Campylobacteriosis 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: ☐ Work ☐ Personal
Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:		
Place of Employment/School:	Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown	
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____	Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home): Address at time of infection if not 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:* YYYY / MM / DD
☐ Does Not Meet Case	YYYY / MM / DD	☐ *Not a Contact*	YYYY / MM / DD	*Specimen type:*
☐ Person Under Investigation	YYYY / MM / DD	☐ *Person Under Investigation*	YYYY / MM / DD	☐ *Blood*
☐ Probable	YYYY / MM / DD			☐ *Urine*
				☐ *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 (specify where)	YYYY / MM / DD
☐ Incomplete – Unable to locate	YYYY / MM / DD		

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_____

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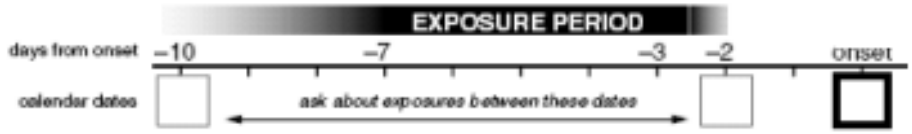
C) SIGNS & SYMPTOMS

INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic	YYYY / MM / DD	YYYY / MM / DD	Nausea	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - bloody	YYYY / MM / DD	YYYY / MM / DD	Pain – abdominal	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - mucousy	YYYY / MM / DD	YYYY / MM / DD	Sepsis (e.g. bactremia, septicemia, etc.)	YYYY / MM / DD	YYYY / MM / DD
Diarrhea - watery	YYYY / MM / DD	YYYY / MM / DD	Stool - bloody	YYYY / MM / DD	YYYY / MM / DD
Headache	YYYY / MM / DD	YYYY / MM / DD	Vomiting	YYYY / MM / DD	YYYY / MM / DD
Malaise	YYYY / MM / DD	YYYY / MM / DD	Cardiac- myocarditis	YYYY / MM / DD	YYYY / MM / DD
Arthritis	YYYY / MM / DD	YYYY / MM / DD	Cardiac-pericarditis	YYYY / MM / DD	YYYY / MM / DD
Guillain-Barre Syndrome	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.



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

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:

E) RISK FACTORS

N – NO, NA – Not Asked, U – Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Add'l Info
Animal Exposure – Farms (Add'l Info)			
Animal Exposure – Other (Add'l Info)			
Animal Exposure – Pet treats and raw food (Add'l Info)			
Animal Exposure – Pets (including reptiles) (Add'l Info)			
Animal Exposure – Rodents/rodent excreta			
Animal Exposure – Wild animals (other than rodents) (Add'l Info)			
Behaviour – Camping/hiking	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 underlying disease or treatment			
Occupation – Child Care Worker	TE		
Occupation – Farmer			
Occupation – Food Handler	TE		

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Panorama Investigation ID: _____

DESCRIPTION	Yes	N, NA, U	Add'l Info
Occupation – Health Care Worker – IOM Risk Factor	TE		
Occupation – Veterinarian or related worker			
Travel – Outside of 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 (Add'l Info)			
Water – Private well or system (Add'l Info)			
Water – Public water system (Add'l Info)			
Water – Untreated water (Add'l Info)	AE		
Water (Recreational) – Pond, stream, lake, river, ocean (Add'l Info)	AE		
Water (Recreational) – Private (swimming pool/whirl pool)	TE		
Water (Recreational) – Public (swimming/paddling pool/whirl pool)			
Other risk factor (Add'l Info)			

F) USER DEFINED FORM (SEE ATTACHED) LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> CAMPYLOBACTERIOSIS FORM

G) TREATMENT LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(to intercept transmission)Panorama = Other Meds) :* _____

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

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

Intervention Type and Sub Type:

Assessment:
☐ Assessed for contacts 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

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

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

Environmental health: YYYY/ MM / DD
☐ Restaurant Inspection ☐ Facility Inspection
Investigator name

Exclusion (recommended): Investigator name
☐ Daycare YYYY/ MM / DD ☐ Preschool YYYY/ MM / DD
☐ School YYYY/ MM / DD ☐ Work YYYY/ MM / DD

Public Health Order:
☐ Other (specify) YYYY/ MM / DD
Investigator name

Referral: Investigator name
☐ Canadian Food Inspection Agency YYYY/ MM / DD
☐ Primary Care Provider YYYY/ MM / DD
☐ Saskatchewan Water Security Agency YYYY/ MM / DD

Other Investigation Findings:
☐ Investigator Notes
☐ Document Management

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	

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Panorama Client ID: _____
Panorama Investigation ID: _____

YYYY / MM / DD			YYYY / MM / DD	

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
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
		☐ Food service establishment ☐ Health Care setting ☐ Public facilities ☐ Household Exposure		
	Campy Contacts – Inv ID# _____	☐ 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