

# Section 10

## Documentation



Public health providers in Saskatchewan use an electronic data system (i.e. iPHIS) in which to document assessment findings and response actions so evaluation of programs and policies can be completed. This application includes individual-based reports (profile reports) that can provide summary data on individual cases.

Designated regional users are able to use a reporting tool (e.g. MicroStrategy) to extract and analyze information that has been entered into the electronic data system (i.e. iPHIS) that can provide summary data to inform regional profiles/reports and to identify trends at a local or regional level. Reports are impacted by the quality of data. The materials in this section may be used to review processes and quality of documentation.

The Ministry is able to complement regional monitoring by using this reporting tool to conduct surveillance at a provincial level and to produce provincial reports. The Ministry is able to assess for trends in disease patterns that cross regional health authority borders and has the ability to identify outbreaks or clustering that may not be recognized within a single health region. In order to complete this type of surveillance, consistent data entry based on business rules and standard definitions is necessary. The Ministry can also use the information to evaluate provincial health policies and programs.

The references included or cited in this section strive to provide consistent interpretation and guidance for documenting assessment and responses. This aids in conducting surveillance and informing programming to prevent and reduce the morbidity, mortality and transmission of communicable disease through an efficient and coordinated public health system.

The Communicable Disease Control Manual serves as a primary reference for the public health response to notifiable communicable diseases in Saskatchewan. The mode of transmission, incubation period, risk factors and the epidemiology of the disease are primary considerations that influence the business rules and form the foundation that will guide the investigation, response and subsequent documentation of the findings.

Refer to [Appendix A – Reporting and Follow-Up Timeframes](#) as an important reference for timeframes for investigation and notification to the Ministry.

Section	Reference	Description
<a href="#">10-20</a>	How to Create/Maintain a Client	Business Rules for entering individuals into iPHIS.
<a href="#">10-23</a>	How to Merge Clients	Steps to follow to merge clients when duplicates have been identified.
<a href="#">10-30</a>	How to Create/Maintain a CD Case	Business Rules for creating <b>communicable disease cases</b> in the CD Module in iPHIS – to be used in conjunction with Appendix A, and Case Status Guidance document.
	<a href="#">Attachment – CD Risks</a>	
<a href="#">10-40</a>	How to Create/Maintain an STI Case	Business Rules for creating <b>sexually transmitted infection cases</b> in the STD Module in iPHIS – to be used in conjunction with Appendix A, and Case Status Guidance document.
	<a href="#">Attachment – STI Risks</a>	
<a href="#">10-50</a>	How to Create/Maintain Laboratory Information	
<a href="#">10-60</a>	How to Enter Animal Exposures – Comprehensive Guide	Business Rules for creating <b>animal exposures</b> in iPHIS.
<a href="#">10-62</a>	How to Enter Animal Exposures – Quick Reference	
	<a href="#">Attachment – Definitions for Animal Exposures in iPHIS</a>	Provides guidance for consistent interpretation and documentation of exposures included in the drop down list.
<a href="#">10-63</a>	How to Enter Animal Exposures - Scenarios	

Data Dictionaries/Supporting Documents	
<a href="#">Attachment –iPHIS Case Management Reference Card</a>	A quick reference that outlines interpretation and business rules for use of common fields.
<a href="#">Attachment – Interjurisdictional Policy</a>	Business Rules to support consistent transferring of cases between jurisdictions in an effort to reduce duplicate case counting. Please refer to <a href="#">Appendix B – Interjurisdictional Communication</a> and <a href="#">Appendix 4 - Rules of Residency for Surveillance</a> .
<a href="#">Attachment – iPHIS Cases Status Guidance Document</a>	A Data Dictionary of Case Status elements – ensures that cases meet required criteria to be accounted for as confirmed, suspect, etc.
<a href="#">Attachment – Minimum Data Elements – Core versus Enhanced</a>	A quick reference that outlines the iPHIS fields that require data entry based on the type of Notifiable disease.

Appendices:		
<a href="#">Appendix 1</a>	iPHIS Quick Reference – Confirmed Cases.	Outlines the laboratory and clinical criteria required for assigning a confirmed case status.
<a href="#">Appendix 2</a>	Criteria for Confirmed Cases.	
<a href="#">Appendix 3</a>	Checklist for doing Quality Assurance of Case Records (to be developed).	A checklist outlining data fields that require entry in order to complete regional or provincial program evaluation and surveillance.
<a href="#">Appendix 4</a>	Rules of Residency for Surveillance.	Provides standardization of practice to ensure useful and interpretable surveillance data.

**Purpose:**

- This chapter describes the iPHIS technical functionality and business processes for searching, creating and maintaining clients in iPHIS.
- There are several tabs and fields for client demographic data in iPHIS; it is the purpose of this chapter to address the fields required by the system and for documentation purposes.
- Additional fields beyond the required fields can be filled out as per regional policy but are not required by the Ministry for reporting purposes.
- Red diamonds  to left of some fields indicate they are system required fields.
- Fields for some sections are hidden and can be expanded by clicking the  sign.

**Revision History**

Date	Changes/Comments
May 11, 2016	Initial Draft
June 29, 2016	Update with instructions on searching using Alias Updated the Alias section to align with Merge chapter

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### 1. Client Searches

The client search screen can be accessed directly from the hot link at the top of the screen or via the Demographics hot link.

There are several reasons that a record might not be found in iPHIS:

- The client is recorded in iPHIS under an incorrect spelling or a different name.
- The client's first name and family name have been accidentally transposed.
- The month and day of the client's birth date have been accidentally transposed.
- The client is not recorded in iPHIS.



### Search Client Screen

**\*\*\*Please always check "Include Aliases in Search" when searching for clients\*\*\***

Client Search

Please fill in the following to search for a Client.

PHN	<input type="text"/>	Birth Date	<input type="text"/>
Family Name	<input type="text"/>	First Name	<input type="text"/>
Second Name	<input type="text"/>	Include Aliases in Search	<input checked="" type="checkbox"/>
Age Range	<input type="text"/> To <input type="text"/>	Year Of Birth Range	<input type="text"/> To <input type="text"/>
Gender	<input type="text"/>	HA	<input type="text"/>
Country Emigrated From	<input type="text"/>	Client Visit Between	<input type="text"/> and <input type="text"/>
Phone	<input type="text"/>	Client ID	<input type="text"/>
DIAND Number	<input type="text"/>		

Client Address Criteria

Type	<input type="text"/>	Street Number	<input type="text"/>	Street Name	<input type="text"/>
Facility Name	<input type="text"/>	Street Type	<input type="text"/>	Street Direction	<input type="text"/>
Unit Number	<input type="text"/>	City	<input type="text"/>		

Sort Order Ascending/Descending

Exact Name Match	<input type="text"/>	DESCENDING
HA	<input type="text"/>	ASCENDING
Name	<input type="text"/>	ASCENDING
Gender	<input type="text"/>	ASCENDING
Birth Date	<input type="text"/>	ASCENDING
Validated	<input type="text"/>	ASCENDING

Search Retrieve Criteria

**a. Creative Querying**

Creative querying reduces the likelihood that a client is already recorded in iPHIS before you add a new client record and can prevent duplicate records from being entered into iPHIS.

**Recommendation:** It is suggested to start with a broader search and narrow it down depending on the number of clients found.

Strategies for creative querying include;

- Use *Wildcard Searches* if:
  - You have missing or incomplete information for a search criterion; and,
  - You want to return a complete list of all entries.
  
- There are five different ways to utilize the wildcard:
  - **%smith** – returns entries that end with smith i.e. Blacksmith, Goldsmith;
  - **smith%** - returns all entries that begin with smith i.e. Smith, Smitherman;
  - **%smith%** - returns all entries that contain “smith” i.e. Blacksmith, Goldsmith Smith, Smitherman;
  - **sm%h** – returns all entries that begin “sm” and end “h” i.e. Smith, Smyth, Smoh; and
  - **%** - returns a complete list of all entries in the database.

**NOTE:** you can combine the above types of wildcard searches in a single search i.e. **%sm%th%**

**Recommendation:** Please do a thorough search to ensure the client you are searching for doesn't already exist before creating a new one.

**b. Reviewing Client Search Results**

All clients that meet the search criteria will be displayed with the following options:

Client Search									
Exact Name Match	Client ID	PHN	HA	Branch	Name	Gender	Birthdate	Validated	
✓	10021040	122333666	0		BOTULISM, BETTY	FEMALE	1945-12-31	✓	<a href="#">Details</a> <a href="#">Select</a> <a href="#">View</a>
	10022306		0		SPEARS, BRIT	FEMALE	1986-05-01		<a href="#">Details</a> <a href="#">Select</a> <a href="#">View</a>
	10003037	898232000	0	SAMPLE BRANCH	SPEARS, BRITTANY	FEMALE	1980-01-07	✓	<a href="#">Details</a> <a href="#">Select</a> <a href="#">View</a>
	10017012		0		SPEARS, BRITTNEY	FEMALE	1980-12-25		<a href="#">Details</a> <a href="#">Select</a> <a href="#">View</a>

[Search Again](#)
[Add Client](#)

**View**

- This will bring up a small window with detailed demographic data. This is useful when you aren't sure if it is the right client or not.

**Details**

- This will take you to the client demographic screen. This is useful if you want to make changes to the client demographics.

**Select**

- This will put the selected client into context. Once in context this will be the client you are working with until you select a different client or log out.

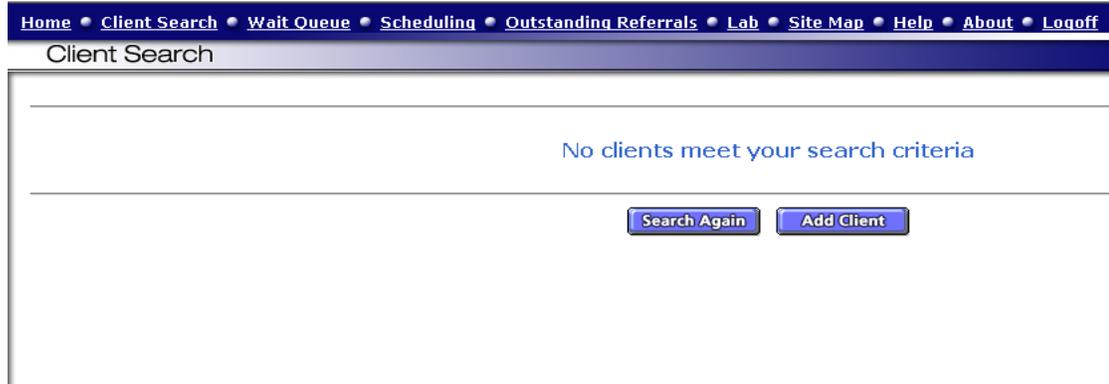
**Search Again**

- This will take you back to the search screen where you can try another search using different criteria if the client you are looking for isn't returned in the search.

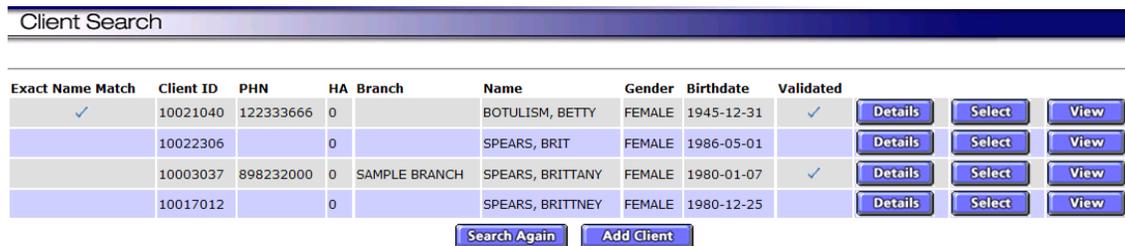
**Add Client**

- This will take you to the Demographics Detail screen where you can create a new client. Use only after you are sure the client doesn't already exist. See section 2 for instructions on adding a new client.

