Government of Saskatchewan

PANORAMA

# Amoebiasis 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: _______<br>Phone #: ☐ Primary Home:<br>☐ Mobile contact:<br>☐ Workplace: | Health Card Province: ________<br>Health Card Number (PHN):<br>____________________________________ | Preferred Communication Method: (specify - i.e. home phone, text):<br>Email Address: ☐ Work ☐ Personal |

| Place of Employment/School: | Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown |
|---|---|
| Alternate Contact: ______________________________<br>Relationship: __________________________<br>Alt. Contact phone: _____________________________ | Address Type:<br>☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description<br>Mailing (Postal address):<br>Street Address or FN Community (Primary Home):<br>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:** |
|---|---|---|---|---|
| ☐ Confirmed | YYYY / MM / DD | ☐ Contact | YYYY / MM / DD | Date specimen collected:<br>YYYY / MM / DD |
| ☐ Does Not Meet Case Definition | YYYY / MM / DD | ☐ Not a Contact | YYYY / MM / DD | Specimen type:<br>☐ Intestinal Fluid |
| ☐ Person Under Investigation | YYYY / MM / DD | ☐ Person Under Investigation | YYYY / MM / DD | ☐ Stool |

**Disposition:**

*FOLLOW UP:*

| | | | |
|---|---|---|---|
| ☐ In progress | YYYY / MM / DD | ☐ Complete | YYYY / MM / DD |
| ☐ Incomplete - Declined | YYYY / MM / DD | ☐ Not required | YYYY / MM / DD |
| ☐ Incomplete – Lost contact | YYYY / MM / DD | ☐ Referred – Out of province | YYYY / MM / DD |
| ☐ Incomplete – Unable to locate | YYYY / MM / DD | (specify where) | |

| **REPORTING NOTIFICATION**<br>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

| | | | | |
|---|---|---|---|---|
| **Site / Presentation:** | ☐ Anogenital | ☐ Extraintestinal | ☐ Intestinal | ☐ Other |
| **Staging:** | ☐ Acute | ☐ Carrier | | |

# Amoebiasis Data Collection Worksheet

Please complete **all** sections

Panorama Client ID: ___________
Panorama Investigation ID: ___________

## D) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

| Description | Yes Date of onset | Date of recovery | Description | Yes Date of onset | Date of recovery |
|---|---|---|---|---|---|
| Asymptomatic | | YYYY / MMM / DD | Abdominal - discomfort | | YYYY / MMM / DD |
| Chills | | YYYY / MMM / DD | Fever | | YYYY / MMM / DD |
| Constipation | | YYYY / MMM / DD | Lesion - genital | | YYYY / MMM / DD |
| Dehydration | | YYYY / MMM / DD | Lesion - perianal - ulcer | | YYYY / MMM / DD |
| Diarrhea | | YYYY / MMM / DD | Pain - abdominal | | YYYY / MMM / DD |
| Diarrhea - bloody | | YYYY / MMM / DD | Weight loss | | YYYY / MMM / DD |
| Diarrhea - mucousy | | YYYY / MMM / DD | | | YYYY / MMM / DD |
| Other Signs & Symptoms if applicable | | | | | |

## 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

*Exposure Calculation details:*

**Communicability for Case (period for transmission):**
**Earliest Possible Communicability Date**: YYYY / MM / DD **Latest Possible Communicability Date**: YYYY / MM / DD

