

Giardiasis Data Collection Worksheet

Please complete all sections.

Panorama QA complete: Yes No

Panorama Client ID: _____

Initials: _____

Panorama Investigation ID: _____

A) CLIENT INFORMATION

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 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"/> Fluid
<input type="checkbox"/> Probable	YYYY / MM / DD			<input type="checkbox"/> Biopsy
				<input type="checkbox"/> Stool

Disposition:

FOLLOW UP:

- | | | | |
|--------------------------------------------------------|-----------------|-----------------------------------------------------|-----------------|
| <input type="checkbox"/> In progress | YYYY / MMM / DD | <input type="checkbox"/> Complete | YYYY / MMM / DD |
| <input type="checkbox"/> Incomplete - Declined | YYYY / MMM / DD | <input type="checkbox"/> Not required | YYYY / MMM / DD |
| <input type="checkbox"/> Incomplete - Lost contact | YYYY / MMM / DD | <input type="checkbox"/> Referred - Out of province | YYYY / MMM / DD |
| <input type="checkbox"/> Incomplete - Unable to locate | YYYY / MMM / DD | (Specify where) | YYYY / MMM / DD |

REPORTING NOTIFICATION

Name of Attending Physician or Nurse:

Location:

Provider's Phone number:

Date Received (Public Health): YYYY / MMM / 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

Staging: Acute Chronic Carrier

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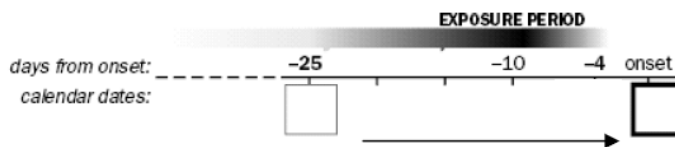
D) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes	Date of recovery	Description	Yes	Date of recovery
Asymptomatic		YYYY / MMM / DD	Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD
Abdominal - bloating or distension		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Abdominal - cramping		YYYY / MMM / DD	Stool - steatorrhea (pale and greasy)		YYYY / MMM / DD
Constipation		YYYY / MMM / DD	Weight loss		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

Exposure Period

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



The communicable period is quite variable—weeks to months without treatment. Infected persons without symptoms are more likely to be infectious than those who are sick.

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
<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 N—No, NA—Not asked, U—Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Animal Exposure - Other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pets (including reptiles) (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Rodents/rodent excreta			YYYY / MM/DD	
Animal Exposure - Wild animals (other than rodents) (Add'l Info)				
Behaviour – Camping/hiking				
Contact – Daycare				
Contact – Persons with diarrhea/vomiting			YYYY / MM/DD	
Contact to a known case (Add'l Info)			YYYY / MM/DD	
Exposure – Diaper changing				
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	
Occupation – Personal Care Worker				
Other risk factor (Add'l Info)			YYYY / MM/DD	
Special Population - Attends childcare	TE		YYYY / MM/DD	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
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	
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) (Add'l Info)			YYYY / MM/DD	
Water (Recreational) - Public (swimming/paddling pool/whirl pool) (Add'l Info)			YYYY / MM/DD	

G) USER DEFINED FORM (SEE ATTACHED)

LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> GIARDIASIS FORM

H) COMPLICATIONS

LHN-> INVESTIGATION->COMPLICATIONS

Description	Yes Date of onset	Description	Yes Date of onset
Arthritis - reactive (Reiter's syndrome)	YYYY / MMM / DD	Malabsorption of fats	YYYY / MMM / DD
Other complications			

I) 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

J) INTERVENTIONS

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

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

K) 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) _____

L) 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		
<input type="checkbox"/> Travel	<input type="checkbox"/> Exposure or consumption of potentially contaminated food or water	<input type="checkbox"/> 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"/> Health Care setting <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Health Care setting <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Health Care setting <input type="checkbox"/> Household Exposure		
		<input type="checkbox"/> Health Care setting <input type="checkbox"/> Household Exposure		
	Giardia Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

M) 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
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