• **Screen shot where no clients matched the search criteria**



• **Screen shot where a few clients matched the search criteria**



- Screen shot with a client in context shown at the top of the screen

Home Client Search Wait Queue Scheduling Outstanding Referrals Lab Site Map Help About Logoff

### Case

Name	* ANTHRAX, ABBY	Birth Date	1999-04-03	Reported Date	2012-06-01	Profile Report
Client ID	10021037	Gender	FEMALE	Episode Date	2012-06-01	
Client Address at Time of Case	No address selected for this case	Age At	13yr 1mo	Episode Date Type	REPORTED	
PHN		Case ID	69093			
Disease	Toxoplasmosis					

Exemptions Adverse Contraindication Notes File

**client** Exemption Adverse Contraind Organ/Bld Allergies Alerts Files

**case** Case Lab Signs/Sym. Comm/Inc Risks Exposures Contacts Interven. Outcome

Imms/TST Physicians Notes

## 2. Creating a new client

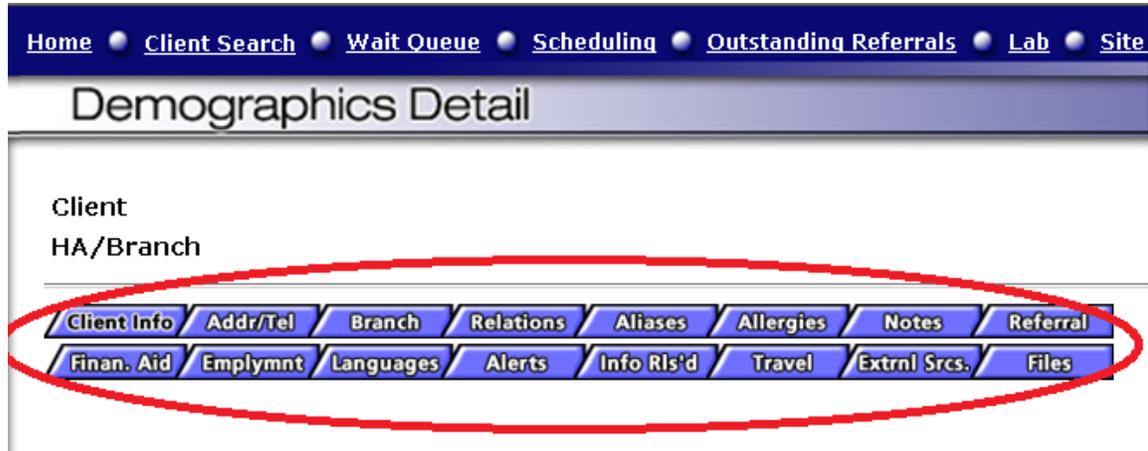
- If the desired client is not found, click the Add Client button and the Demographics Detail screen appears. The clients details that were entered in the Search Criteria screen will pre-populate on the Client Demographics screen.
- Complete the Demographics Detail screens as per instructions below.

## 3. Updating an existing client

- If the desired client is found, click the Details button to set the client into context and bring up the Client Detail screen.
- Review and update the Demographics Detail screens as per instructions below.
- Most clients get registered from lab reports where all required information is not known. It is important to complete the required fields as the information becomes available.

#### 4. Client demographic module

- There are several tabs in the demographic module. The intent of this chapter is to only cover the tabs and elements that are most commonly used and the system required elements.



**a. Client Info**

[Home](#) • [Client Search](#) • [Wait Queue](#) • [Scheduling](#) • [Outstanding Referrals](#) • [Lab](#) • [Site Map](#) • [Help](#) • [About](#) • [Logout](#)

**Demographics Detail**

Client \* / ANTHRAX, ABBY / 10021037 / FEMALE / 1999-04-03 / (250) 747-3265

HA/Branch SAMPLE HA / SAMPLE BRANCH

Client Info / [Addr/Tel](#) / [Branch](#) / [Relations](#) / [Aliases](#) / [Allergies](#) / [Notes](#) / [Referral](#)  
[Inm Aid](#) / [Emplmnt](#) / [Languages](#) / [Alerts](#) / [Info Rpt](#) / [Travel](#) / [Extral Srcs](#) / [Files](#)

**Client Information**

PHN Assigning Authority   
 PHN  Validated  Sensitive   
 HA  Branch   
 Family Name  First Name   
 Second Name  Common Name   
 Birth Date   Accurate  OR Birth Year (YYYY)   
 Marital Status  Date of Death   Accurate   
 Birth Province (if born in Canada)  Gender   
 Ethnicity   
 Inactive Reason  Active  Inactive Date   
 Client Email Address  Consent to use email

**Immigration and Other**

Immigration File Number  Birth Country (if born outside Canada)   
 Immigration Form Received Date   Fathers Country of Birth   
 Mothers Country of Birth   
 Arrived Date   Accurate  OR Arrived Year   
 Country Emigrated From   
 Country Last Resided   
 Country Last Resided - Mother   
 Country Last Resided - Father   
 Current Immigration Status   
 Immigration Status At Time Of Arrival into Canada   
 Date Reported For Surveillance

**First Nations**

DIAND Number  Status   
 Community  Health Centre Zone   
 \*Check Filter by Community and/or enter Band of Origin  
 Band of Origin Filters   Band of Origin    
 Band of Origin

Enter Required Fields and click Save.

- Required Fields:

Client Info Tab		
Field Name	Description	Business Rule / Comments
PHN	Enter the Health Services Number (HSN)	This is the unique client identifier and should be entered if known. Always try to obtain this number before creating a client. Shared Client Index (SCI) can be used to obtain the HSN number if it isn't known.  HSNs from other jurisdictions should be used and appropriate PHN Assigning Authority designated.
PHN Assigning Authority	From the drop-down list, select the HSN type.	Make sure you select the proper Assigning Authority switching from the default when entering out of province HSNs.  If no HSN is known leave this field blank and create the client without a PHN.
Validated	This field must be checked for every client that is entered regardless if a PHN number is entered.	The system will not allow users with access to the CD Module to see clients that are not "validated". This results in duplicate clients being entered into the system.

**Important:** The validated field must be checked for every client that is entered regardless if a PHN number is entered.

Client Info Tab		
Field Name	Description	Business Rule / Comments
HA	From the drop-down list, select the Health Authority.	Defaults to the users' regions.
Branch	From the drop-down list, select the branch. List is RHA configured and varies by region.	Mandatory for FNIHB and NITHA to select the RHA the client is geographically located in.  Health regions may choose to

Client Info Tab		
Field Name	Description	Business Rule / Comments
		associate with a branch office.  NOTE: If the branch is updated it impacts the historical cases/encounters
Family Name	Free text field, enter the clients last name.	Care should be taken to ensure proper spelling so the client can be found when searching.
First Name	Free text field, enter the clients first name.	Care should be taken to ensure proper spelling so the client can be found when searching. Enter first name as included on lab report. Middle name should be entered in the middle name field (i.e. not as part of the first name).
Common Name		If the client goes by a name other than their first name, enter their common name here.
Birth Date	Either select from the calendar the correct month and year and update to the appropriate year OR enter the date in YYYY-MM-DD format.	Care should be taken to ensure proper format so the client can be found when searching, or use the calendar to select the date and change the year.
Date of Death	Either select from the calendar OR enter the date in YYYY-MM-DD format.	When the Date of Death is entered in a Case/Encounter this field will be auto populated.  Only enter Date of Death in the Case/Encounter if the disease is related to the cause of death.  If death is unrelated to the Case/Encounter, it is not mandatory to complete. However, if desired it should be entered into the Client Info tab and not in the Case or Encounter tab.
Gender	From the drop-down list, select the gender of the client.	Unless known to be wrong, use what is on the lab report.
Ethnicity	From the drop-down list, select the ethnicity of the client.	<b>Only if relevant to the case</b> – refer to <a href="#">Disease-Specific Requirements</a> (Under development).
<b>Immigration – click the + sign to expand - Only if relevant to the case</b>		
Birth Country	From the drop-down list, select	Only if relevant to the case – refer to

Client Info Tab		
Field Name	Description	Business Rule / Comments
	the country where the client was born.	<a href="#">Disease-Specific Requirements</a> (Under development).
Year Arrived	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format.	Actual date or approx. This is the date that they arrived in Canada regardless of refugee status.
Country last Resided	Drop down list	The last country the client permanent address
Date Reported for Surveillance	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format.	Due to the sensitive nature of the diseases that are required to report for surveillance, documentation in the demographics could constitute a breach of privacy; Therefore this information should be documented within the Notes of the case or encounter.
<b>First Nations - click the  sign to expand (Mandatory for FNIHB and NITHA if known) not required for RHA input</b>		
Community		Used by FNIHB/NITHA (not required for reporting) – Not on the lab and may not be known at time of registration but should be completed later when known.  NOTE: As the community is updated it effects the historical case/encounters

**b. Address and Telephone Tab**

- Document the client’s address or telephone data to facilitate future communication with the case. Refer to regional policy.
- In the Address and Telephone tab click the New Address button.

The screenshot shows the top navigation bar with links: Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, Logoff. Below this is the 'Address/Telecommunication' section. Client information is displayed: / HUGH, BOB / 10031956 / MALE / 2012-02-20 / 0. There are buttons for 'Assign to wait queue' and 'Client Profile Report'. A horizontal menu contains tabs: Client Info, **Addr/Tel**, Branch, Relations, Aliases, Allergies, Notes, Referral, Finan. Aid, Employment, Languages, Alerts, Info Risk, Travel, Extnl Srvc, Files. Below the menu, the 'New Address' button is circled in red. A note says: 'Remember to set the "Effective To" date for old/historical addresses.' Below this is a table with columns: Type, Street, City, Province, Postal Code, Effective From, Effective To. Another 'New Telephone' button is circled in red. A note says: 'Remember to set the "Effective To" date for old/historical telecommunications.' Below this is a table with columns: Type, Area Code, Number, Effective From, Effective To.

- On the Address screen enter required fields and save.
- Previous addresses: Use if applicable city and province or state where resident lived when first diagnosed.
- **Fields:**

Address/Telephone		
Field	Description	Business Rule / Comments
Type	From the drop-down list, select the type of address.	Choose as appropriate from the drop-down list.
Effective From	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format.	If accurate date is not known, choose one month prior to specimen collection date.
Effective To	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format.	Update as information becomes available with subsequent cases.
Street Name	Free text field, enter the street name.	Include the complete address at the time of the case referring to the <a href="#">Rules of Residency</a> . The appropriate address will be assigned in the CD/STD Module. It is required for some diseases and for reporting to Public Health Agency of Canada – refer to Reference Guides for Creating Cases and Encounters. NOTE: If no address is entered, the field “Address at time of case” in the CD and STD modules does not display.
City	From the drop-down list, select the city.	As above
Province	From the drop-down list, select the province.	As above
Country	From the drop-down list, select the country.	As above
Postal Code	Free text field, enter the postal code.	As above

**Address/Telecommunication**

Client / HUGH, BOB / 10031956 / MALE / 2012-02-20 / () [Assign to wait queue](#) [Client Profile Report](#)

HA/Branch SAMPLE HA /

[Client Info](#) [Addr/Tel](#) [Branch](#) [Relations](#) [Aliases](#) [Allergies](#) [Notes](#) [Referral](#)  
[Finan. Aid](#) [Emplymnt](#) [Languages](#) [Alerts](#) [Info RIS'd](#) [Travel](#) [Extrnl Srcs.](#) [Files](#)

**Client Address Information**

Type  Primary Indicator   
 Effective From  Effective To

Shared by 0 client(s)

**Shared Address Information**

Street  
 Street Number  Street Name   
 Street Type  Street Direction   
 Unit Number   
 City  Municipality   
 Province  SASK  
 Country  CANADA Postal Code   
 Comments

[Save](#) [Delete](#)

- After saving the address you are returned to the main Address and Telephone screen where the address will be displayed.
- You can make changes to the address by clicking the Details button.

