYYY / MM / DD Investigator name		
<b>Communication:</b>		<b>Testing:</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		<input type="checkbox"/> Laboratory testing recommended 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>Education/counseling:</b> Investigator name				
<input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided YYYY / MM / DD				
<b>Exclusion:</b> Investigator name				
<input type="checkbox"/> Daycare YYYY / MM / DD <input type="checkbox"/> School YYYY / MM / DD		<input type="checkbox"/> Preschool YYYY / MM / DD <input type="checkbox"/> Work YYYY / MM / DD		
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	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	

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Please complete all sections.

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### J) 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) \_\_\_\_\_

### K) Transmission Events

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

Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Household Exposure		
	varicella Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

### L) TOTAL NUMBER OF CONTACTS

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

Anonymous contacts: \_\_\_\_\_ (total number of individuals [including groups that do not require 1:1 follow-up])

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