

## Salmonellosis 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: 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"/> Blood <input type="checkbox"/> Urine <input type="checkbox"/> Stool
<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			
<b>Disposition:</b> FOLLOW UP: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> In progress  <input type="checkbox"/> Incomplete - Declined  <input type="checkbox"/> Incomplete - Lost contact  <input type="checkbox"/> Incomplete - Unable to locate             </div> <div> <input type="checkbox"/> Complete  <input type="checkbox"/> Not required  <input type="checkbox"/> Referred - Out of province              (specify where)           </div> </div>				
<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: <input type="checkbox"/> Health Care Facility <input type="checkbox"/> Lab Report <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Other _____				

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Please complete **all** sections.

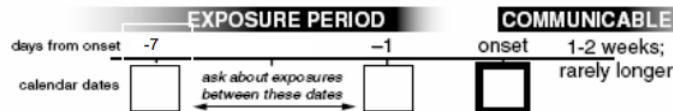
Panorama Client ID: \_\_\_\_\_  
Panorama Investigation ID: \_\_\_\_\_

### 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	Fever	YYYY / MM / DD	YYYY / MM / DD
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Headache	YYYY / MM / DD	YYYY / MM / DD
Chills	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Dehydration	YYYY / MM / DD	YYYY / MM / DD	Pain – abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bacteremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea – bloody	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Extra-intestinal infection	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.



**NOTE:** If *Salmonella* was isolated from blood or urine, exposure period should be adjusted to reflect most likely onset of initial enteric symptoms.

Exposure period:

#### D) INCUBATION AND COMMUNICABILITY

## LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

<b>Incubation for Case (period for acquisition):</b> <b>Earliest Possible Exposure Date:</b> YYYY / MM / DD		<b>Latest Possible Exposure Date:</b> YYYY / MM / DD	
<i>Exposure Calculation details:</i>			
<b>Communicability for Case (period for transmission):</b> <b>Earliest Possible Communicability Date:</b> YYYY / MM / DD		<b>Latest Possible Communicability Date:</b> 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
<b>Animal Exposure</b> - Pet treats and raw food (Add'l Info)_			YYYY / MM/DD	
<b>Animal Exposure</b> - Pets (including reptiles) (Add'l Info)_			YYYY / MM/DD	
<b>Animal Exposure</b> - Rodents/rodent excreta			YYYY / MM/DD	
<b>Animal Exposure</b> - Wild animals (other than rodents) (Add'l Info)_			YYYY / MM/DD	
<b>Animal Exposure</b> - Other Animal Exposure (Add'l Info)_			YYYY / MM/DD	
<b>Chronic Medical Condition</b> - Other (Add'l Info)_			YYYY / MM/DD	
<b>Contact</b> - Persons with diarrhea/vomiting			YYYY / MM/DD	
<b>Contact to a known case</b> (Add'l Info)			YYYY / MM/DD	
<b>Immunocompromised</b> - Related to underlying disease or treatment			YYYY / MM/DD	
<b>Occupation</b> - Child Care Worker	TE		YYYY / MM/DD	
<b>Occupation</b> - Food Handler	TE		YYYY / MM/DD	
<b>Occupation</b> – Health Care Worker IOM Risk Factor			YYYY / MM/DD	
<b>Occupation</b> - Personal Care Worker	TE		YYYY / MM/DD	
<b>Travel</b> - Outside of Canada (Add'l Info)_	AE		YYYY / MM/DD	

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

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

DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
<b>Travel</b> - Outside of Saskatchewan, but within Canada (Add'l Info)	AE		YYYY / MM/DD	
<b>Water</b> - Bottled water (Add'l Info)			YYYY / MM/DD	
<b>Water</b> - Public water system (Add'l Info)			YYYY / MM/DD	
<b>Water</b> - Private well or system (Add'l Info)			YYYY / MM/DD	
<b>Water</b> - Untreated water (Add'l Info)			YYYY / MM/DD	
<b>Water (Recreational)</b> - Pond, stream, lake, river, ocean			YYYY / MM/DD	
<b>Water (Recreational)</b> - Private (swimming pool/whirl pool)			YYYY / MM/DD	
<b>Water (Recreational)</b> - Public (swimming/paddling pool/whirl pool)			YYYY / MM/DD	

**F) USER DEFINED FORM**  
(SEE ATTACHED)

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

**G) TREATMENT**

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

**H) INTERVENTION**

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

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

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

### I) OUTCOMES

LHN-> INVESTIGATION-> OUTCOMES

- ☐ Not yet recovered/recovering YYYY / MM / DD    ☐ ICU/intensive medical care YYYY / MM / DD    ☐ Hospitalization YYYY / MM / DD  
☐ Recovered YYYY / MM / DD    ☐ Intubation /ventilation YYYY / MM / DD    ☐ Unknown YYYY / MM / DD  
☐ Fatal YYYY / MM / DD    ☐ 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		
	Salmonella 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