**Address/Telecommunication**

Client / HUGH, BOB / 10031956 / MALE / 2012-02-20 / () [Assign to wait queue](#) [Client Profile Report](#)

HA/Branch SAMPLE HA /

[Client Info](#) [Addr/Tel](#) [Branch](#) [Relations](#) [Aliases](#) [Allergies](#) [Notes](#) [Referral](#)  
[Finan. Aid](#) [Emplymnt](#) [Languages](#) [Alerts](#) [Info RIS'd](#) [Travel](#) [Extrnl Srcs.](#) [Files](#)

[New Address](#) Remember to set the "Effective To" date for old/historical addresses.

Type	Street	City	Province	Postal Code	Effective From	Effective To	<a href="#">Details</a>
HOME		REGINA	SASK		2012-02-27		

[New Telephone](#) Remember to set the "Effective To" date for old/historical telecommunications.

Type	Area Code	Number	Effective From	Effective To
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- A client can have multiple addresses. Add additional addresses by clicking on the New Address button.

**c. Branch**

**d. Relations**

- Documenting in this tab is not mandatory.

**e. Aliases**

- When duplicate clients have been inadvertently created following a name change and have subsequently been merged, the user can merge the client's name as an alias.

**f. Allergies**

- Documenting in this tab is not mandatory.

**g. Notes**

**h. Referral**

- Documenting in this tab is not mandatory.

**i. Financial Aid**

- Documenting in this tab is not mandatory.

j. Employment

**Updated Recommendation: Do not use Employment Tab**  
 Communicable disease information should not be included in the Demographics module. Use the Sensitive Occupation field in the CD/STD module

The screenshot shows the 'Employment' tab of a client management system. At the top, there's a header 'Employment' and client information: 'Client / HUGH, BOB / 10031956 / MALE / 2012-02-20 / ()'. Below this are buttons for 'Assign to wait queue' and 'Client Profile Report'. A navigation bar contains tabs: Client Info, Addr/Tel, Branch, Relations, Aliases, Allergies, Notes, Referral, Finan. Aid, Employmt, Languages, Alerts, Info RI's'd, Travel, Extrnl Srce., and Files. The 'Employment' tab is selected. The form includes:
 

- Occupation: A dropdown menu with a red arrow icon.
- Employer Name: A text input field.
- Estimated Start Date: A date picker.
- Estimated End Date: A date picker.
- Population At Risk Type: A text input field.
- Comments: A large text area.
- Work Address: A text input field.
- Area Code: A text input field.
- Work Phone: A text input field.
- # Of Years At Occupation: A text input field.
- Buttons: 'Save' (circled in red) and 'Delete'.

k. Languages

- Documenting in this tab is not mandatory

l. Alerts

- Documenting in this tab is not mandatory

m. Information Released

- Documenting in this tab is not mandatory

n. Travel

- Documenting in this tab is not mandatory

o. External Sources

- Documenting in this tab is not mandatory

p. Files

- Documenting in this tab is not mandatory

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## Purpose

- This chapter describes the required steps to merge two clients in iPHIS into a single client.

## Revision History

Date	Version	Author	Changes/Comments
Dec 03, 2015	V0.1	Vincent Poliquin eHS	Initial Draft
Jan 07, 2016	V0.2	Vincent Poliquin eHS	Update with instructions on selecting Merge Into and From Clients and Data quality checks following the merge.
Jun 16	V0.3	Vincent Poliquin eHS	Updated document to include: <ul style="list-style-type: none"><li>• The create Alias functionality;</li><li>• How to search for duplicates; and</li><li>• Notes on how you cannot merge into an invalidated client</li></ul>

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### 1. Cautions/Warning

Merging two iPHIS clients into a single client is not reversible. Please ensure you have enough hard copy information to recreate the Clients, Labs, Cases and/or Investigations if needed.

**Important:** Ensure you have enough hard copy information to recreate the Clients, Labs, Cases and/or Investigations if needed.

### 2. Merge Functionality

Each RHA has a designated user trained in merging. Merge permission has been granted to these users.

Users who find a duplicate client should speak to the designated user for the authority and request a merge of the clients.

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### 3. Pre Merge

Ensure you have enough information before the merge (i.e., screen shots, profile reports, demographic and case/encounters, etc.) for both clients so you can:

- Verify the data merged correctly; or
- Recreate the original clients and corresponding cases in the event of an error.

#### a. Determine Destination Client

To determine which client record will be the **Merged Into** Client (aka Master) and which will be the **Merged From** Client (aka Duplicate), review both client records and determine the Destination Client.

- The **Merge Into** or Destination client (aka 'Master' record), is the client record that remains active and receives the selected data from
- The **Merge From** Client (aka 'Duplicate' record), is the client record that becomes idle and is no longer accessible after the merge is completed.

#### Important – Selecting the Destination Client Guidelines

- The client with the oldest internal Id should be the Destination Client.
- The Destination Client should be the Client with the most case/encounter details currently included.
- The Destination Client cannot be an invalidated client. If the client you want to merge into isn't validated, you will need to change them to validated before you start the merge.

Ensure you have enough hard copy information to recreate the Clients, Labs, Cases and/or Investigations if needed.

### 4. Post Merge

#### a. Data qualities check following the merge

It is important to check the client record after the merge to ensure all demographic, case/encounter, and Lab data merged correctly to the correct client.

The following checklist can be used to manually review and update the Destination Client's clinical record after the merge has been submitted.

**Client Level** ([Refer to How to Create/Maintain a Client](#))

	Personal Information: Check to ensure the Date of Birth does not fall after the Date of Death (if there is one).
	Correct address and telephone numbers are on the merged record and any incorrect addresses and telephone numbers are or inactivated.
	Allergies and Risk Factors: Delete any duplicates.
	Notes cannot be deleted. Instead update the note to indicate if it is a duplicate. If an update is required, prefix the subject line with "Duplicate".
	Client Alerts: Delete any duplicates. Delete any Client Warnings added by users when manually tagging the duplicate record.

**Case/Encounter Information** ([See How to Create/Maintain a CD Case](#) and [How to Create/Maintain an STI Encounter](#))

	Case/Encounter details (diagnosis, date and case status).
	Laboratory information for each case.
	Case details including symptoms, notes, interventions, treatments, exposures, etc.

## 5. Merge Client Steps

Step	Action	Outcome
<b>1</b>	<b>Logon to iPHIS</b>	
	1.1 Open a browser and navigate to the iPHIS logon screen 1.2 Enter your username and password (Organization\username) 1.3 Click the <b>LOGON</b> logo	User is logged onto iPHIS
<b>2</b>	<b>Navigate to the MERGE CLIENTS screen</b>	
	2.1 On the left hand navigation bar click on <b>ADMINISTRATION</b> and select <b>MERGE CLIENTS</b>	User is on the Merge/Duplicate Search screen
	 <p>The screenshot shows the 'Welcome to the Public Health Informatics' interface. On the left is a navigation menu with 'ADMINISTRATION' highlighted in yellow. Under 'ADMINISTRATION', 'MERGE CLIENTS' is also highlighted in yellow. Other menu items include DEMOGRAPHICS, GENERAL, SYSTEM ADMIN, CD, TB, STD, LAB, MASS, PUBLIC HEALTH, OUTBREAK, REPORTS, LOGOFF, WAIT QUEUE MAINTENANCE, MAINTAIN EXTERNAL SOURCES, SCHEDULE MAINTENANCE, FIRST NATIONS SURVEY, IMM MAINTENANCE, and SKIN TEST MAINTENANCE. The main area features the iPHIS logo and the text 'Public Health Informatics'.</p>	

3	Search for and select the Merge Into and Merge From Clients																														
<p>There are two different ways to look for and merge duplicate clients in iPHIS:</p> <ul style="list-style-type: none"> <li>The first way (Step 3A) is when you know the name of the two duplicate records that you want to merge; and</li> <li>The second way (Step 3B) uses the system to find potential duplicates.</li> </ul> <p>Follow the steps in either 3A or 3B and then continue on with step 4.</p> <div style="border: 1px solid #ccc; padding: 10px; margin: 10px 0;"> <div style="background-color: #d9d9d9; padding: 2px; border: 1px solid #ccc; margin-bottom: 5px;">Merge/Duplicate Search</div> <div style="border: 2px solid red; padding: 5px;"> <p><b>Search for Clients</b></p> <p><input type="button" value="Find Client"/>      Family Name      First Name</p> <p>Merge Into Merge From</p> <p><input type="button" value="Go to Merge"/></p> </div> <p style="text-align: center; color: red; font-size: 2em; margin: 10px 0;">← Step 3A</p> <p style="text-align: center; color: blue; font-weight: bold;">OR</p> <div style="border: 2px solid red; padding: 5px;"> <p><b>Check for Duplicate Clients</b></p> <p><input checked="" type="radio"/> HA      <input type="radio"/> Province</p> <p>First Name      <input type="checkbox"/></p> <p>Family Name      <input type="checkbox"/></p> <p>Birthdate      <input type="checkbox"/></p> <p>PHN      <input type="checkbox"/></p> <p><input type="button" value="Search"/></p> </div> <p style="text-align: center; color: red; font-size: 2em; margin: 10px 0;">← Step 3B</p> </div>																															
3A	Search Select Two known Duplicate Clients to Merge																														
<p>3A.1 Click on the <b>Find Client</b> button</p> <div style="border: 1px solid #ccc; padding: 10px; margin: 10px 0;"> <p><b>Search for Clients</b></p> <p><input style="border: 2px solid red;" type="button" value="Find Client"/>      Family Name      First Name</p> <p>Merge Into Merge From</p> </div> <p>3A.2 Search for the client that the duplicate client will be merged into</p> <p>3A.3 Click the <b>Select</b> button</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th>Exact Name Match</th> <th>Client ID</th> <th>PHN</th> <th>HA#</th> <th>Branch Name</th> <th>Gender</th> <th>Birthdate</th> <th>Validated</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">✓</td> <td>10123277</td> <td></td> <td>0</td> <td>FLINSTONE, FRED</td> <td>MALE</td> <td>1963-02-18</td> <td style="text-align: center;">✓</td> <td style="border: 2px solid red;"><input type="button" value="Select"/></td> <td><input type="button" value="View"/></td> </tr> <tr> <td style="text-align: center;">✓</td> <td>10123278</td> <td></td> <td>0</td> <td>FLINSTONE, FREDDY</td> <td>MALE</td> <td>1963-02-18</td> <td style="text-align: center;">✓</td> <td><input type="button" value="Select"/></td> <td><input type="button" value="View"/></td> </tr> </tbody> </table>	Exact Name Match	Client ID	PHN	HA#	Branch Name	Gender	Birthdate	Validated			✓	10123277		0	FLINSTONE, FRED	MALE	1963-02-18	✓	<input type="button" value="Select"/>	<input type="button" value="View"/>	✓	10123278		0	FLINSTONE, FREDDY	MALE	1963-02-18	✓	<input type="button" value="Select"/>	<input type="button" value="View"/>	<p>Two clients are selected (One Merge Into and one Merge From) and we are ready to begin the merge</p>
Exact Name Match	Client ID	PHN	HA#	Branch Name	Gender	Birthdate	Validated																								
✓	10123277		0	FLINSTONE, FRED	MALE	1963-02-18	✓	<input type="button" value="Select"/>	<input type="button" value="View"/>																						
✓	10123278		0	FLINSTONE, FREDDY	MALE	1963-02-18	✓	<input type="button" value="Select"/>	<input type="button" value="View"/>																						

3A.4 Click on the **Find Client** button again

3A.5 Search for the client that will be merged into the first client selected

3A.6 click the **Select** button

Exact Name Match	Client ID	PHN	HA#	Branch Name	Gender	Birthdate	Validated		
✓	10123277		0	FLINSTONE, FRED	MALE	1963-02-18	✓	<input type="button" value="Select"/>	<input type="button" value="View"/>
✓	10123278		0	FLINSTONE, FREDDY	MALE	1963-02-18	✓	<input style="border: 2px solid red;" type="button" value="Select"/>	<input type="button" value="View"/>

3A.7 You should now be on the Merge/Duplicate Search screen with two clients (1 Merge Into and 1 Merge From client)

Merge/Duplicate Search

Search for Clients

Merge Into

Merge From

Family Name	First Name
FLINSTONE	FRED
FLINSTONE	FREDDY

3A.8 Click on the **Go to Merge** button

Merge/Duplicate Search

Search for Clients

Merge Into

Merge From

Family Name	First Name
FLINSTONE	FRED
FLINSTONE	FREDDY

3A.9 Go to **Step 4** next

**3B Use the System to Search for Potential Duplicates**

The **Check for Duplicate Clients** functionality can be used to search for potential duplicate clients. The search criteria (first name, last name, etc.) can be used independently or in any combination.

