

Please complete all sections.

Panorama QA complete: Yes No
 Initials: _____

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	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	Specimen type:
<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"/> CSF
				<input type="checkbox"/> Other
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 _____				

Streptococcal Invasive Disease (group A) Data Collection Worksheet

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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
Acute respiratory distress syndrome (ARDS) - CXR/CT*		YYYY / MM / DD	Muscle inflammation (myositis)		YYYY / MM / DD
Arthritis - septic		YYYY / MM / DD	Necrosis - skin and tissue		YYYY / MM / DD
Cardiac - myocardial infarction		YYYY / MM / DD	Necrotizing fasciitis		YYYY / MM / DD
Cellulitis		YYYY / MM / DD	Confusion		YYYY / MM / DD
Chills		YYYY / MM / DD	Pain - severe		YYYY / MM / DD
Fever		YYYY / MM / DD	Cardiac - pericarditis		YYYY / MM / DD
Gangrene		YYYY / MM / DD	Pharyngitis (sore throat)		YYYY / MM / DD
Hypotension*		YYYY / MM / DD	Pneumonia		YYYY / MM / DD
Infection - soft tissue		YYYY / MM / DD	Rash - erythematous macular *		YYYY / MM / DD
Infection - wound		YYYY / MM / DD	Renal impairment * (refer to CDC Manual for parameters)		YYYY / MM / DD
Lab - liver function abnormality* (refer to CDC Manual for parameters)		YYYY / MM / DD	Sepsis (e.g. bacteremia, septicemia, etc.)		YYYY / MM / DD
Lab - platelet count low* (refer to CDC Manual for parameters)		YYYY / MM / DD	Skin - pain and swelling		YYYY / MM / DD
Meningitis		YYYY / MM / DD	Streptococcal toxic shock syndrome (STSS) Includes hypotension and 2 or more of the S/S with an *		YYYY / MM / DD
Other s/s					

D) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

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

E) 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
Chronic Medical Condition - Cardiac Disease +			Medical Risk Factor - Varicella	YYYY / MM / DD	
Chronic Medical Condition - Diabetes Mellitus +			Medical Treatment - Surgery/surgical wound	YYYY / MM / DD	
Chronic Medical Condition - Liver disease +			Setting - Crowded living conditions (>1 person per room excluding bathrooms)		
Chronic Medical Condition - Lung disease +			Special Population – Homeless +		
Chronic Medical Condition - Renal disease +			Special Population - Lives in a communal setting		
Contact to a known case (Add'l Info)	YYYY / MM / DD		Special Population - LTC Facility +		

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DESCRIPTION	YES	N – No NA – not asked U - Unknown	DESCRIPTION	YES	N – No NA – not asked U - Unknown
Immunocompromised - HIV +			Special Population - Self-reported Indigenous identity		
Immunocompromised - Related to underlying disease or treatment			Substance Use - Alcohol		
Medical Risk Factor - Postpartum			Substance Use - Injection drug use (including steroids) +		
Medical Risk Factor History of injury (Add'l Info)	YYYY / MM / DD		Travel - Outside of Canada (Add'l Info)	YYYY / MM / DD	
Medical Risk Factor - Skin infection or dermatological condition	YYYY / MM / DD		Travel -Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM / DD	

F) TREATMENT

INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

G) INTERVENTIONS

INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

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	

Intervention Type and Sub Type:	
Assessment: <input type="checkbox"/> Assessed for contacts Investigator name _____ YYYY / MM / DD	Education/counselling: Investigator name _____ <input type="checkbox"/> Prevention/Control measures <input type="checkbox"/> Disease information provided YYYY / MM / DD YYYY / MM / DD
Communication: <input type="checkbox"/> Phone call attempted (day) _____ YYYY / MM / DD <input type="checkbox"/> Phone call attempted (evening) _____ YYYY / MM / DD <input type="checkbox"/> Home visit attempted _____ YYYY / MM / DD <input type="checkbox"/> Letter sent _____ YYYY / MM / DD <input type="checkbox"/> Text message sent _____ YYYY / MM / DD <input type="checkbox"/> Other communication (See Investigator Notes) _____ YYYY / MM / DD <input type="checkbox"/> Letter (See Document Management) _____ YYYY / MM / DD Investigator name _____	Immunization: <input type="checkbox"/> Eligible Immunization(s) recommended _____ YYYY / MM / DD Investigator name _____ Isolation: <input type="checkbox"/> Facility isolation _____ YYYY / MM / DD <input type="checkbox"/> Home isolation _____ YYYY/MM/DD Investigator name _____ Referral <input type="checkbox"/> Consult with MHO _____ YYYY / MM / DD Investigator name _____
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	Other Investigation Findings: <input type="checkbox"/> Investigator Notes _____ YYYY / MM / DD <input type="checkbox"/> Document Management

Streptococcal Invasive Disease (group A) Data Collection Worksheet

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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) _____

I) Transmission Events

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

Transmission Event ID <small>(system-generated can be documented below)</small>	Exposure Name	Setting type <small>(Select the most appropriate setting for the TE; if >1 select multiple settings will be entered into Panorama)</small>	Date/Time	# of contacts
		<input type="checkbox"/> Childcare worker/attende <input type="checkbox"/> Household <input type="checkbox"/> Type of community contact <input type="checkbox"/> Congregate/communal living setting <input type="checkbox"/> Health care setting <input type="checkbox"/> Sexual exposure		
		<input type="checkbox"/> Childcare worker/attende <input type="checkbox"/> Household <input type="checkbox"/> Type of community contact <input type="checkbox"/> Congregate/communal living setting <input type="checkbox"/> Health care setting <input type="checkbox"/> Sexual exposure		
		<input type="checkbox"/> Childcare worker/attende <input type="checkbox"/> Household <input type="checkbox"/> Type of community contact <input type="checkbox"/> Congregate/communal living setting <input type="checkbox"/> Health care setting <input type="checkbox"/> Sexual exposure		
		<input type="checkbox"/> Childcare worker/attende <input type="checkbox"/> Household <input type="checkbox"/> Type of community contact <input type="checkbox"/> Congregate/communal living setting <input type="checkbox"/> Health care setting <input type="checkbox"/> Sexual exposure		
	iGAS Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

J) TOTAL NUMBER OF CONTACTS

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

Anonymous contacts: _____ (total number of individuals exposed)

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