

Yersiniosis 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		<i>Date specimen collected:</i>
<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	<i>Specimen type:</i>
<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"/> Urine <input type="checkbox"/> Stool <input type="checkbox"/> Swab
Disposition:				
<i>FOLLOW UP:</i>				
<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		Location:		
Name of Attending Physician or Nurse:				
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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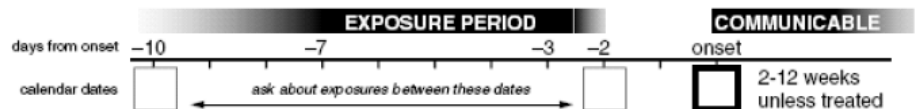
C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes	Date of recovery	Description	Yes	Date of recovery
Diarrhea		YYYY / MMM / DD	Loss of appetite (anorexia)		YYYY / MMM / DD
Diarrhea - bloody		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea - watery			Stool - bloody		
Fever			Stool - mucousy		
Headache			Vomiting		
Other Signs & Symptoms if applicable					

Exposure Period

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 - Petting zoos/zoos/special events/other (Add'l Info)			YYYY / MM/DD	
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)			YYYY / MM/DD	
Contact – Persons with similar symptoms			YYYY / MM/DD	
Contact to a known case (Add'l Info)			YYYY / MM/DD	
Immunocompromised - Related to underlying disease or treatment			YYYY / MM/DD	
Medical Treatment - Blood, blood product or tissue recipient (add'l info)			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	
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	

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DESCRIPTION	Yes	N, NA, U	Start date	Add'l Info
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	

F) USER DEFINED FORM (SEE ATTACHED)

LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> YERSINIOSIS 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: <input type="checkbox"/> Assessed for contacts Investigator name	YYYY/ MM/DD	Immunization: <input type="checkbox"/> Eligible Immunization recommended Investigator name	YYYY/ MM/DD	
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	YYYY/ MM/DD	
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	YYYY/ MM/DD YYYY/ MM/DD	
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	YYYY/ MM/DD YYYY/ MM/DD	Testing: Investigator name <input type="checkbox"/> Stool testing recommended (e.g. for follow-up)
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 *(optional except for severe influenza,*

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		
	Yersiniosis 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



Yersiniosis Routine Questionnaire - August 2018



Record type:

Record ID:

Record Name:

In this form the answers (Yes, Probably, No, and Don't know) are from the perspective of the person being interviewed. "Probably" can be used if the client thinks he/she may have eaten this food or usually eats this food, but is unsure if it was eaten during the period in question.

Diet and Allergies[Show/Hide](#)

Are you a vegetarian?

- Yes
 No
 Don't know
 Not asked

Do you have any food Allergies / avoidances / special diet?

- Yes
 No
 Don't know
 Not asked

If yes, specify details

Food Exposures[Show/Hide](#)

In the 10 days prior to onset, did you eat...

Any pork?

- Yes
 Probably
 No
 Don't know
 None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any ham?

- Yes
 Probably
 No
 Don't know



If yes, specify details (E.g., where consumed, type, brand, location)

None of the Above

Any bacon?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any pork rinds?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any raw, local direct-from-farm produce?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Any processed meats?

- Yes
- Probably
- No
- Don't know
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)



Any unpasteurized milk?

-
- Yes
-
-
- Probably
-
-
- No
-
-
- Don't know
-
-
- None of the Above

If yes, specify details (E.g., where consumed, type, brand, location)

Social Functions

[Show/Hide](#)

In the 10 days prior to onset, did you attend any social functions (e.g. parties, weddings, showers, potlucks, community events)?

-
- Yes
-
-
- No
-
-
- Don't know
-
-
- Not asked

Click the Add button to add social event/function details

Add

Restaurants

[Show/Hide](#)

In the 10 days prior to onset, did you attend any restaurants (including take-out, cafeteria, bakery, deli, kiosk)?

-
- Yes
-
-
- No
-
-
- Don't know
-
-
- Not asked

Click the Add button to add restaurant details

Add

Grocery Stores

[Show/Hide](#)

In the past 10 days prior to onset, did you visit grocery stores for foods consumed during the incubation period?

-
- Yes
-
-
- No
-
-
- Don't know
-
-
- Not asked



Click the Add button to add grocery store details

Add

Loyalty card/store issued card (for outbreak investigation only)

[Show/Hide](#)

This section is only for use in some specific outbreak situations, with client consent. It is not a routine question for sporadic cases.

Has the client given consent (written or verbal)?

- Yes
 No
 Not applicable

Loyalty card details (names and numbers)

Interviewer Details and Notes

[Show/Hide](#)

Interviewer Name

Interview date

9/26/2018

Any special notes regarding this interview