3B.1 Check the boxes you want the system to look for duplicates and click the **Search** button. Note: You can only search within your Health Authority (HA).

Merge is started

### Check for Duplicate Clients

HA       Province  
 First Name        
 Family Name        
 Birthdate        
 PHN     

Search

3B.2 If any duplicates are found they will be displayed in the **Merge/Duplicate Search Results table**. In the sample below I searched for all clients with the same first name. If no duplicates are return or you determine the clients are not duplicates you can go back to the search screen by clicking the **Search Again** button. If it is determined that the clients are duplicates go to step **3B.3**.

Merge/Duplicate Search Results

HA	PHN	Name	Gender	Birthdate	To	From
SAMPLE HA		EXCEPTION4, SQL	FEMALE	1980-11-18	<input type="radio"/>	<input type="radio"/>
SAMPLE HA		EXCEPTION, SQL	FEMALE	2000-11-05	<input type="radio"/>	<input type="radio"/>
SAMPLE HA		EXCEPTION3, SQL	FEMALE	1999-11-26	<input type="radio"/>	<input type="radio"/>

Go to Merge      Search Again



All clients have the same first name

3B.3 If you determine that two (or more) clients are duplicates you can merge them by selecting the To and From clients by highlighting the radio buttons beside the names and clicking the **Go To Merge** button.

Merge/Duplicate Search Results

HA	PHN	Name	Gender	Birthdate	To	From
SAMPLE HA		EXCEPTION4, SQL	FEMALE	1980-11-18	<input type="radio"/>	<input type="radio"/>
SAMPLE HA		EXCEPTION, SQL	FEMALE	2000-11-05	<input checked="" type="radio"/>	<input type="radio"/>
SAMPLE HA		EXCEPTION3, SQL	FEMALE	1999-11-26	<input type="radio"/>	<input checked="" type="radio"/>

Go to Merge      Search Again

<p>3B.4 Continue on at <b>Step 4</b></p> <p><b>Note:</b> You can only merge two clients at one time. If 3 or more duplicates are found you will need to walk through the steps again.</p>	
<b>4</b>	<b>Merge the Clients</b>
<p><b>Notes before starting:</b></p> <ul style="list-style-type: none"> <li>• <b>Merging two clients into one client is not reversible. Ensure you have enough hard copy data to recreate the Client(s), Case(s)/Investigation(s) and Lab(s) if required.</b></li> <li>• <b>After merging the two clients, double check all Client, Case(s), Investigation(s) and Lab(s) to ensure the data was properly merged and adjust as needed.</b></li> </ul>	
<p>4.1 In the Merge <b>Clients, TB, STD and Other, Immigration And Other,</b> and <b>First Nations</b> section, merge any additional or current information by using the  buttons located between the <b>Merge Into</b> and <b>Merge From</b> clients.</p> <p>4.2 If you need to merge all of the information, click  .  <b>NOTE:</b> Merging all of the information will cause everything in the <b>Merge Into</b> information to be overwritten with the <b>Merge From</b> information. For example, if the branch field in the <b>Merge Into</b> information is set to Saanich and the corresponding field in the <b>Merge From</b> is blank, the field is changed to the blank setting.</p> <p>4.3 If you need to clear all of the changes made, click  .      Both the <b>Merge Into</b> and <b>Merge From</b> fields are reset with their original information values.</p> <p>4.4 In the <b>Merge Comments</b> field, enter any details regarding the merge.</p> <p>4.5 To create an alias of the <b>Merge From</b> record:</p> <ul style="list-style-type: none"> <li>• From the <b>Create From As Alias</b> drop-down list, select the appropriate type of alias.</li> <li>• Check the <b>Create From As Alias</b> checkbox.</li> </ul> <p>4.6 Click  .      The Merge/Duplicate Search screen reappears and all records created for both clients will be merged into one ('merge into' client).</p>	<p>Merge is completed and user is returned to the Merge/Duplicate Search screen</p> <p>This records the merge from client's name as an alias in the merge into client record</p>

<p><b>NOTE:</b> If both the 'merge-from' client and 'merge-into' client have open TB Episodes they cannot be merged. One of the Episodes will need to be closed before they can be merged.</p> <p><b>NOTE:</b> If both the 'merge-from' client and 'merge-into' client have TB Episodes and thus status history records, the history records from the 'merge-from' client will be deleted and the 'merge-into' client's will be kept.</p> <p><b>NOTE:</b> Upon a successful merge, the current client will be refreshed with current data if the client is either the 'merge from' or 'merge into' client.</p>		
<b>5</b>	<b>Verify Merged Data</b>	
<p>5.1 Look at the <b>Merged Into</b> client to verify that the Client Demographic, Case(s), Encounter(s) and Lab(s) data was properly and successfully merged.</p>		Merge data is validated
<b>End</b>		

**Purpose:**

- This chapter describes the iPHIS technical functionality and business processes for creating CD Cases.
- There are several tabs and fields in the CD Module; it is the purpose of this chapter to cover the fields required by the system and for notification purposes.
- Even though not all fields are required for notification purposes, in the interest of creating a comprehensive public health record, comprehensive documentation should be completed in iPHIS.
- Red diamonds ♦ to left of some fields indicate they are system required fields.
- Fields for some sections are hidden and can be expanded by clicking + sign.

[Appendix A – Reporting and Follow-up Timelines](#) must be followed. As case investigations progress within RHAs and FN jurisdictions, information should be updated into iPHIS, particularly for the diseases with reporting timeframes of less than two weeks.

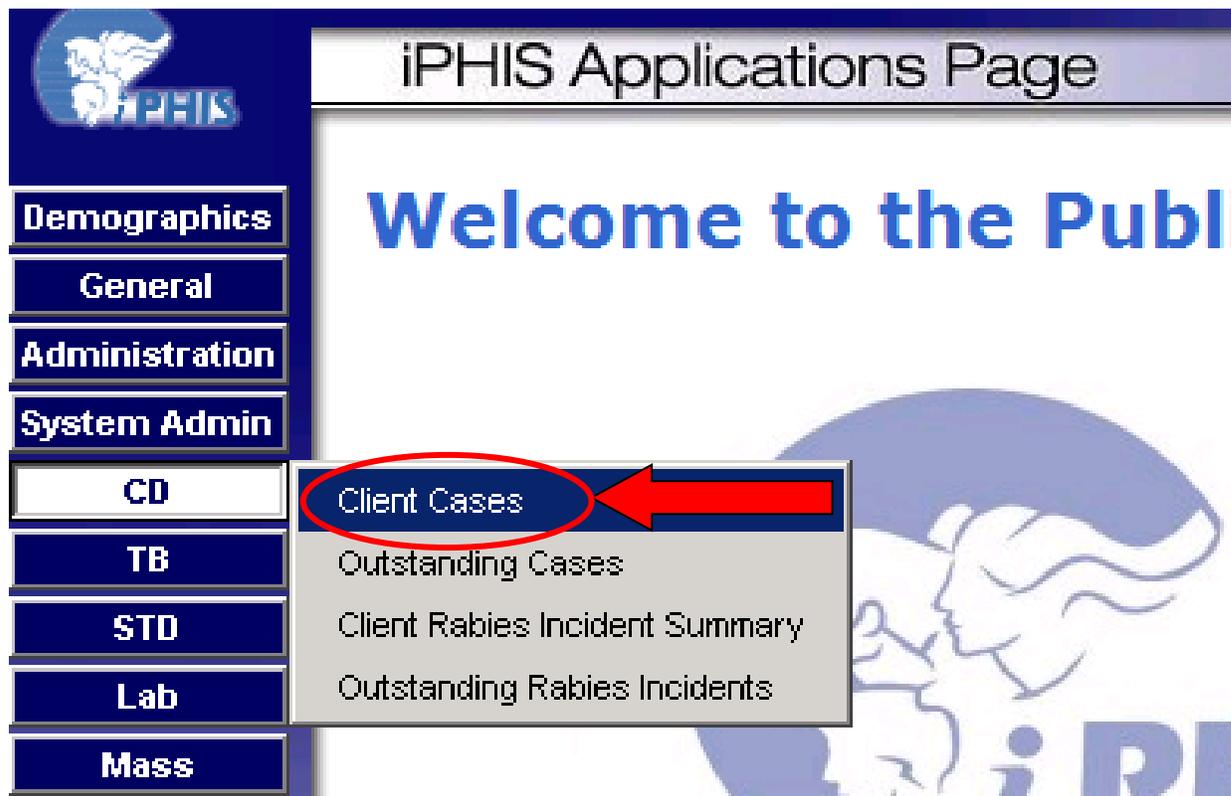
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  - a. [New Case](#)
  - b. [Updating Case](#)
3. [Communicable Disease Module](#)
  - a. [Case](#)
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  - e. [Risks](#)
  - f. [Exposures](#)
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  - i. [Outcome](#)
  - j. [Immunization/TST \(Tuberculin Skin Test\)](#)
  - k. [Physicians](#)
  - l. [Notes](#)

## 1. Client Searches

See [Create/Maintain a Client](#) for more information

Once a client has been selected, click on CD hot link in the left navigation bar and select Client Cases



## 2. Determining when to Update a case or create a New case

If the client has previous cases, the cases will be listed.

Regardless of the trigger for reporting a case (e.g. a call from a physician, a referral from another health region or receiving a lab report from the local or provincial lab), it is important to follow the steps outlined below:

1. Review current cases reported for the client.
2. If a case currently exists for the disease that is being reported details about the disease must be considered by the public health investigator to determine if the current case should be updated or if a new case should be created.

Considerations:

- Acute or chronic nature of the disease being reported (e.g. invasive meningococcal versus hepatitis C).
  - Chronic diseases typically should be updated rather than entered as a new case.
  - For acute diseases, the date of the previous reported case should be considered to determine if this is a new episode of the same disease or if this is merely updated information for the same case. Diseases have timeframes within which a subsequent lab report would still be considered the same case (e.g. some enteric illnesses require stool specimens from workers before returning to work. These positive results would not indicate a new case). This is for the Public Health investigator to determine based on the organism.
- Is this an updated lab report of the previously reported case? NOTE – the specimen collection date should be reviewed as some diseases require samples to undergo further testing or be sent to the national microbiology lab (NML) or other specialty labs for further testing which can create significant time lapses and the appearance that it is a new case (e.g. typing for Salmonella).

Other Considerations:

- Lab results may be directed to MHOs for both a First Nations jurisdiction (FNIHB or NITHA) and the RHA of the client's address. In these situations, it is important for First Nations and RHA counterparts to communicate when it is not clear which health authority should be reporting the case. Sometimes this may take multiple calls to make the final determination.
- When the case has been entered by one authority in error, it is essential that case status be updated to accurately reflect the appropriate status (e.g. referred and counted in another health authority).

**Important: Creating new encounters (cases) when cases should be updated causes data quality issues.**

Careful consideration of previously reported cases by the Public Health Investigator or the CD Coordinator before new cases are created can save much time of regional staff (data entry, PHI, PHN and CD Coordinator) as well as Ministry staff (CD Information Consultant and CD Epidemiologists) and will improve accuracy of CD Reports. If cases are entered in error, the case status field should be updated to reflect the error – CASES MUST NOT BE DELETED. Refer to [iPHIS Case Status Guidance Document](#)

**Please do a thorough search to ensure the client you are searching for doesn't already exist before creating a new one.**

**a. New Case**

To start a new Case click the New Case button (The focus of this document is on creating new cases; however the business rules and application function for each tab are the same when editing cases.)