*Communicability Calculation Details:*

## F) RISK FACTORS N—No, NA–Not asked, U–Unknown

LHN-> SUBJECT->RISK FACTORS

| DESCRIPTION | Yes Start date | N, NA, U | Add'l Info |
|---|---|---|---|
| **Contact** - At risk population (international travellers or immigrants) | YYYY / MM/DD | | |
| **Contact** - Daycare | | | |
| **Contact** - Persons with diarrhea/vomiting | YYYY / MM/DD | | |
| **Occupation** - Child Care Worker | | | |
| **Occupation** – Food Handler | YYYY / MM/DD | | |
| **Sexual Behaviour** - Oral-anal | | | |
| **Special Population -** From or residence in an endemic country (add'l info) | | | |
| **Travel** - Outside of within Canada (Add'l Info) | YYYY / MM/DD AE | | |
| **Travel** - Outside of Saskatchewan, but within Canada (add'l info) | YYYY / MM/DD AE | | |
| **Water** – Bottled water (specify) | | | |
| **Water** - Private well or system (Add'l Info) | | | |
| **Water** - Public water system (Add'l Info) | | | |
| **Water** - Untreated water (Add'l Info) | | | |
| **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 pool/paddling pool/whirl pool) (Add'l Info) | YYYY / MM/DD | | |

# Amoebiasis Data Collection Worksheet

Please complete **all** sections

Panorama Client ID: ___________
Panorama Investigation ID: ___________

## G) COMPLICATIONS

INVESTIGATION->COMPLICATIONS

| Description | Yes<br>Date of onset | Description | Yes<br>Date of onset |
|---|---|---|---|
| Abscess - brain | YYYY / MMM / DD | Disseminated infection | YYYY / MMM / DD |
| Abscess - liver | | Hemorrhage - Intestinal | |
| Abscess - lung | | Intussusception | |
| Ameboma (amebic granulomata) | YYYY / MMM / DD | | |
| Other complications | | | |

## H) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds) :* ___________________________________________

Prescribed by:_________________________________________ Started on: YYYY / MMM / DD

## I) INTERVENTION

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

**Intervention Type and Sub Type:**

**Assessment:** Investigator name
- ☐ Assessed for contacts YYYY / MM / DD

**Immunization:** Investigator name
- ☐ Eligible immunizations recommended YYYY / MM / DD

**Communication:**
- ☐ Other communication (See Investigator Notes) YYYY / MM / DD
  Investigator name
- ☐ Letter (See Document Management) YYYY / MM / DD
  Investigator name

**Public Health Order:**
- ☐ Order (specify)_________________ YYYY / MM / DD
  Investigator name

**General:** Investigator name
- ☐ Disease-Info/Prev-Control YYYY/ MM / DD
- ☐ Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD

**Referral:**
- ☐ Canadian food inspection agency YYYY / MM / DD
  Investigator name
- ☐ Primary care provider YYYY/ MM / DD
  Investigator name
- ☐ Consultation with MHO YYYY / MM / DD
  Investigator name

**Education/counselling:**
- ☐ Prevention/Control measures YYYY / MM / DD
- ☐ Disease information provided YYYY / MM / DD
  Investigator name

**Testing:** Investigator name
- ☐ Stool testing recommended (e.g. contacts) YYYY / MM / DD
- ☐ Laboratory testing recommended (contacts) YYYY / MM / DD

**Exclusion:** Investigator name
- ☐ Daycare YYYY / MM / DD ☐ Preschool YYYY / MM / DD
- ☐ School YYYY / MM / DD ☐ Work YYYY / MM / DD

**Other Investigation Findings:**
- ☐ Investigator Notes
- ☐ 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 | |
| YYYY / MM / DD | | | YYYY / MM / DD | |
| YYYY / MM / DD | | | YYYY / MM / DD | |
| YYYY / MM / DD | | | YYYY / MM / DD | |

# Amoebiasis Data Collection Worksheet

Please complete **all** sections

Panorama Client ID: ___________
Panorama Investigation ID: ___________

**J) OUTCOMES *(optional except for severe influenza)*** 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 ☐ Other YYYY / MM / DD
☐ Fatal YYYY / MM / DD ☐ Unknown ______________________

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 |
|---|---|---|---|---|
| | | ☐ Household ☐ Public Facility | | |
| | | ☐ Household ☐ Public Facility | | |
| | | ☐ Household ☐ Public Facility | | |
| | | ☐ Household ☐ Public Facility | | |
| | Amoebiasis Contacts – Inv ID# _____ | ☐ 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 / MMM / DD |
|---|---|---|