

## Viral Hemorrhagic Fever 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 AND 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> YYYY / MM / DD
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	<i>Specimen type:</i> <input type="checkbox"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Throat <input type="checkbox"/> Tissue <input type="checkbox"/> Other
<input type="checkbox"/> Does Not Meet Case	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			

**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)                                     |                |

**Responsible Organization**

**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 \_\_\_\_\_

**C) IMMIGRATION INFORMATION**

SUBJECT -> CLIENT DETAILS -> PERSONAL INFORMATION->IMMIGRATION INFORMATION

Country Born in: \_\_\_\_\_

Country Emigrated from: \_\_\_\_\_

Arrival Date: YYYY / MMM / DD

OR Arrival Year \_\_\_\_\_

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Please complete all sections

### D) SIGNS & SYMPTOMS

INVESTIGATION->SIGNS & SYMPTOMS

Refer to clinical illness criteria outlined in the case definition to select signs and symptoms to support case classification

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Arthralgia		YYYY / MMM / DD	Lab - liver function abnormality		YYYY / MMM / DD
Bleeding – eyes		YYYY / MMM / DD	Lab - platelet count low		YYYY / MMM / DD
Bleeding – gastrointestinal		YYYY / MMM / DD	Lab-proteinuria		YYYY / MMM / DD
Bleeding – gums		YYYY / MMM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD
Bleeding – lungs		YYYY / MMM / DD	Loss of appetite (anorexia)		YYYY / MMM / DD
Bleeding - nose (epistaxis)		YYYY / MMM / DD	Malaise		YYYY / MMM / DD
Bleeding – urine		YYYY / MMM / DD	Myalgia (muscle pain)		YYYY / MMM / DD
Bleeding – uterus		YYYY / MMM / DD	Nausea		YYYY / MMM / DD
Bruising – excessive		YYYY / MMM / DD	Pain – abdominal		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Pain-back		YYYY / MMM / DD
Confusion		YYYY / MMM / DD	Pain – chest		YYYY / MMM / DD
Conjunctiva-inflammation (conjunctivitis)		YYYY / MMM / DD	Pain – groin		YYYY / MMM / DD
Cough		YYYY / MMM / DD	Pain – limbs		YYYY / MMM / DD
Dehydration		YYYY / MMM / DD	Pain - photophobia (sensitivity to light)		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pain - retro-orbital		YYYY / MMM / DD
Diarrhea – bloody		YYYY / MMM / DD	Pharyngitis (sore throat)		YYYY / MMM / DD
Dyspnea (shortness of breath)		YYYY / MMM / DD	Prostration		YYYY / MMM / DD
Edema - face and neck		YYYY / MMM / DD	Rash-maculopapular		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Rash – petechial		YYYY / MMM / DD
Flushing		YYYY / MMM / DD	Rash – purpura		YYYY / MMM / DD
Headache		YYYY / MMM / DD	Seizures		YYYY / MMM / DD
Hemorrhage – unexplained		YYYY / MMM / DD	Shock		YYYY / MMM / DD
Hypotension		YYYY / MMM / DD	Stool – bloody		YYYY / MMM / DD
Jaundice		YYYY / MMM / DD	Vomiting		YYYY / MMM / DD
Lab-leukopenia		YYYY / MMM / DD	Vomiting - bloody (hematemesis)		YYYY / MMM / DD
Other Signs & Symptoms if applicable					

### E) INCUBATION AND COMMUNICABILITY

INVESTIGATION->INCUBATION & COMMUNICABILITY

<b>Incubation for Case:</b>	
<b>Earliest Possible Exposure Date:</b> YYYY / MMM / DD	<b>Latest Possible Exposure Date:</b> YYYY / MMM / DD
<i>Exposure Calculation details:</i>	
<b>Communicability for Case:</b>	
<b>Earliest Possible Communicability Date:</b> YYYY / MMM / DD	<b>Latest Possible Communicability Date:</b> YYYY / MMM / DD
<i>Communicability Calculation Details:</i>	

### F) RISK FACTORS

INVESTIGATION-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	START DATE	END DATE	ADD'L INFO
Animal Exposure-Bats					
Animal Exposure- Wild animals (other than rodents) (Add'l Info)					

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Animal Exposure-Other (Add'l Info)					
Behaviour - Lack of personal protective measures					
Contact - Contact to a known case (Add'l Info)			YYYY / MM/DD	YYYY / MM/DD	Include INV ID # if known in add'l info Create an AE with details
Contact - Persons with similar symptoms			YYYY / MM/DD	YYYY / MM/DD	Create an AE with details
Occupation-Health Care Worker					Create an AE with details
Occupation-Laboratory					Create an AE with details
Travel - Outside of Canada (Add'l Info)			YYYY / MM/DD	YYYY / MM/DD	Include name of country in add'l info
Other Risk Factor (Add'l Info)			YYYY / MM/DD	YYYY / MM/DD	

### G) TREATMENT

INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (*Panorama = Other Meds*) : \_\_\_\_\_

