

Influenza Data Collection Worksheet

Please complete the following sections:

Panorama QA complete: Yes No
Initials: _____

Severe - intensive medical care - **Sections D, F, G, and I;**
Novel - **Sections D, E, F, H, I, J, K and L;**

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	Specimen type:
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Nasopharyngeal
<input type="checkbox"/> Probable	YYYY / MM / DD			<input type="checkbox"/> Swab
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 _____				

C) DISEASE EVENT HISTORY

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

Site / Presentation: <input type="checkbox"/> Severe - intensive medical care <input type="checkbox"/> Novel <input type="checkbox"/> Other	Complete sections D, F, G, and I for Severe Cases; Complete sections D, E, F, H, I, J, K and L;
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D) SIGNS & SYMPTOMS

INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Acute onset of symptoms		YYYY / MMM / DD	Muscle inflammation (myositis)		YYYY / MMM / DD
Acute respiratory distress syndrome (ARDS)		YYYY / MMM / DD	Myalgia (muscle pain)		YYYY / MMM / DD
Arthralgia		YYYY / MMM / DD	Nasal congestion		YYYY / MMM / DD
Bronchiolitis		YYYY / MMM / DD	Neurologic - delerium		YYYY / MMM / DD
Cardiac - myocarditis		YYYY / MMM / DD	Otitis media		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Coryza or rhinitis		YYYY / MMM / DD	Pharyngitis (sore throat)		YYYY / MMM / DD
Cough		YYYY / MMM / DD	Pneumonia - CXR/CT		YYYY / MMM / DD
Croup (laryngotracheobronchitis)		YYYY / MMM / DD	Prostration		YYYY / MMM / DD
Dyspnea (shortness of breath)		YYYY / MMM / DD	Respiratory compromise		YYYY / MMM / DD
Encephalitis		YYYY / MMM / DD	Respiratory failure - requiring mechanical ventilation		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Reye's syndrome		YYYY / MMM / DD
Gastrointestinal symptoms		YYYY / MMM / DD	Seizures		YYYY / MMM / DD
Headache		YYYY / MMM / DD	Sinusitis		YYYY / MMM / DD
Malaise		YYYY / MMM / DD			YYYY / MMM / DD

E) INCUBATION AND COMMUNICABILITY FOR NOVEL INFLUENZA ONLY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

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

F) RISK FACTORS FOR NOVEL AND SEVERE INFLUENZA ONLY

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Start date Yes	N, NA, U	Add'l Info
Access to healthcare services > 4 hours by road			
Chronic Medical Condition - Cardiac Disease+			
Chronic Medical Condition - Diabetes Mellitus+			
Chronic Medical Condition - Lung Disease+			
Chronic Medical Condition - Malignancies/Cancer+			
Chronic Medical Condition - Morbid Obesity			
Chronic Medical Condition - Neurological conditions that impede the clearance of respiratory/oral secretions+			
Chronic Medical Condition - Other (add'l info)			
Chronic Medical Condition - Renal Disease+			
Contact to a known case (add'l info)	YYYY / MM/DD		
Exposure - Second hand smoke			
Immunocompromised - Related to underlying disease or treatment			
Immunocompromised - Transplant Candidate or Recipient - Solid Organ/Tissue+			
Setting - Crowded living conditions (>1 person per room excluding bathrooms)			

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DESCRIPTION	Start date Yes	N, NA, U	Add'l Info
Special Population - Attends childcare			
Special Population - Homeless+			
Special Population - Lives in a communal setting			
Special Population - LTC Facility+			
Special Population - Pregnancy			
Special Population - Self-reported Indigenous identity			
Substance Use - Alcohol			
Substance Use - Injection drug use (including steroids)+			
Substance Use - Tobacco			
Travel - Outside of Canada (Add'l Info)	YYYY / MM/DD AE		
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM/DD AE		

G) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

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

H) INTERVENTION

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

Intervention Type and Sub Type:				
Assessment: <input type="checkbox"/> Assessed for contacts YYYY / MM / DD Investigator name		Isolation: <input type="checkbox"/> Facility isolation Investigator name YYYY / MM / DD <input type="checkbox"/> Home isolation Investigator name YYYY / MM / DD		
Communication: <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		Other Investigation Findings: <input type="checkbox"/> Investigator Notes YYYY / MM / DD <input type="checkbox"/> See document management YYYY / MM / DD		
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		Quarantine: <input type="checkbox"/> Quarantine YYYY / MM / DD Investigator name		
Education/counselling: Investigator name <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided YYYY / MM / DD		Testing: <input type="checkbox"/> Lab testing recommended YYYY / MM / DD Investigator name		
Exclusion: Investigator name <input type="checkbox"/> Work YYYY / MM / DD <input type="checkbox"/> Preschool YYYY / MM / DD <input type="checkbox"/> School YYYY / MM / DD <input type="checkbox"/> Daycare YYYY / MM / DD		Referral: <input type="checkbox"/> Consultation with MHO Investigator name YYYY / MM / DD <input type="checkbox"/> Primary Care Provider Investigator name YYYY / MM / DD <input type="checkbox"/> Infection prevention and Control Investigator name YYYY / MM / DD		
Immunization: Investigator name <input type="checkbox"/> Eligible Immunization recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization given 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	

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Panorama Client ID: _____
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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

I) OUTCOMES (required)

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"/> ER Visit YYYY / MM / DD	<input type="checkbox"/> Other _____ YYYY / MM / DD	
<input type="checkbox"/> Fatal YYYY / MM / DD	Cause of Death: (if Fatal was selected) _____	

J) Acquisition Event

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

Acquisition Event ID: _____

Exposure Name: _____

Acquisition Start YYYY / MM / DD **to Acquisition End:** YYYY / MM / DD

Location Name: _____

Setting Type

Travel Health care setting Public facilities Recreational facilities Most likely source

K) 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	YYYY / MM / DD to YYYY / MM / DD	
		<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	YYYY / MM / DD to YYYY / MM / DD	
	influenza Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

L) 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])

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