

## Leprosy Data Collection Worksheet

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) 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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### C) INVESTIGATION INFORMATION

LHN -> SUBJECT SUMMARY -> ZOO NOTIC & VECTORBORNE GROUP -> CREATE INVESTIGATION

Disease Summary Classification:	Date	Classification:	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	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			

#### 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)                                     |                |

<b>REPORTING NOTIFICATION</b> 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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Panorama Investigation ID: \_\_\_\_\_

## D) DISEASE EVENT HISTORY

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

Site / Presentation:  Lepromatous  Tuberculoid  Borderline  Other  Unknown

## E) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Alopecia (loss of normal hair distribution)		YYYY / MMM / DD	Rash - papules - erythematous		YYYY / MMM / DD
Bleeding - nose (epistaxis)		YYYY / MMM / DD	Skin - infiltrative disorders		YYYY / MMM / DD
Iritis (inflammation of the iris)		YYYY / MMM / DD	Skin - lesions - hypopigmented and anaesthetic (painless)		YYYY / MMM / DD
Keratitis (inflammation of the cornea)		YYYY / MMM / DD	Skin nodules		YYYY / MMM / DD
Neurologic - peripheral nerve - swelling or thickening (neuritis)			Skin - thickening		
Neuropathy		YYYY / MMM / DD	Skin - nodules - erythematous		YYYY / MMM / DD
Rash - macules - hypopigmented		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

## A) RISK FACTORS (during risk period)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	YES	N – No NA – not asked U - Unknown	DESCRIPTION	YES	N – No NA – not asked U - Unknown
<b>Contact</b> - Visitor from an endemic country	YYYY / MM / DD		<b>Travel</b> - Outside of Canada (Add'l Info)	YYYY / MM / DD AE	
<b>Contact</b> to a known case (Add'l Info)	YYYY / MM / DD		<b>Travel</b> - Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM / DD AE	
<b>Special Population</b> - From or residence in an endemic country (Add'l Info)	YYYY / MM / DD				

## B) MEDICATIONS

INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

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

## C) INTERVENTIONS

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

Intervention Type and Sub Type:				
<b>Assessment:</b> <input type="checkbox"/> Assessed for contacts Investigator name		YYYY / MM / DD	<b>Education/counseling:</b> Investigator name <input type="checkbox"/> Prevention/Control measures <input type="checkbox"/> Disease information provided	
<b>Communication:</b> <input type="checkbox"/> Other communication (See Investigator Notes) Investigator name <input type="checkbox"/> Letter (See Document Management) Investigator name		YYYY / MM / DD	<b>Immunization:</b> Investigator name <input type="checkbox"/> Eligible Immunization recommended	
<b>General:</b> Investigator name <input type="checkbox"/> Disease-Info/Prev-Control <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"/> Document Management	
<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				

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

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				

**D) 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"/> Other _____ YYYY / MM / DD_	<input type="checkbox"/> Hospitalization    YYYY / MM / DD <input type="checkbox"/> Unknown    YYYY / MM / DD
Cause of Death: (if Fatal was selected) _____		

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