Prescribed by: \_\_\_\_\_ Started on: YYYY / MMM / DD

### H) INTERVENTIONS

INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

<b>Intervention Type and Sub Type:</b>				
<b>Assessment:</b> <input type="checkbox"/> Assessed for contacts Investigator name YYYY / MM / DD	<b>Communication:</b> <input type="checkbox"/> Letter- (see Document Management) Investigator name YYYY / MM / DD <input type="checkbox"/> Other communication (specify) Investigator name YYYY / MM / DD			
<b>Education/counselling:</b> Investigator name <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD	<b>Exclusion:</b> Investigator name <input type="checkbox"/> Work YYYY / MM / DD <input type="checkbox"/> School YYYY / MM / DD <input type="checkbox"/> Preschool YYYY / MM / DD <input type="checkbox"/> Daycare YYYY / MM / DD			
<b>General:</b> <input type="checkbox"/> Disease-Info/Prev-Control YYYY / MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts YYYY / MM / DD Investigator name	<b>Isolation:</b> <input type="checkbox"/> Facility isolation YYYY / MM / DD <input type="checkbox"/> Home isolation YYYY / MM / DD Investigator name			
<b>Other Investigation Findings</b> <input type="checkbox"/> Investigator Notes YYYY / MM / DD <input type="checkbox"/> See Document Management YYYY / MM / DD	<b>Public Health Order</b> <input type="checkbox"/> Order (see Document Management) YYYY / MM / DD <input type="checkbox"/> Order to report to Public Health YYYY / MM / DD			
<b>Quarantine</b> <input type="checkbox"/> Home YYYY / MM / DD <input type="checkbox"/> Designated facility YYYY / MM / DD	<b>Referral:</b> <input type="checkbox"/> Consultation with MHO YYYY / MM / DD <input type="checkbox"/> Infectious Disease Specialist YYYY / MM / DD <input type="checkbox"/> Infection Prevention and Control YYYY / MM / DD <input type="checkbox"/> Other/Multiple (see Investigator Notes) YYYY / MM / DD Investigator name			
<b>Symptom Monitoring</b> <input type="checkbox"/> Direct <input type="checkbox"/> Indirect, active <input type="checkbox"/> Indirect, passive	<b>Testing:</b> <input type="checkbox"/> Lab testing recommended YYYY / MM / DD Investigator name			
<b>Treatment</b> <input type="checkbox"/> Treatment recommended (see Investigator Notes) YYYY / MM / DD				
<b>Date</b>	<b>Intervention subtype</b>	<b>Comments</b>	<b>Next follow-up Date</b>	<b>Initials</b>
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	

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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 (if applicable)** INVESTIGATION->OUTCOMES

<input type="checkbox"/> Not yet recovered/recovering <input type="checkbox"/> Recovered <input type="checkbox"/> Fatal	<input type="checkbox"/> ICU/intensive medical care: <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____	<input type="checkbox"/> Hospitalization <input type="checkbox"/> Intubation/ventilation
Cause of Death: (if Fatal was selected) _____		

**J) EXPOSURES – CONSIDER THE MODE OF TRANSMISSION** LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> MULTIPLE AE ENTRY

**Acquisition Event**

Exposure Name (use the most appropriate and most specific Key Descriptor check box as the name)	Location City/Town	Setting type (Consider the following settings for TE; if >1 select “multiple settings” in Panorama)	Start/End Date	Most likely source
<input type="checkbox"/> Contact to a case		<input type="checkbox"/> Household exposures <input type="checkbox"/> Private Function <input type="checkbox"/> Type of community contact	YYYY / MM / DD to YYYY / MM / DD	<input type="checkbox"/>
<input type="checkbox"/> EMS <input type="checkbox"/> Integrated Facility <input type="checkbox"/> Physician Office	<input type="checkbox"/> Hospital <input type="checkbox"/> Laboratory	<input type="checkbox"/> Health care setting	YYYY / MM / DD to YYYY / MM / DD	<input type="checkbox"/>
City, Province OR City, Country		<input type="checkbox"/> Travel	YYYY / MM / DD to YYYY / MM / DD	<input type="checkbox"/>

**Transmission Events** LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> EXPOSURE QUICK ENTRY

Exposure Name (use the most appropriate Key Descriptor as per the RF/AE Quick Reference as the name)	Location City/Town	Setting type (Consider the following settings for TE; if >1 select “multiple settings” in Panorama)	Date/Time
Use key descriptor or the name of the setting	City, name of facility	<input type="checkbox"/> Educational institution <input type="checkbox"/> Household <input type="checkbox"/> Recreational Facility	YYYY / MM / DD to YYYY / MM / DD
<input type="checkbox"/> Daycare/day home		<input type="checkbox"/> Public Facilities	YYYY / MM / DD to YYYY / MM / DD
City, Province OR City, Country		<input type="checkbox"/> Travel	YYYY / MM / DD to YYYY / MM / DD
<input type="checkbox"/> Close non-household <input type="checkbox"/> Visiting friends and relatives		<input type="checkbox"/> Type of Community Contact	

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