

## Cyclosporiasis 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: <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:
<b>CASE</b>		<b>CONTACT</b>		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"/> Biopsy
<input type="checkbox"/> Probable	YYYY / MM / DD			<input type="checkbox"/> Intestinal Fluid
				<input type="checkbox"/> Stool
<b>Disposition:</b>				
<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)		
<b>REPORTING NOTIFICATION</b>		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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Please complete all sections

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

### C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes	Date of recovery	Description	Yes	Date of recovery
	Date of onset			Date of onset	
Abdominal - bloating or distension		YYYY / MMM / DD	Fever - low grade		YYYY / MMM / DD
Cardiac - endocarditis		YYYY / MMM / DD	Flatulence		YYYY / MMM / DD
Asymptomatic		YYYY / MMM / DD	Loss of appetite (anorexia)		YYYY / MMM / DD
Constipation		YYYY / MMM / DD	Nausea		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea - watery		YYYY / MMM / DD	Vomiting		YYYY / MMM / DD
Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD	Weight loss		YYYY / MMM / DD
Fever		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

### 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
Exposure Calculation details:	

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Add'l Info
	Start date		
<b>Contact</b> - At risk population (international travellers or immigrants)	YYYY / MM/DD		
<b>Contact</b> - Persons with diarrhea/vomiting	YYYY / MM/DD		
<b>Contact to a known case</b> (add'l info)			
<b>Immunocompromised</b> - Related to underlying disease or treatment			
<b>Special Population</b> - From or residence in an endemic country (add'l info)			
<b>Travel</b> - Outside of within Canada (Add'l Info)	YYYY / MM/DD AE		
<b>Travel</b> - Outside of Saskatchewan, but within Canada (add'l info)	YYYY / MM/DD AE		
<b>Water</b> – Bottled water (specify)			
<b>Water</b> - Private well or system (Add'l Info)			
<b>Water</b> - Public water system (Add'l Info)			
<b>Water</b> - Untreated water (Add'l Info)			
<b>Water (Recreational)</b> - Pond, stream, lake, river, ocean (Add'l Info)	YYYY / MM/DD		
<b>Water (Recreational)</b> - Private (swimming pool/whirl pool) (Add'l Info)	YYYY / MM/DD		
<b>Water (Recreational)</b> - Public (swimming pool/paddling pool/whirl pool) (Add'l Info)	YYYY / MM/DD		

### F) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication ( <i>Panorama = Other Meds</i> ) : _____
Prescribed by: _____ Started on: YYYY / MMM / DD

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Please complete all sections

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

### G) INTERVENTION

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

Intervention Type and Sub Type:				
<b>Assessment:</b> Investigator name <input type="checkbox"/> Assessed for contacts YYY / MM / DD	<b>Immunization:</b> Investigator name <input type="checkbox"/> Eligible immunizations recommended YYY / MM / DD			
<b>Communication:</b> <input type="checkbox"/> Other communication (See Investigator Notes) YYY / MM / DD Investigator name <input type="checkbox"/> Letter (See Document Management) YYY / MM / DD Investigator name	<b>Public Health Order:</b> <input type="checkbox"/> Order (specify) _____ YYY / MM / DD Investigator name			
<b>General:</b> Investigator name <input type="checkbox"/> Disease-Info/Prev-Control YYY/MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts YYY/MM / DD	<b>Referral:</b> <input type="checkbox"/> Canadian food inspection agency YYY / MM / DD Investigator name <input type="checkbox"/> Primary care provider YYY/MM / DD Investigator name <input type="checkbox"/> Consultation with MHO YYY / MM / DD Investigator name			
<b>Education/counselling:</b> <input type="checkbox"/> Prevention/Control measures YYY / MM / DD <input type="checkbox"/> Disease information provided YYY / MM / DD Investigator name	<b>Testing:</b> Investigator name <input type="checkbox"/> Stool testing recommended (e.g. contacts) YYY / MM / DD <input type="checkbox"/> Laboratory testing recommended (contacts) YYY / MM / DD			
<b>Exclusion:</b> Investigator name <input type="checkbox"/> Daycare YYY / MM / DD <input type="checkbox"/> Preschool YYY / MM / DD <input type="checkbox"/> School YYY / MM / DD <input type="checkbox"/> Work YYY / MM / DD	<b>Other Investigation Findings:</b> <input type="checkbox"/> Investigator Notes <input type="checkbox"/> Document Management Notes			
Date	Intervention subtype	Comments	Next follow-up Date	Initials
YYY / MM / DD			YYY / MM / DD	
YYY / MM / DD			YYY / MM / DD	
YYY / MM / DD			YYY / MM / DD	
YYY / MM / DD			YYY / MM / DD	
YYY / MM / DD			YYY / MM / DD	
YYY / MM / DD			YYY / MM / DD	

### H) OUTCOMES (optional except for severe influenza)

LHN-> INVESTIGATION-> OUTCOMES

<input type="checkbox"/> Not yet recovered/recovering YYY / MM / DD	<input type="checkbox"/> ICU/intensive medical care YYY / MM / DD	<input type="checkbox"/> Hospitalization YYY / MM / DD
<input type="checkbox"/> Recovered YYY / MM / DD	<input type="checkbox"/> Intubation /ventilation YYY / MM / DD	<input type="checkbox"/> Other YYY / MM / DD
<input type="checkbox"/> Fatal YYY / MM / DD	<input type="checkbox"/> Unknown _____	
Cause of Death: (if Fatal was selected) _____		

### I) EXPOSURES

LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> ACQUISITION QUICK ENTRY

<b>Acquisition Event</b> Acquisition Event ID: _____
Exposure Name: _____
<b>Acquisition Start</b> YYY / MM / DD <b>to Acquisition End:</b> YYY / MM / DD
Location Name: _____
<b>Setting Type</b> <input type="checkbox"/> Travel <input type="checkbox"/> Exposure or consumption of potentially contaminated food or water <input type="checkbox"/> Most likely source

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