**b. Updating Case**

When the above considerations have determined that the case should be updated, choose the Details button and make any necessary updates to the case.

The screenshot shows the iPHIS Case Management System interface. The top navigation bar includes links for Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, and Logoff. The main content area is titled 'Case' and displays client information for ANTHRAX, ABBY, including Client ID 10021037, Gender FEMALE, and Birth Date 1999-04-03. A sidebar on the left contains navigation tabs for Demographics, General, Administration, System Admin, CD, TB, STD, Lab, Mass, Public Health, Outbreak, Reports, and Logoff. The 'New Case' button in the CD tab is circled in red. Below the sidebar is a table of cases with columns for Reported Date, Case, Case Status, Follow-Up Status, and Health Area. The 'Details' button for each row is circled in red.

Reported Date	Case	Case Status	Follow-Up Status	Health Area
2010-11-29	Botulism	CONFIRMED	OPEN - AWAITING MORE HISTORY/INFORMATION	SAMPLE HA
2010-11-04	Diphtheria	CONFIRMED		SAMPLE HA
2010-11-01	Giardiasis	CONFIRMED		SAMPLE HA
2006-03-30	Salmonellosis	CONFIRMED		SAMPLE HA

### 3. Communicable Disease Module

#### a. Case

- Enter Required Fields and click Save
- Note: The Case tab must be completed and saved before moving to other tabs
- **Required Fields:**

Case Tab		
Field	Description/Use	Business Rule / Comments
Health Area	From the drop-down list, select the Health Area this case is related to (based on the current logged-on user).	The Health Authority of the Public Health office who is entering the case. NOTE - The system will not allow users to choose Health Authority other than the one they are logged under.
Case Report Date	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format	The most common date is the lab reported date, however the case reported date should be the earliest of all of the following dates: Date case was reported to public health; it may be a phone call from the referring physician, it may be receipt of a notification form or most commonly is the lab reported date. Note - if this was a referral from HR A to HR B, the date the original HR received the report (notification, phone call, lab report) should be used.
Immunized Up to Date by Client Report at Case Reported Date	From the drop-down list, select whether the client, as of the reported date, has advised that he/she is up to date for their immunizations.	This relates to immunizations <u>specific to the disease being reported</u> .  In the context of case investigation, an individual is considered to be up to date for immunization if they have received the full number of doses of specific disease antigen-containing vaccine for their age according to the immunization schedule outlined in the Saskatchewan Immunization Manual.
Follow-up status	From the drop down list, select the appropriate status. NOTE: this field defaults to "Open" but can be updated.	Should be open while the investigation is occurring. Should only be closed once the investigation and all documentation requirements have been entered. If closed prior to having all data elements completed, a note must be entered. The system will not allow updates to be made to closed cases; cases must be reopened prior to adding further details.

Case Tab		
Field	Description/Use	Business Rule / Comments
Case Closed Date		
Disease Code	From the drop-down list, select the appropriate disease code.	Is based on the case definitions. The organism on the lab report may assist in determining which disease is being reported.
Etiological Agent	For the selected Disease Code, if the Disease only has one active Etiologic Agent associated to it, the Etiologic Agent will be defaulted. Should the Etiologic Agent field be empty when saving the record, a warning will be displayed.	Pre-populates with the associated organisms of the disease code chosen. When there are multiple choices, select the appropriate option.
Subtype	From the drop-down list, select the appropriate disease subtype. For the selected Etiologic Agent, if there is only one active Subtype associated to it, the Subtype will be defaulted. If there are no Subtypes for the disease the drop down menu will be blank	Pre-populates with the associated subtypes of that organism (etiological agent). The subtype should be chosen based on what the lab report indicates as the subtype. This indicates the species of the organism. In some cases, the categorization of the disease may be captured in the subtype field (acute, chronic, etc).  If the subtype listed on the lab report is not listed in the drop down, a request should be directed to the eHealth Service Desk at <a href="mailto:ServiceDesk@eHealthsask.ca">ServiceDesk@eHealthsask.ca</a> or 306-337-0600 to have it added.
Further Information	Text field that can be used to document information for which there is no data field specific for the information	This field should not be used routinely. It is used when the details of the disease cannot be captured in the Further Differentiation data fields (e.g. if PFGE information is provided, it should be documented in the PFGE field of the further differentiation options).

Case Tab		
Field	Description/Use	Business Rule / Comments
Further Differentiation: <ul style="list-style-type: none"> <li>• BIOTYPE</li> <li>• EMM TYPE</li> <li>• ET PROFILE</li> <li>• GENOTYPE</li> <li>• OPACITY FACTOR (SOF)</li> <li>• PFGE</li> <li>• PHAGE TYPE</li> <li>• SEROGROUP</li> <li>• SEROTYPE</li> <li>• SUBTYPE</li> <li>• T TYPE</li> </ul>	These are the data fields where characterization information about the organism is documented (e.g. molecular patterns, phage typing, species typing, etc).	These are text boxes so care must be taken to accurately document the details. It is used for routine surveillance and epidemiological purposes. The Ministry also uses this to determine if cases are epidemiologically linked or related to a provincial or national outbreak. <p>DIRECTIONS:</p> <ul style="list-style-type: none"> <li>• Copy the “characterization details” directly as written on the laboratory report (e.g. Meningococcal C serougroup reported; the investigator would document C in the Serogroup field).</li> <li>• For PFGE – when two patterns are included, separate the patterns with a “/” For example: “XbaI###/Bln###.###” (See Screen shot that follows)</li> </ul> This field must be updated in iPHIS as soon as lab reports with this detail are received.

Disease Code  
 Etiologic Agent  
 Subtype  
 Further Information

Further Differentiation	
BIOTYPE	
EMM TYPE	
ET PROFILE	
GENOTYPE	
OPACITY FACTOR (SOF)	
PFGE	XbaI.001/BlnI.002
PHAGE TYPE	13a
SEROGROUP	
SEROTYPE	
SUBTYPE	
T TYPE	

**Recommendation:**

- Copy the “characterization details” directly as written on the laboratory report (e.g. Meningococcal C serougroup reported; the investigator would document C in the Serogroup field)
- For PFGE – when two patterns are included, separate the patterns with a “/” For example: “XbaI###/Bln###.###”

Case Tab		
Field	Description/Use	Business Rule / Comments
Case Status	From the drop-down list, select the current status of the case.	Must match the case definitions as outlined in the CDC Manual. (Lab confirmation may not be the only criteria for a case to be "Confirmed".) Refer to the most current Case Status Guidance document for details and definitions. If cases are entered in error, the case status should be updated to the most appropriate option as cases must not be deleted.  Refer to <a href="#">Attachment – iPHIS Case Status Guidance</a>
<p><b>Note:</b> The public health investigator (PHN/PHI) must assign case statuses of confirmed, probable, suspect, possible, and does not meet case definition.</p>		
Date / Time	Either select from the calendar the case status date, or enter the date in YYYY-MM-DD format. The time will default to the current time in HH:MM:SS format and can be updated if required.	Date the case status is assigned as suspect, probable, confirmed, transferred to another health authority, etc... This is a system generated date that can be overwritten to the most accurate date as defined in the most current <a href="#">Reference Card</a> .
Client Address at Time of Case	From the drop-down list, select the client's address at the time of case.  NOTE – this field may not appear on the screen if there are no addresses included in the demographics module.	If the address is not listed in the drop down list you will first have to update the client's address in the demographic module – see adding addresses in the <a href="#">How to Create/Maintain a Client Guideline</a>  This is important to complete so regions can monitor location of cases within the region.
Branch Responsible	From the drop-down list, select the branch responsible for the case.	Is required by the Ministry for FNIHB and NITHA to enter the branch as the health region where the case is geographically located.

Case Tab		
Field	Description/Use	Business Rule / Comments
Sensitive Occupation	From the drop-down list, select the clients occupation.	Occupation that relates to risk of disease transmission from the case to others. This is not intended to capture if this is a likely source of infection, but rather that the occupation poses a risk to the clients/population they work with: Childcare Provider – Food handler Healthcare Provider – Laboratory Worker – Personal Care Provider – Other Swine/Poultry/Pelt Worker Details would be expanded on in the exposures tab as outlined on the following pages.

**b. Lab**

- Refer to [How to Use Laboratory Module](#)

**c. Signs/Symptoms**

- Enter Required Fields and click Add
- After clicking the Add button the symptom and start date will show below where you can Update or Delete them
- Note: Not all diseases have symptoms associated with them, if the Symptom drop down menu is empty enter nothing
- **Required Fields:**

Signs/Sym. Tab		
Field	Description	Business Rule / Comments
Symptom	From the Symptom drop-down list, select the appropriate symptom.	Symptoms are required to be entered to support the reported case status. For example, some case definitions require documentation of symptoms to meet the case definition. Refer to <a href="#">Appendix 2 – Criteria for Confirmed Cases</a> .

Start Date	Either select from the calendar the date on which the symptom first appeared, or enter this date in YYYY-MM-DD format.	When a symptom is documented, enter the date of onset as this helps to determine risk periods and contact tracing timeframes and ensures accurate epidemiological assessment.  This is often useful in determining the period of communicability, the risk period for contacts and contact eligibility for immuno or chemoprophylaxis (e.g Hepatitis A).
End Date	Either select from the calendar the date on which the symptom ended or resolved, or enter this date in YYYY-MM-DD format.	When a symptom is documented, enter the date of symptom resolution as this may help to determine risk periods and contact tracing timeframes and ensures accurate epidemiological assessment.
Duration		
Site/Description	Text field to provide details of the symptom.	Details of the symptom documented to be included here. For example, when fever is chosen as the symptom, the temperature details can be included or when redness/swelling is chosen, the body site or extent of redness/swelling can be included here.

The screenshot shows the 'Signs and Symptoms' web application. The top navigation bar includes links for Home, Client Search, Walk Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, and Logoff. The main header displays 'Signs and Symptoms'. Below this, there is a patient profile for 'ANTHRAX, ABBY' with fields for Name, Client ID, Client Address at Time of Case, PHN, Disease, Birth Date, Gender, Age At, Case ID, Reported Date, Episode Date, and Episode Date Type. A 'Profile Report' button is visible. Below the patient information, there are tabs for 'client' (Exemption, Adverse, Contraind, Organ/Bld, Allergies, Alerts, Files) and 'case' (Case, Lab, Signs/Sym., Comm/Inc, Risks, Exposures, Contacts, Interven., Outcome). The 'Signs/Sym.' tab is highlighted in red. Below the tabs, there is a table with columns for Symptom, Start Date, Start Time, End Date, End Time, Duration Days, Duration Hours, and Site / Description. The 'Add' button in the table is highlighted in red.

**Important:** The case definitions for some diseases require documentation of clinical characteristics. For quality assurance, this field must be completed as outlined in [Appendix 2 – Criteria for confirmed cases](#).

**d. Communicability/Incubation**

- Allows for documenting the period of communicability and the incubation period which will assist in identifying source and transmission risk periods and will help to guide the investigation.
- Documenting in this tab is not mandatory.

**e. Risks**

- This tab is used mainly for communicable diseases which are under enhanced surveillance such as invasive Group A Streptococcal disease (iGAS), invasive pneumococcal disease (IPD), invasive *H. influenzae*, severe influenza, severe acute respiratory illness (SARI), etc.
- Expand the desired sections by clicking on the + sign; alternatively you can collapse the section again by clicking – sign.
- Note: All the list items under each category will default to Not Asked. If the answer to all the questions in one of the sections is “no” you can click on the No to All button.
- Enter required fields and click Save.
- **Required Fields:**

Risk Tab		
Field	Description	Business Rule / Comments
Exposure Setting	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable.	These risks relate to the <u>case</u> and are to be used for for severe influenza, SARI and other invasive diseases.
Medical Risk Factors	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable.	<p>These risks relate to the <u>individual</u> and will be relevant to multiple cases. Documentation of medical risk factors is required for diseases such as severe influenza, invasive pneumococcal disease, etc. This is useful for understanding risks of individuals for acquiring the disease. Includes chronic conditions that likely will not resolve over time.</p> <p>When the disease has been reported as an underlying or contributing cause of death, medical risks must be entered.</p>

Risk Tab		
Field	Description	Business Rule / Comments
Behavioural Social Factors	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable.	These risks relate to the <u>case</u> and are useful for understanding the behavioral/social factors that help explain what makes individuals susceptible to the disease reported. Must be completed for severe influenza, SARS, SARI and other invasive diseases.  When the disease has been reported as an underlying or contributing cause of death, behavior/social risks must be entered.

