Meningococcal Disease (invasive) Data Collection Worksheet

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: _____ Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:	Health Card Province: _____ Health Card Number (PHN): _____	Preferred Communication Method: (specify - i.e. home phone, text): Email Address: ☐ Work ☐ Personal
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 the same:	

B) INVESTIGATION INFORMATION

LHN ->SUBJECT SUMMARY-> RESPIRATORY & DIRECT CONTACT ENCOUNTER GROUP-> CREATE INVESTIGATION

Disease Summary Classification: CASE:	**Date**	**Classification: CONTACT:**	**Date**	**LAB TEST INFORMATION:**
☐ Confirmed	YYYY / MMM / DD	☐ *Contact*	*YYYY / MMM / DD*	*Date specimen collected:*
☐ Does Not Meet Case	YYYY / MMM / DD	☐ *Not a Contact*	*YYYY / MMM / DD*	*YYYY / MMM / DD*
☐ Person Under Investigation	YYYY / MMM / DD	☐ *Person Under Investigation*	*YYYY / MMM / DD*	☐ *Blood* ☐ *Other* ☐ *CSF* ☐ *Joint fluid* ☐ *Pericardial fluid*
☐ Probable	YYYY / MMM / DD			

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:
Provider's Phone number:	Date Received (Public Health): YYYY / MMM / DD
Type of Reporting Source: ☐ Health Care Facility ☐ Lab Report ☐ Nurse Practitioner ☐ Physician ☐ Other_____	

C) DISEASE EVENT HISTORY

LHN-> INVESTIGATION->DISEASE SUMMARY (UPDATE)->DISEASE EVENT HISTORY

Site / Presentation: ☐ Meningitis ☐ Sepsis ☐ Unknown

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D) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION-> SIGNS & SYMPTOMS

Description	No	Yes – Date of onset	Description	No	Yes - Date of onset
Arthritis - septic		YYYY / MMM / DD	Neurologic - delerium		YYYY / MMM / DD
Bruising - ecchymoses		YYYY / MMM / DD	Pain - photophobia (sensitivity to light)		YYYY / MMM / DD
Cellulitis - orbital		YYYY / MMM / DD	Prostration		YYYY / MMM / DD
Coma		YYYY / MMM / DD	**Purpura fulminans (coagulation of small blood vessels)**		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Rash - maculopapular		YYYY / MMM / DD
Headache		YYYY / MMM / DD	Rash - petechial		YYYY / MMM / DD
Meningitis		YYYY / MMM / DD	**Sepsis (e.g. bacteremia, septicemia, etc.)**		YYYY / MMM / DD
Nausea		YYYY / MMM / DD	**Shock**		YYYY / MMM / DD
Neck stiffness (nuchal rigidity)		YYYY / MMM / DD			YYYY / MMM / DD
Other s/s					

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 (RF followed by + impact the Immunization Forecaster)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start Date	N, NA, U	Add'l Info
Chronic Medical Condition - Cochlear Implant +			
Chronic Medical Condition Congenital or Acquired, or Functional Asplenia +			
Contact At risk population (international travellers or immigrants) (i.e. risk areas)			
Contact - IMD Case: serogroup A, Y, or W-135 +	YYYY / MM/DD		
Contact - IMD Case: serogroup B +	YYYY / MM/DD		
Contact - IMD Case: serogroup C +	YYYY / MM/DD		
Contact to a known case (Add'l Info)	YYYY / MM/DD		
Immunocompromised – Acquired Complement Deficiency +			
Immunocompromised – Congenital immunodeficiency +			
Immunocompromised - Related to disease or treatment (Add'l Info)			
Immunocompromised - Transplant Candidate or Recipient - Solid Organ/Tissue +			
Occupation - Health care worker - IOM Risk Factor	TE		
Occupation - Child care worker	TE		
Behaviour - Sharing personal items (cigarettes, water bottles, etc)	TE		
Setting - Crowded living conditions (>1 person per room excluding bathrooms)	TE		
Special Population – Attends childcare	TE		
Special Population - Attends school	TE		
Special Population - Lives in a communal setting	TE		

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DESCRIPTION	Yes Start Date	N, NA, U	Add'l Info
Special Population - Post secondary education institution	TE		
Special Population - Self-reported Indigenous			
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		
Travel Within of Saskatchewan (Add'l Info)			
Other risk factor (Add'l Info)			

G) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

Interpretation Date: YYYY / MM / DD **serotype: _____**

Interpretation of Disease Immunity: ☐ IOM - Fully immunized (for age) ☐ IOM - Partially immunized

☐ IOM – Unimmunized ☐ IOM - Unclear immunization history **Valid doses received**: _____ **Doses needed**: _____

Reason:

☐ Previous disease ☐ Previous responder/Previous history of immunity ☐ Date Of Birth

☐ IOM – Interpretation of history by investigator

H) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication ***(Panorama = Other Meds)*** **:** _____

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

I) INTERVENTIONS

INVESTIGATION->TREATMENT & INTERVENTIONS->INTERVENTION SUMMARY

Intervention Type and Sub Type:

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

Immunization: Investigator name
☐ Eligible Immunization recommended YYYY / MM / DD
☐ Disease-specific immunization recommended YYYY / MM / DD
☐ Disease-specific immunization given YYYY / MM / DD

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

Immunoprophylaxis
☐ Immunoprophylaxis (Contacts only)

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

Isolation:
☐ Facility isolation Investigator name YYYY / MM / DD
☐ Home isolation Investigator name YYYY / MM / DD

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

Testing:
☐ Lab testing recommended YYYY / MM / DD
Investigator name

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

Referral:
☐ Consultation with MHO ☐ Primary Care Provider

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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YYYY / MM / DD			YYYY / MM / DD	

J) 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) ____________________________

K) Acquisition Event LHN-> INVESTIGATION-> EXPOSURE SUMMARY-> ACQUISITION EVENT SUMMARY -> QUICK ENTRY

Acquisition Event ID:_________

Exposure Name: ____

Acquisition Start YYYY / MM / DD to **Acquisition End:** YYYY / MM / DD

Location Name: ____

Setting Type

☐ Travel ☐ Health care setting ☐ Public facilities ☐ Recreational facilities ☐ Most likely source

L) Transmission Events LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY

Transmission Event ID	Exposure Name	Setting type (Consider the following settings for TE; if >1 select "multiple settings" in Panorama)	Date/Time	# of contacts
		☐ Congregate/Communal living ☐ Health Care setting ☐ Type of community contact ☐ Household Exposure ☐ Public facilities (daycare, school, etc)	YYYY / MM / DD to YYYY / MM / DD	
		☐ Congregate/Communal living ☐ Health Care setting ☐ Type of community contact ☐ Household Exposure ☐ Public facilities (daycare, school, etc)	YYYY / MM / DD to YYYY / MM / DD	
		☐ Congregate/Communal living ☐ Health Care setting ☐ Type of community contact ☐ Household Exposure ☐ Public facilities (daycare, school, etc)	YYYY / MM / DD to YYYY / MM / DD	
		☐ Congregate/Communal living ☐ Health Care setting ☐ Type of community contact ☐ Household Exposure ☐ Public facilities (daycare, school, etc)	YYYY / MM / DD to YYYY / MM / DD	
	Meningococcal Contacts – Inv ID# _____	☐ Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

M) TOTAL NUMBER OF CONTACTS

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK -> UNKNOWN/ANONYMOUS CONTACTS

Anonymous contacts:________ (total number of individuals [including groups that 1:1 follow-up is not required or is not feasible])

Initial Report completed by:		**Date initial report completed:** YYYY / MMM / DD