

Shigellosis 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) 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"/> 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 _____

C) DISEASE EVENT HISTORY

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

Staging: ☐ Acute ☐ Carrier

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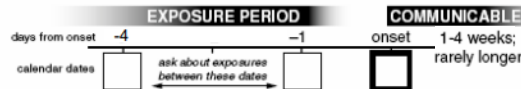
Panorama Client ID: _____
Panorama Investigation ID: _____

D) SIGNS & SYMPTOMS

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	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	Seizures	YYYY / MM / DD	YYYY / MM / DD
Diarrhea – bloody	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bactremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea – mucousy	YYYY / MM / DD	YYYY / MM / DD	Tenesmus	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	Arthritis	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: Exposure period for *S. dysenteriae* is up to one week.

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
Contact - Daycare			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 disease or treatment	TE		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	
Sexual Behaviour – Oral-anal				
Special Population – Homeless				
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			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			YYYY / MM/DD	
Water (Recreational) - Private (swimming pool/whirl pool)			YYYY / MM/DD	
Water (Recreational) - Public (swimming/paddling pool/whirl pool)			YYYY / MM/DD	

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Panorama Client ID: _____
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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
Other risk factor (Add'l Info)			YYYY / MM/DD	

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G) USER DEFINED FORM (SEE ATTACHED)

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

H) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication (*Panorama = Other Meds*): _____

Prescribed by: _____ Started on: YYYY / MM / DD

I) INTERVENTIONS

INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

Intervention Type and Sub Type:

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

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	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
YYYY / MM / DD			YYYY / MM / DD	
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J) 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) _____

K) 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"/> Health care setting <input type="checkbox"/> Food service establishment <input type="checkbox"/> Household <input type="checkbox"/> Private Function (FOOD PREP)		
		<input type="checkbox"/> Health care setting <input type="checkbox"/> Food service establishment <input type="checkbox"/> Household <input type="checkbox"/> Private Function (FOOD PREP)		
		<input type="checkbox"/> Health care setting <input type="checkbox"/> Food service establishment <input type="checkbox"/> Household <input type="checkbox"/> Private Function (FOOD PREP)		
		<input type="checkbox"/> Health care setting <input type="checkbox"/> Food service establishment <input type="checkbox"/> Household <input type="checkbox"/> Private Function (FOOD PREP)		
	Shigella Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

L) 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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