**f. Exposures**

- Enter Required Fields and click Add
- After clicking the Add button the Exposure category start date and case event/location and details will show below where you can Update or Delete them.

Exposure Tab		
Field	Description	Business Rule / Comments
Exposure category	From the Exposure Category drop-down list, select the appropriate Exposure Category.	<p>This is important information for determining the potential source of the exposure and where further transmission from the case to others may have occurred.</p> <p>Only <u>relevant exposures</u> of the disease reported should be documented (i.e. only those exposures related to the incubation period and period of communicability of the disease and exposures that are likely sources of infection or where further transmission may have occurred).</p> <p>When the case is related to travel, travel inside province or travel outside province/country should be chosen. At least one other exposure should be included that includes details about the exposure while traveling (e.g. contact with ticks or food – consumption of risk foods).</p>
Start date	Either select from the calendar, or enter this date in YYYY-MM-DD format.	<p>Estimated or accurate date should be documented and is used to determine risk periods for contact and source investigations.</p> <p>Only exposure that fall within the incubation period or period of communicability should be entered. Anything else is extraneous and irrelevant.</p>
Case Event/Location	Enter in the location of the exposure.	Objective information about the case event and location. The text in this field should be <u>succinct</u> with further details included in the comments.

Exposure Tab		
Field	Description	Business Rule / Comments
		When the case is related to travel, specific details of the travel destination should be included (e.g. resort name or city and country). Travel information should <u>not</u> be included in the Demographics module.
Comments		Further information about the exposure should be documented in comments.

**Recommendation:** Succinct documentation of the information regarding exposure events and locations is required. This is to provide details about the category that was identified.

Example: Exposure Category – Food Service – non-profit

Case Event – Wedding banquet

Location – Community Hall, Lumsden

Comments – case ate at wedding banquet in Lumsden – caterer was local service organization (CWL, Royal Purple).

**Recommendation:** When several exposures are identified as a potential source, the exposures should be entered in sequence from highest to lowest likelihood of source based on investigators' assessment and judgement.

Transmission exposures, if identified should be entered in sequence following the potential source exposures.

Dates of exposures communicates if the exposure is considered to be relevant to source or transmission.

**g. Contacts**

- Refer to [Creating/Maintaining Contacts](#) for details.

**h. Intervention**

- Click the New Intervention button

- Enter Required Fields and click Save
- After clicking the Add button, the intervention and start date will show below where you can Update or Delete them
- **Required Fields:**

Intervention Tab		
Field	Description	Business Rule / Comments
Intervention Type	Select the appropriate Intervention Type from the drop-down list.	Details of the interventions provided by public health can be documented here. Need to create a data dictionary for this. Required for severe influenza (intensive medical care/intubation/ventilation, antiviral use, and oxygen therapy during hospital stay).
Date	Either select from the calendar, or enter this date in YYYY-MM-DD format.	Enter the date of intervention.
Provider	Select the appropriate Provider from the drop-down list.	The provider should be the user who provided the public health intervention, or in the case of treatment, the provider who investigated the case and gathered the information.  This does not mean the physician who prescribed the treatment.
Comments		Further detail about the intervention should be documented in the comments.

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

**Interventions**

Name ANTHRAX, ABBY Birth Date 1999-04-03 Reported Date 2012-03-30 Profile Report  
 Client ID 10021037 Gender FEMALE Episode Date 2012-03-30  
 Client Address at Time of Case No address selected for this case Age At 12yr 11mo Episode Date Type REPORTED  
 PHN Disease Mumps Case ID 69089

Exemptions Adverse Contraindication Notes File

client Exemption Adverse Contraind Organ/Bld Allergies Alerts Files  
 case Case Lab Signs/Sym Comm/Inc Risks Exposures Contacts **Interven.** Outcome  
 Imms/TST Physicians Notes

**Interventions**

Intervention Type   
 Date 2012-03-30  
 Location   
 Provider POLIQUIN, VINCENT  
 Comments

Save Delete

- After Saving an Intervention you will be returned to the main Intervention screen where you can edit existing or add additional interventions

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

**Interventions**

Name ANTHRAX, ABBY Birth Date 1999-04-03 Reported Date 2012-03-30 Profile Report  
 Client ID 10021037 Gender FEMALE Episode Date 2012-03-30  
 Client Address at Time of Case No address selected for this case Age At 12yr 11mo Episode Date Type REPORTED  
 PHN Disease Mumps Case ID 69089

Exemptions Adverse Contraindication Notes File

client Exemption Adverse Contraind Organ/Bld Allergies Alerts Files  
 case Case Lab Signs/Sym Comm/Inc Risks Exposures Contacts **Interven.** Outcome  
 Imms/TST Physicians Notes

New Intervention

**Interventions**

Intervention Type	Date	Location	Provider	Comments
EDUCATION	2012-03-30		VPOLIQUIN	

Details

**i. Outcome**

- To enter an Outcome for the case select the outcome from the drop down menu and click Save
- To enter a hospital stay, complete the desired fields and click the Add button. After adding a hospital stay it will show in a line listing below the fields where it can be Updated or Deleted
- **Required Fields:**
  - Case investigation worksheets for specific diseases will provide details of information required within this module.

Outcome Tab		
Field	Description	Business Rule / Comments
Outcome	Select the appropriate Outcome from the drop-down list	This is a proxy for the severity of the disease.  When fatal is chosen from the drop down, additional fields will appear for completion.
<p>Fatal shall be chosen only when the disease is a contributing or underlying cause of death. This is described as:</p> <ul style="list-style-type: none"> <li>• When a patient is admitted to the hospital with a Notifiable disease and dies, OR</li> <li>• When a patient is diagnosed with a Notifiable disease while in hospital and dies.</li> </ul> <p>EXCEPTION: deaths are not reportable when a patient with a Notifiable disease dies due to an injury. In this situation (and any other situation when death is incidentally noted [e.g. obituary], documentation of death should only occur in the Client Info tab of the Demographic module as per regional policy.</p> <p>NOTE: When Fatal is selected as the outcome the Date of Death field in the Client demographic screen will be auto-populated.</p>		
Date of Death	Either select from the calendar, or enter this date in YYYY-MM-DD format.	Only enter Date of Death in the Case/Encounter if the disease is related to the cause of death Check the accurate box if this is the known date of death. If estimated, leave the accurate box empty.

Outcome Tab		
Field	Description	Business Rule / Comments
Cause of Death	Select the appropriate Cause of Death option from the drop-down list.	Amendments to the Disease Control Regulations require reporting to public health when a Category I or Category II communicable disease is the immediate or contributing cause of death of the individual.
Hospital	Select the appropriate Hospital from the drop-down list.	Documentation of hospitalization is only required when it is related to the disease reported and can be used as a proxy for the severity of disease.  Documentation of Hospitalization is mandatory for certain diseases (e.g. severe influenza and West Nile Virus).  Enter whenever public health becomes aware that hospitalization is required for a communicable disease –usually is an indicator for severity.
Length of Stay		
Purpose	Select the appropriate Purpose from the drop down list.	Specific terms are required to denote severity: <ul style="list-style-type: none"> <li>• Diagnostics</li> <li>• ICU Admissions</li> <li>• Isolation</li> <li>• Observation</li> <li>• Palliative Care</li> <li>• Respite</li> <li>• Treatment</li> </ul> For example - The severity of Influenza is flagged by the selection of “ICU Admission”.
Admission Date		
Discharge Date		Complete this information when it is known.

The screenshot shows the 'Outcome' page for a client named ANTHRAX, ABBY. The page includes a navigation menu on the left with options like Demographics, General, Administration, System Admin, CD, TB, STD, Lab, Mass, Public Health, Outbreak, Reports, and Logoff. The main content area has a header with navigation links (Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, Logoff) and a 'Profile Report' button. Below the header, there are tabs for 'client' (Exemption, Adverse, Contraind, Organ/Bld, Allergies, Alerts, Files) and 'case' (Case, Lab, Signs/Sym, Comm/Inc, Risks, Exposures, Contacts, Interven., Outcome). The 'Outcome' tab is selected. Below the tabs, there is a 'Save' button. At the bottom, there is a table with columns for Hospital, Length Of Stay(Days), Purpose, Admission Date, and Discharge Date. The table contains one row for 'BEAUVAIL HEALTH CENTRE' with a length of stay of 2 days and purpose of 'DIAGNOSTICS'. An 'Add' button is highlighted in red in the table header.

Hospital	Length Of Stay(Days)	Purpose	Admission Date	Discharge Date
BEAUVAIL HEALTH CENTRE	2	DIAGNOSTICS		

#### j. Immunization/TST (tuberculin skin test)

- Allows for documenting immunizations provided to the case.
- The immunization record in Panorama is the legal immunization record.
- Documenting details of past or current immunizations in this tab is not mandatory.
- Including a note about immunization history and where to obtain record for details is appropriate and recommended rather than documenting in this field as part of communicable disease investigation.
- EXCEPTION - Rabies follow-up requires documentation in the immunization module.

#### k. Physician

- Documenting in this tab is not mandatory.

## I. Notes

- Click the Create new Note button

The screenshot shows the iPHIS Case Notes page. At the top, there is a navigation bar with links like Home, Client Search, Wait Queue, etc. Below that, the 'Case Notes' section displays client details for 'ANTHRAX, ABBY'. A secondary navigation bar for the 'client' includes tabs like Exemption, Adverse, and Notes. A third navigation bar for the 'case' includes tabs like Case, Lab, Signs/Sym, and Notes. The 'Notes' tab is highlighted. Below the navigation, there is a 'Notes' section with a 'Create New Note' button circled in red and a 'Print' button. A table header is visible below the buttons, with columns for 'Note Date and Time', 'Note', 'Created By', and 'Created Date'.

- Complete the Note field and click Save

**Recommendation:** To the extent possible, the signs/symptoms, risks, exposures, interventions and outcomes should be documented in the designated field in iPHIS, not in Notes.

Notes Tab		
Field	Description	Business Rule / Comments
Note Date and Time	Either select from the calendar, or enter this date in YYYY-MM-DD format.	
Note	Free text field. This is a field that would be equivalent to the health providers notes in a client's medical chart.	To the extent possible, the signs/symptoms, risks, exposures, interventions and outcomes should be documented in the designated field in iPHIS.  Notes allows for a narrative description of additional details relevant to the history, investigation, interventions, etc. This is accessed frequently by the Ministry when reviewing cases that may be related to an outbreak or when cases are of particular public health significance.

Notes Tab		
Field	Description	Business Rule / Comments
		<p>This is where additional details requested by the Ministry can be documented such as immunization history for vaccine preventable diseases (dates, dose in series, immunization status of household members).</p> <p>If an error is apparent within a note, a new note should be created as amendment to the note with the error.</p>

<b>Name</b>	ANTHRAX, ABBY	<b>Birth Date</b>	1999-04-03	<b>Reported Date</b>	
<b>Client ID</b>	10021037	<b>Gender</b>	FEMALE	<b>Episode Date</b>	
<b>Client Address at Time of Case</b>	No address selected for this case	<b>Age At</b>	12yr 11mo	<b>Episode Date Type</b>	
<b>PHN</b>		<b>Case ID</b>	69089		
<b>Disease</b>	Mumps				

Exemptions Adverse Contraindication **Notes** File

<b>client</b>	Exemption	Adverse	Contraind	Organ/Blid	Allergies	Alerts	Files		
<b>case</b>	Case	Lab	Signs/Sym.	Comm/Inc	Risks	Exposures	Contacts	Interven.	Outcome
	Imms/TST	Physicians	<b>Notes</b>						

**Note**

Note Date and Time

Note

Client Comments

Created By VPOLIQUIN  
 Created Date

- After saving the note users are returned to the main note screen where another note can be added.

