

Verotoxigenic Escherichia Coli Infection Data Collection Worksheet

Please complete all sections.

Panorama Client ID: _____

Panorama Investigation ID: _____

Panorama QA complete: Yes No

Initials: _____

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:	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	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"/> 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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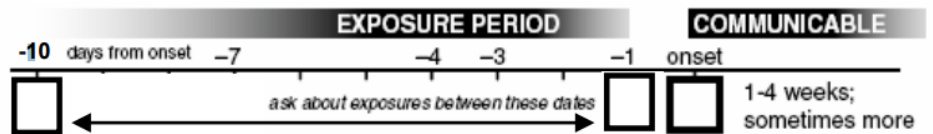
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C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Abdominal - cramping	YYYY / MM / DD	YYYY / MM / DD	Hemolytic uremic syndrome (HUS)	YYYY / MM / DD	YYYY / MM / DD
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Pain - abdominal	YYYY / MM / DD	YYYY / MM / DD
Dehydration	YYYY / MM / DD	YYYY / MM / DD	Stool - bloody	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - bloody	YYYY / MM / DD	YYYY / MM / DD	Thrombotic thrombocytopenic purpura (TTP)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - watery	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Fever	YYYY / MM / DD	YYYY / MM / DD		YYYY / MM / DD	YYYY / MM / DD
Other Signs & Symptoms if applicable					

Enter onset date in heavy box. Count back to figure the probable exposure period.



D) 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
<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>	

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Animal Exposure - Farms (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pet treats and raw food (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pets (including reptiles) (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Petting zoos/zoos/special events/other (Add'l Info)			YYYY / MM/DD	
Contact – Persons with diarrhea/vomiting			YYYY / MM/DD	
Contact to a known case (Add'l Info)			YYYY / MM/DD	
Immunocompromised - Related to underlying disease or treatment			YYYY / MM/DD	
Occupation - Child Care Worker	TE		YYYY / MM/DD	
Occupation - Food Handler	TE		YYYY / MM/DD	
Occupation - Health Care Worker - IOM Risk Factor	TE		YYYY / MM/DD	
Other risk factor (Add'l Info)			YYYY / MM/DD	
Special Population - Attends childcare	TE		YYYY / MM/DD	
Special Population - Attends school	TE		YYYY / MM/DD	
Travel - Outside of Canada (Add'l Info)	AE		YYYY / MM/DD	
Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	AE		YYYY / MM/DD	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Water – Bottled water (Add'l Info)			YYYY / MM/DD	
Water - Private well or system (Add'l Info)			YYYY / MM/DD	
Water - Public water system (Add'l Info)			YYYY / MM/DD	
Water - Untreated water (Add'l Info)			YYYY / MM/DD	
Water (Recreational) - Pond, stream, lake, river, ocean (Add'l Info)			YYYY / MM/DD	
Water (Recreational) - Private (swimming pool/whirl pool)			YYYY / MM/DD	
Water (Recreational) - Public (swimming/paddling pool/whirl pool)			YYYY / MM/DD	

F) USER DEFINED FORM (SEE ATTACHED) LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> VEROTOXIGENIC E. COLI FORM

G) TREATMENT LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (Antibiotics are contraindicated – refer to physician if on Rx) (Panorama = Other Meds) : _____	
Prescribed by: _____	Started on: YYYY / MM / DD

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

Intervention Type and Sub Type:					
Assessment:			Outbreak Declared YYYY / MM / DD		
<input type="checkbox"/> Assessed for contacts	YYYY/ MM/DD		Investigator name		
Communication:			Public Health Order:		
<input type="checkbox"/> Other communication (See Investigator Notes)	YYYY / MM / DD		<input type="checkbox"/> Other (specify)	YYYY/ MM/DD	
Investigator name			Investigator name		
<input type="checkbox"/> Letter (See Document Management)	YYYY / MM / DD				
Investigator name					
General: Investigator name			Other Investigation Findings:		
<input type="checkbox"/> Disease-Info/Prev-Control	YYYY/ MM / DD		<input type="checkbox"/> Investigator Notes		
<input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts	YYYY/ MM / DD		<input type="checkbox"/> Document Management		
Education/counselling: Investigator name			Referral: Investigator name		
<input type="checkbox"/> Prevention/Control measures	YYYY/ MM/DD		<input type="checkbox"/> Canadian food inspection agency	YYYY/ MM/DD	
<input type="checkbox"/> Disease information provided	YYYY/ MM/DD		<input type="checkbox"/> Primary care provider	YYYY/ MM/DD	
Exclusion: Investigator name			Testing: Investigator name		
<input type="checkbox"/> Daycare YYYY/ MM/DD		<input type="checkbox"/> Preschool YYYY/ MM/DD	<input type="checkbox"/> Stool testing recommended (e.g. for follow-up)	YYYY/ MM/DD	
<input type="checkbox"/> School YYYY/ MM/DD		<input type="checkbox"/> Work YYYY/ MM/DD			
Immunization:					
<input type="checkbox"/> Eligible Immunization recommended	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	
YYYY / MM / DD				YYYY / MM / DD	
YYYY / MM / DD				YYYY / MM / DD	

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I) OUTCOMES

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) EXPOSURES

Acquisition Event

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

Acquisition Event ID: _____

- Exposure Name: _____
- Acquisition Start** YYYY / MM / DD to **Acquisition End:** YYYY / MM / DD
- Location Name: _____
- Setting Type**
- Travel Exposure or consumption of potentially contaminated food or water Most likely source

Transmission Events

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

Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Food service establishment <input type="checkbox"/> Health Care setting <input type="checkbox"/> Public facilities <input type="checkbox"/> Household Exposure		
	VTEC 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 exposed)

Initial Report completed by: _____

Date initial report completed: YYYY / MM / DD