

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: _____		Preferred Communication Method: (specify - i.e. home phone, text):	
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace:		Health Card Number (PHN): _____		Email Address: <input type="checkbox"/> Work <input type="checkbox"/> Personal	
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:		Classification:		LAB TEST INFORMATION:
CASE	Date	CONTACT	Date	
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	Date specimen collected: 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"/> Intestinal Fluid <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: <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)				
<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 _____				

# Cryptosporidiosis Data Collection Worksheet

Please complete all sections

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

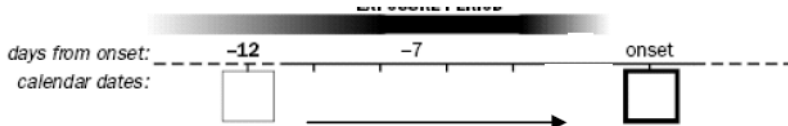
## C) SIGNS & SYMPTOMS

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	Loss of appetite (anorexia)		YYYY / MM / DD	YYYY / MM / DD
Asymptomatic		YYYY / MM / DD	YYYY / MM / DD	Malaise		YYYY / MM / DD	YYYY / MM / DD
Diarrhea		YYYY / MM / DD	YYYY / MM / DD	Nausea		YYYY / MM / DD	YYYY / MM / DD
Diarrhea - profuse		YYYY / MM / DD	YYYY / MM / DD	Pain - abdominal		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			YYYY / MM / DD	YYYY / MM / DD
Other Signs & Symptoms if applicable							

### Exposure Period

Enter onset date in heavy box. Count backwards to figure probable exposure period.



Most persons shed infectious oocysts in stool during the period of diarrhea. Shedding may continue in some patients for several days—possibly longer.

## D) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

<b>Incubation for Case (period for acquisition):</b>	
Earliest Possible Exposure Date: YYYY / MM / DD	Latest Possible Exposure Date: YYYY / MM / DD
<i>Exposure Calculation details:</i>	
<b>Communicability for Case (period for transmission):</b>	
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 - Other (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pet treats and raw food (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Pets (including reptiles) (Add'l Info)			YYYY / MM/DD	
Animal Exposure - Petting zoos/zoos/ special events/ other (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	
Behaviour - Camping/hiking			YYYY / MM/DD	
Contact - Daycare			YYYY / MM/DD	
Contact - Persons with diarrhea/vomiting			YYYY / MM/DD	
Exposure – Diaper changing			YYYY / MM/DD	
Occupation - Child Care Worker			YYYY / MM/DD	
Occupation - Health Care Worker - IOM Risk Factor			YYYY / MM/DD	
Occupation - Personal Care Worker			YYYY / MM/DD	
Sexual Behaviour – MSM +			YYYY / MM/DD	
Sexual Behaviour - Oral-anal			YYYY / MM/DD	
Travel - Outside of within Canada (Add'l Info)			YYYY / MM/DD	
Travel - Outside of Saskatchewan, but within Canada (add'l info)				
Water – Bottled water (specify)			YYYY / MM/DD	

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

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

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

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

Medication ( <i>Panorama = Other Meds</i> ) : _____
Prescribed by: _____      Started on:    YYYY / MMM / 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>Public Health Order:</b> <input type="checkbox"/> Order (specify) _____      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>Referral:</b> <input type="checkbox"/> Canadian food inspection agency                      YYYY / MM / DD Investigator name <input type="checkbox"/> Primary care provider                                      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>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>Environmental health:</b> YYYY/ MM / DD <input type="checkbox"/> Restaurant Inspection <input type="checkbox"/> Water system inspection <input type="checkbox"/> Food/Water sampling <input type="checkbox"/> Environmental sampling Investigator name	<b>Other Investigation Findings:</b> <input type="checkbox"/> Investigator Notes <input type="checkbox"/> Document Management Notes			
<b>Immunization:</b> Investigator name <input type="checkbox"/> Eligible immunizations recommended              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	

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### I) OUTCOMES

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"/> Other           | YYYY / MM / DD |
| <input type="checkbox"/> Fatal                        | YYYY / MM / DD | <input type="checkbox"/> Unknown                    | _____          |  |                |

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"/> 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)		
	Crypto 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)

<b>Initial Report completed by:</b>		<b>Date initial report completed:</b> YYYY / MMM / DD
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