

## Haemophilus influenzae infection (invasive) Data Collection Worksheet

Please complete all sections.

Panorama QA complete:  Yes  No

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

Initials: \_\_\_\_\_

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 investigation 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

**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**

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 \_\_\_\_\_

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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
Arthritis - septic		YYYY / MM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MM / DD
Bulging fontanelle		YYYY / MM / DD	<b>Meningitis</b>		
<b>Cardiac - pericarditis</b>		YYYY / MM / DD	Neck stiffness (nuchal rigidity)		YYYY / MM / DD
Cellulitis		YYYY / MM / DD	Confusion		YYYY / MM / DD
Dyspnea (shortness of breath)		YYYY / MM / DD	<b>Pneumonia</b>		YYYY / MM / DD
<b>Epiglottitis</b>		YYYY / MM / DD	Respiratory compromise		YYYY / MM / DD
Fever		YYYY / MM / DD	<b>Sepsis (e.g. bactremia, septicemia, etc.)</b>		YYYY / MM / DD
<b>Infection - empyema</b>		YYYY / MM / DD			
Other s/s					

### D) 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>	

### E) RISK FACTORS

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start Date	N, NA, U	Add'l Info
Contact - Daycare	YYYY / MM / DD TE		
Contact to a known case (Add'l Info)	YYYY / MM / DD AE		
<b>Special population</b> – Attends Childcare	YYYY / MM / DD TE		
<b>Special population</b> – Attends school	YYYY / MM / DD TE		
<b>Travel</b> - Outside of Canada (Add'l Info)	YYYY / MM / DD TE		
<b>Travel</b> - Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM / DD TE		

### 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"/> IOM - Fully immunized (for age) <span style="margin-left: 100px;"><input type="checkbox"/> IOM - Partially immunized</span>
<input type="checkbox"/> IOM – Unimmunized <span style="margin-left: 50px;"><input type="checkbox"/> IOM - Unclear immunization history</span>	<b>Valid doses received:</b> _____ <b>Doses needed:</b> _____
<b>Reason:</b> <input type="checkbox"/> IIOM – Interpretation of history by investigator	

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

## G) TREATMENT

INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication ( <i>Panorama = Other Meds</i> ) : _____
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 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>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 <input type="checkbox"/> Letter YYYY / MM / DD Investigator name	<b>Testing:</b> <input type="checkbox"/> Laboratory testing recommended YYYY / MM / DD Investigator name  <b>Treatment:</b> <input type="checkbox"/> Treatment not 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>Other Investigation Findings:</b> <input type="checkbox"/> Investigator Notes <input type="checkbox"/> See Document Management			
<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>Referral:</b> <input type="checkbox"/> Consultation with MHO <input type="checkbox"/> Primary Care Provider <input type="checkbox"/> Infectious Disease Specialist			
<b>Immunization:</b> <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				
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	

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

**I) 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) \_\_\_\_\_

**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 (e.g daycare)		
		<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(e.g daycare)		
		<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 (e.g daycare)		
	Hib 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])