**Important: Do not Delete Notes for Quality Assurance**

If an error is apparent within a note, a new note should be created as an amendment to the note with the error.

Exemptions Adverse Contraindication Notes File

client Exemption Adverse Contraind Organ/Bld Allergies Alerts Files

case Case Lab Signs/Sym. Comm/Inc Risks Exposures Contacts Interven. Outcome

Imms/IST Physicians **Notes**

Notes

Create New Note Print

Note Date and Time	Note	Created By	Created Date
2012-03-30 14:34	client says he will not do needle drugs again	VPOLIQUIN	2012-03-30 14:43

Update

### **Purpose:**

- This chapter describes the iPHIS technical functionality and business processes for creating STD Encounters.
- There are several tabs and fields in the STD Module; it is the purpose of this chapter to cover the fields required by the system and for notification purposes.
- Even though not all fields are required for notification purposes, in the interest of creating a comprehensive public health record, comprehensive documentation should be completed in iPHIS.
- Red diamonds ♦ to left of some fields indicate they are system required fields.
- Fields for some sections are hidden and can be expanded by clicking + sign.

[Appendix A – Reporting and Follow-up Timelines](#) must be followed. As case investigations progress within RHAs and FN jurisdictions, information should be updated into iPHIS, particularly for the diseases with reporting timeframes of less than two weeks.

### **Index:**

- 1. Client Searches**
- 2. Determining when to Create a New Encounter or Update an Encounter**
  - a. New Encounter
  - b. Updating Encounter
- 3. STD Quick Entry**
- 4. Sexually Transmitted Disease Module**
  - a. Encounter
  - b. Symptoms
  - c. History
  - d. Physicians
  - e. Abx (Antibiotics) - inactivated
  - f. Risks
  - g. IDU (Injection Drug Use)
  - h. Support
  - i. Exam - inactivated
  - j. Immunization/TST (Tuberculin Skin Test)
  - k. Lab
  - l. Diagnosis/Treatment
  - m. Follow-up

- n. [Notes](#)
- o. [Contacts](#)
- p. [Informant](#)
- q. [Birth control](#)
- r. [Psych](#)
- s. [Outreach - inactivated](#)

### 1. Client Searches

See [Create/Maintain a Client](#) for more information

Once a client has been selected, click on STD hot link in the left navigation bar and select Encounter Summary



## 2. Determining when to Update a case or create a New case

If the client has previous encounters they will be listed. If not, the display will appear blank.

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

**STD Encounter Summary**

Client 898232000 / SPEARS, BRITTANY / 10003037 / 1980-01-07 / FEMALE (306) 545-2311

Date	Branch#	Reason(s)	Diagnosis	Treatment	Encounter Type	Status			
2013-08-22	0		Z21		NOTIFICATION	0	<input type="button" value="Details"/>	<input type="button" value="Delete"/>	<input type="button" value="Continue Quick Entry"/>
2007-10-11	0		A51.0	BICILLIN	OUTREACH CLINIC	0	<input type="button" value="Details"/>	<input type="button" value="Delete"/>	<input type="button" value="Continue Quick Entry"/>
2005-06-23	0	CO-INFECTION	Multiple	Multiple	NOTIFICATION	0	<input type="button" value="Details"/>	<input type="button" value="Delete"/>	<input type="button" value="Continue Quick Entry"/>
2004-07-05	0	HIV	Multiple		NOTIFICATION	0	<input type="button" value="Details"/>	<input type="button" value="Delete"/>	<input type="button" value="Continue Quick Entry"/>

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About

**STD Encounter Summary**

Client 321671333 / PERTUSSIS, FREDA / 10074819 / 1956-05-06 / FEMALE ()

Date	Branch#	Reason(s)	Diagnosis	Treatment	Encounter Type
------	---------	-----------	-----------	-----------	----------------

Regardless of the trigger for reporting a case (e.g. a call from a physician, a referral from another health region or receiving a lab report from the local or provincial lab), it is important to follow the steps outlined below:

- 1) Review current cases reported for the client.
- 2) If a case currently exists for the disease that is being reported details about the disease must be considered by the public health investigator to determine if the current case should be updated or if a new case should be created.

Considerations:

- Acute or chronic nature of the disease being reported (e.g. chlamydia versus HIV)
  - Chronic diseases (HIV) typically should be updated rather than entered as a new case. Syphilis requires much clinical interpretation before new encounters are created.

- 
- For acute diseases, the date of the previous reported case and if treatment had been provided previously. Diseases have timeframes within which a subsequent lab report would still be considered the same case (e.g. a repeat positive gonorrhea or chlamydia case by PCR within 4 weeks of treatment would **not** be considered a new case.). This is for the Public Health investigator to determine.
  - Is this an updated lab report of the previously reported case?
    - The specimen collection date should be reviewed as some diseases require samples be sent to the national microbiology lab (NML) or other specialty labs for further testing which can create significant time lapses and the appearance that it is a new case (e.g. syphilis or AMR-GC).

Other Considerations:

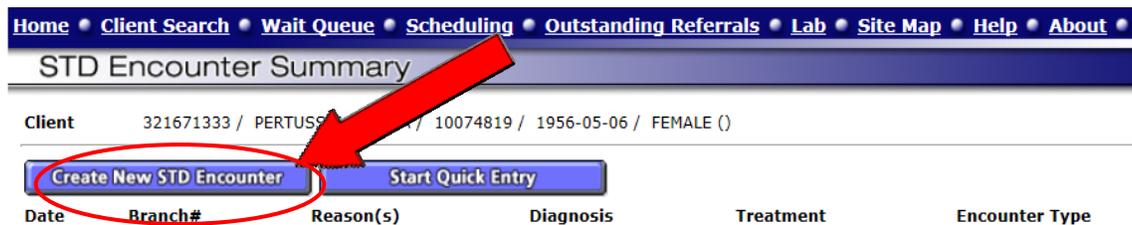
- Lab results may be directed to MHOs for both a First Nations jurisdiction (FNIHB or NITHA) and the RHA of the client's address. In these situations, it is important for First Nations and RHA counterparts to communicate when it is not clear which health authority should be reporting the case. Sometimes this may take multiple calls to make the final determination.
- When the case has been entered by one authority in error, it is essential that case status be updated to accurately reflect the appropriate status. Refer to [Attachment – iPHIS Cases Status Guidance Document](#).

**Important: Creating new encounters (cases) when cases should be updated causes data quality issues.**

Careful consideration of previously reported cases by the Public Health Investigator or the CD Coordinator before new cases are created can save much time of regional staff (data entry, PHI, PHN and CD Coordinator) as well as Ministry staff (CD Information Consultant and CD Epidemiologists) and will improve accuracy of communicable disease reports. If cases are entered in error, the case status field should be updated to reflect the error – **CASES MUST NOT BE DELETED**. Refer to [Attachment – iPHIS Cases Status Guidance Document](#).

**a. New Encounter**

To start a new Encounter, click the Start Quick Entry or Create New STD Encounter button (the focus of this chapter is on creating new cases; however the business rules and application function for each tab are the same when updating cases).



**b. Updating Case**

When the above considerations have determined that the case should be updated, choose the Details button and make any necessary updates to the case.



**3. STD QuickEntry**

- As the name implies, the STD Quick Entry allows for simplified access to enter the details of a case when setting the case up.
- Expand the Encounter Details section by clicking on the + sign; refer to [Encounter](#) in the [Sexually Transmitted Disease Module](#).
- Expand the Diagnosis Details and Treatment Details sections by click on the corresponding + signs; this provides limited data fields to expedite entry.
- Following data entry, select Add.
- Completing the full details in the [Diagnosis/Treatment](#) section is required when completing the case documentation.

**Client Information**

Family Name	ANTHRAX	First Name	ABBY
Second Name		Common Name	
Birth Date	1999-04-03	Date of Death	2008-03-25
Marital Status		Gender	FEMALE
Birth Province (if born in Canada)		Ethnicity	

- + Encounter Details
- + Diagnosis Details
- + Treatment Details
- + Contacts
- + Follow-up

#### 4. Sexually Transmitted Disease Module

There are several tabs in the STD module. The intent of this chapter is to only cover the tabs and elements that are required for reporting and the system required elements.

Exemptions Adverse Contraindication Notes File

client

encounter

Encounter Information

##### a) Encounter

- Enter the required fields and click Save
- **Note:** The Encounter tab must be completed and saved before you can navigate to the other tabs.
- **Required Fields:**

Encounter Tab		
Field	Description	Business Rule / Comments
Encounter Type	From the drop-down list, select the appropriate encounter type	Should be the way in which public health was notified of the case. It may be lab note, or phone call or STI clinic visit, etc. The Ministry doesn't use this

Encounter Tab		
Field	Description	Business Rule / Comments
		field; it will be for the regions to determine as it is system mandatory.
Encounter Date	Either select from the calendar the date the encounter was reported, or enter this date in YYYY-MM-DD format. <b>NOTE:</b> This field defaults to the current date	It should be the earliest date of which public health was notified of the case. Most commonly is the lab reported date. Alternatively, public health is seldomly notified by a phone call from the referring physician or receipt of a notification form. Note - if this was a referral from HR A to HR B, the date the original HR received the report (notification, phone call, lab report) should be used.
Encounter Status	From the drop-down list, select the appropriate encounter status. <b>NOTE:</b> This field defaults to "open" but can be updated	Should be "Open" while the investigation is occurring. Should only be "Closed" once the investigation and all reporting requirements have been entered. If closed prior to having all data elements completed, a note must be entered. The system will not allow updates to be made to closed cases; cases must be reopened prior to adding further details.
Outcome	From the drop-down list, select the appropriate outcome	Deceased if applicable to the case  Only enter Date of Death in the Case/Encounter if the disease is related to the cause of death.  If Fatal is selected as the outcome the Date of Death on the Clients demographic screen will be auto populated.  If death is unrelated to the Case/Encounter it is not mandatory to complete; however, if desired it should be entered into the Client Info tab of Demographics and not in the Case or Encounter tab
Fatal shall be chosen only when the disease is a contributing or underlying cause of death. This is described as:		

Encounter Tab		
Field	Description	Business Rule / Comments
	<ul style="list-style-type: none"> <li>When a patient is admitted to the hospital with a Notifiable disease and dies; or,</li> <li>When a patient is diagnosed with a Notifiable disease while in hospital and dies.</li> </ul> <p><b>EXCEPTION:</b> deaths are not reportable when a patient with a Notifiable disease dies due to an injury. In this case (and any other case when death is incidentally noted [e.g. obituary], documentation of death should only occur in the <b>Client Info tab of the Demographic</b> module as per regional policy.</p> <p><b>NOTE:</b> When Fatal is selected as the outcome the Date of Death field in the Client demographic screen will be auto-populated</p>	
HA	From the drop-down list, select the appropriate Health Area	The Health Authority of the Public Health office who is entering the case. <b>NOTE</b> - The system will not allow users to choose Health Authority other than the one they are logged in under.
Branch	From the drop-down list, select the appropriate branch	Is required by the Ministry for FNIH and NITHA to enter the branch as the health region where the case is geographically located.
Exam Category	From the drop-down list, select the appropriate exam category	System mandatory, not required by the Ministry. Refer to Exam Category data dictionary for guidance on appropriate selection.
Client Address At Time Of Encounter	From the drop-down list, select the client's address	If the address is not listed in the drop down list you will first have to update the clients address – see adding addresses in <a href="#">Section 10-20: How to Create/Maintain a Client</a> This is important to complete so regions can monitor location of cases within the region.
Reasons for encounter		Refer to Reasons for Encounter data dictionary for guidance on appropriate selection.

