

Legionellosis 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-> ENTERIC ENCOUNTER GROUP ->CREATE INVESTIGATION

Disease Summary Classification: CASE	Date	Classification: CONTACT	Date	LAB TEST INFORMATION:
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	Date specimen collected: 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"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Respiratory Secretions
<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			

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 _____

C) DISEASE EVENT HISTORY

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

Site Description: Legionnaires' disease Pontiac fever Other

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

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Loss of appetite (anorexia)		YYYY / MMM / DD	Headache		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Malaise		YYYY / MMM / DD
Confusion			Myalgia (muscle pain)		
Cough		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pneumonia		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Respiratory distress		YYYY / MMM / DD

E) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

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

F) RISK FACTORS N—No, NA—Not asked, U—Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Chronic Medical Condition - Malignancies/Cancer+			
Immunocompromised - Related to underlying disease or treatment			
Immunocompromised - Transplant Candidate or Recipient - Solid Organ/Tissue+			
Travel - Outside of within Canada (Add'l Info)	YYYY / MM/DD AE		
Travel - Outside of Saskatchewan, but within Canada (add'l info)	YYYY / MM/DD AE		
Water - Aerosol - Air conditioning unit	YYYY / MM/DD		
Water - Aerosol - Other (add'l info)	YYYY / MM/DD		
Water - Aerosol - Room/central humidifier	YYYY / MM/DD		
Water - Aerosol - Shower head	YYYY / MM/DD		

G) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

H) INTERVENTION

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

Intervention Type and Sub Type:	
Assessment: Investigator name <input type="checkbox"/> Assessed for contacts (individuals exposed to same source) YYYY / MM / DD	Immunization: Investigator name <input type="checkbox"/> Eligible immunizations recommended YYYY / MM / DD
Communication: <input type="checkbox"/> Other communication (See Investigator Notes) Investigator name YYYY / MM / DD <input type="checkbox"/> Letter (See Document Management) Investigator name YYYY / MM / DD	Referral: <input type="checkbox"/> Infection Prevention and Control Investigator name YYYY / MM / DD <input type="checkbox"/> Consultation with MHO Investigator name 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	Other Investigation Findings: <input type="checkbox"/> Investigator Notes <input type="checkbox"/> Document Management Notes
Education/counselling: <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided Investigator name YYYY / MM / DD	

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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	

I) OUTCOMES *(optional except for severe influenza)*

LHN-> INVESTIGATION-> OUTCOMES

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

J) EXPOSURES

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

Acquisition Event

Acquisition Event ID: _____

Exposure Name: _____
Acquisition Start YYYY / MM / DD to Acquisition End: YYYY / MM / DD
Location Name: _____
Setting Type <input type="checkbox"/> Travel <input type="checkbox"/> Exposure or consumption of potentially contaminated food or water <input type="checkbox"/> Most likely source

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