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

### Encounter Details

- Demographics
- General
- Administration
- System Admin
- CD
- TB
- STD
- Lab
- Mass
- Public Health
- Outbreak
- Reports
- Logoff

Client / ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250) 747-3265  
 Client Address At Time Of Encounter /  
 Episode Date / Type /  
 Encounter ID / Date / Type / Status / Encounter Created Date /

---

Exemptions   Adverse   Contraindication   Notes   File

Exemption   Adverse   Contraind   Organ/Bld   Allergies   Alerts   Files

Encounter   Symptoms   History   Physicians   Abx   Risks   IDU   Support   Exam   Imms/TST

encounter   Lab   Diag-Treat   Follow-up   Notes   Contacts   Informant   Birth Ctrl   Psych   Outreach

---

**Encounter Information**  
 Encounter Type    Encounter Date   
 Encounter Status    Encounter End Date   
 Admission Date    Discharge Date   
 Outcome   
 Immunized Up To Date By Client Report at Encounter Date   
 Care Provider   
 HA   
 Branch   
 Clinic   
 Exam Category   
 Client Address At Time Of Encounter

**Comments**

**Unvalidated Telecommunications**  
 Area Code   
 Number    Local

**Reporting Information**  
 Received Date   
 Notification Method   
 Investigation Start Date

**Reporting Source**  
\* Enter External Source Type and either Source Name or City for filter  
 External Source Type    Source Name    City      
 Type   Name   
 Other Reporting Source Type   
 Other Reporting Source Name   
 HA Referred From   
 Referred Date

**Reasons for Encounter**  

Available TREATMENT CO-INFECTION CONTACT INVESTIGATION ER GONNORHEA INFECTION HIV HIV RETEST IMMUNIZATION INFORMATION LAB REPORT	<input type="button" value="&gt;"/> <input type="button" value="&lt;"/>	Current
--	--	---------

**b) Symptoms**

**Important:** Before the symptom tab can be completed the Diag-Treat Tab must first be completed as the symptoms are linked to the disease.

- Enter Required Fields and click Add
- After clicking the Add button the symptom and start date will show below where you can Update or Delete them
- **Note:** Not all diseases have symptoms associated with them; if the Symptom drop down menu is empty, enter nothing.

Symptoms Tab		
Field	Description	Business Rule / Comments
Symptom	From the Symptom drop-down list, select the appropriate symptom	Symptoms are required to be entered to support the reported case status. For example, some case definitions require documentation of symptoms to meet the case definition. Refer to Appendix 2 – Criteria for confirmed cases.
Start Date	Either select from the calendar the date on which the symptom first appeared, or enter this date in YYYY-MM-DD format	When a symptom is documented, enter the date of onset as this helps to determine risk periods and contact tracing timeframes and ensures accurate epidemiological assessment.  This is often useful in determining the period of communicability and the risk period for contacts.

**Important:** The case definitions for some diseases require documentation of clinical characteristics. For quality assurance, this field must be completed as outlined in [Appendix 2 – Criteria for confirmed cases](#).

**c) History**

- This tab is only required for HIV & AIDS
- Expand the HIV History sections by click on the + sign
- Complete required fields and click Save

History Tab		
Field	Description	Business Rule / Comments
Previous HIV Test	From the drop-down list, select either Yes or No	Document what is known about a previous HIV test for the individual.
Date	Either select from the calendar the date that the HIV test was performed, or enter this date in YYYY-MM-DD format	Details of the previous testing should be entered for reference.
Accurate	Check the checkbox if the HIV test had been validated	In this case, validated refers to if the results have been validated through the testing physician or laboratory.
Location	Enter the location of where the HIV test was performed	
Result	From the drop-down list, select the appropriate test result	This information helps to determine the risk period for transmission.
Comments	Enter any additional comments	

The screenshot shows the 'STD Client History' interface. On the left is a navigation menu with options like Demographics, General, Administration, System Admin, CD, TB, STD, Lab, Mass, Public Health, Outbreak, Reports, and Logoff. The main content area has a header 'STD Client History' and client information: Client / ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250) 747-3265. Below this are tabs for client and encounter management. The 'History' tab is circled in red. Underneath, there's a 'HIV History' section with a 'Save' button also circled in red.

**d) Physicians**

- Documenting in this tab is not mandatory

**e) Abx (Antibiotics)**

- This tab has been inactivated in iPHIS

**f) Risks**

- Expand the desired sections by clicking on the + sign; alternatively you can collapse the section again by clicking - sign
- Refer to [Attachment – STI Risks](#) for a data dictionary on risk options.
- Note: If the answer to all the questions in one of the sections is no you can click on the No to All button
- Enter required fields and click Save

Risk Tab		
Field	Description	Business Rule / Comments
Exposure Setting	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable.	The risks are prefixed with HIV or STI. Only answer the risks relevant to the STI if HIV is not reported. If co-infected with HIV and another STI, enter relevant questions for both.  <b>Exposure setting risks are associated with the encounter.</b> Those prefixed with DO NOT USE should not be used as they are “inactivated”

Risk Tab		
Field	Description	Business Rule / Comments
<p>If entering risks for a new STI case, the risks override the previous written risks.</p>		
Medical Risk Factors	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable	<p>The risks are prefixed with HIV or DO NOT USE. Only select the risks with HIV prefix if applicable to the HIV case being reported.</p> <p>Those prefixed with DO NOT USE should not be used as they are “inactivated”</p> <p><b>Medical Risk Factors are associated with the <u>client</u> and will overwrite what has been previously documented.</b></p>
Behavioural	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable	<p>The risks are prefixed with HIV or STI. Only answer the risks relevant to the STI if HIV is not reported. If co-infected with HIV and another STI, enter relevant questions for both.</p> <p><b>Behavioral/Social Risks are associated with the <u>client</u> and will overwrite what has been previously documented.</b></p> <p>Those prefixed with DO NOT USE should not be used as they are “inactivated”</p>
Contraception Methods		
Condom Use		
Sites Exposed		Anatomical site of exposure informs the appropriate treatment for the case. It is important to document the exposure site in order to verify adequate treatment.

**IMPORTANT** - the *Exposure Setting Risks* are associated with the encounter while the *Medical Risk Factors* and the *Behavioural Social Factors* are associated with the client (meaning entry within Medical and Behavioural will overwrite historical information; entry within Exposure setting will not impact historical data).

<b>client</b>	<a href="#">Exemption</a>	<a href="#">Adverse</a>	<a href="#">Contraind</a>	<a href="#">Organ/Bld</a>	<a href="#">Allergies</a>	<a href="#">Alerts</a>	<a href="#">Files</a>
<b>encounter</b>	<a href="#">Encounter</a>	<a href="#">Symptoms</a>	<a href="#">History</a>	<a href="#">Physicians</a>	<a href="#">Abx</a>	<a href="#">Risks</a>	<a href="#">IDU</a>
	<a href="#">Lab</a>	<a href="#">Diag-Treat</a>	<a href="#">Follow-up</a>	<a href="#">Notes</a>	<a href="#">Contacts</a>	<a href="#">Informant</a>	<a href="#">Birth Ctrl</a>
					<a href="#">Psych</a>	<a href="#">Outr</a>	

**Risks**

**Exposure Setting**

STI - Unprotected Sex	NOT ASKED
STI - Condom failure	NOT ASKED
STI - Infant born to infected mother	NOT ASKED
STI - Sexual assault	NOT ASKED
HIV - Occupationally exposed to HIV contaminated blood or body fluids	NOT ASKED
HIV - Non medical exposure (e.g., tattoo, aggravated contact with blood) Please Specify	NOT ASKED
HIV - Perinatal Transmission	NOT ASKED
HIV - From endemic country (please specify)	NOT ASKED
DO NOT USE - Sexual Contact with confirmed case	NOT ASKED

[No to All](#)

**Medical Risk Factors**

**Behavioural Social Factors**

**Risk**

**Client** / ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250)  
**Client Address At Time Of Encounter** No address selected for this case  
**Episode Date/Type** 2012-04-02 / REPORTED  
**Encounter ID/Date/Type/Status/Encounter Created Date** 18341 / 2012-04-02 / CONTACT INVESTIGATION / OPEN / 2012

**Exemptions Adverse Contraindication Notes File**

<b>client</b>	<a href="#">Exemption</a>	<a href="#">Adverse</a>	<a href="#">Contraind</a>	<a href="#">Organ/Bld</a>	<a href="#">Allergies</a>	<a href="#">Alerts</a>	<a href="#">Files</a>
<b>encounter</b>	<a href="#">Encounter</a>	<a href="#">Symptoms</a>	<a href="#">History</a>	<a href="#">Physicians</a>	<a href="#">Abx</a>	<a href="#">Risks</a>	<a href="#">IDU</a>
	<a href="#">Lab</a>	<a href="#">Diag-Treat</a>	<a href="#">Follow-up</a>	<a href="#">Notes</a>	<a href="#">Contacts</a>	<a href="#">Informant</a>	<a href="#">Birth Ctrl</a>
					<a href="#">Psych</a>	<a href="#">Outreach</a>	

**Risks**

**Exposure Setting**

**Medical Risk Factors**

**Behavioural Social Factors**

**Contraception Methods**

Available: CERVICAL CAPS, CONDOM, CONTRACEPTIVE PATCH, DEFO PROVERA, DIAPHRAGM

Current: [ ]

**Condom Use**

Available: BARRIER-VULVA, CASUALS ONLY, GENITAL, INSERTIVE ORAL, INSERTIVE RECTAL, NO, REC RECTAL, RECEPTIVE RECTAL, RECTAL ONLY, SEX TRADE ONLY

Current: [ ]

**Sites Exposed**

Available: RECTAL, GENITAL, THROAT, OTHER, INSERTIVE RECTAL, RECEPTIVE RECTAL

Current: [ ]

**Comments**

[ ]

[Save](#)

**g) IDU (Injection Drug Use)**

- Enter required fields and click Save

IDU Tab		
Field	Description	Business Rule / Comments
Needle Drug User	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable	
Ever Shared Needle	Select the appropriate responses to the questions from the drop-down list, and complete the text field where applicable	
Age First Used		
Last Used Date		
Accurate		
Last Shared Date		
Accurate		

**Intravenous Drug Use**

Client / ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250) 747-3265  
 Client Address At Time Of Encounter No address selected for this case  
 Episode Date/Type 2012-04-02 / REPORTED  
 Encounter ID/Date/Type/Status/Encounter Created Date 18341 / 2012-04-02 / CONTACT INVESTIGATION / OPEN / 2012-04-02

Exemptions Adverse Contraindication Notes File

client Exemption Adverse Contraind Organ/Blid Allergies Alerts Files  
 encounter Encounter Symptoms History Physicians Abx Risks IDU Support Exam Imms/TST  
 Lab Diag-Treat Follow-up Notes Contacts Informant Birth Ctrl Psych Outreach

**IDU Risks**

Needle Drug User NOT ASKED [dropdown] [text field]  
 Ever Shared Needle NOT ASKED [dropdown] [text field]

Age First Used [text field]  
 Last Used Date [text field] Accurate   
 Last Shared Date [text field] Accurate

IDU Risks Comment [text area]

**Save**

**Needle Use**  
 Needle Exchange Source(s) [dropdown] **Add**

**Drugs Currently Used (non-STD)**  
 Drug [text field] Route [dropdown] **Add**

**h) Support**

- Documenting in this tab is not mandatory

**i) Exam**

- This tab has been inactivated in iPHIS

**j) Immunization/TST (Tuberculin Skin Test)**

- Allows for documenting immunizations provided to the case.
- The immunization record in Panorama is the legal immunization record.

**k) Lab**

- Refer to [How to Use Laboratory Module](#)

**l) Diagnosis/Treatment**

**Important: This tab must be completed before Symptoms tab**

The available symptoms are prepopulated with those related to the disease

- Enter required fields and click the Add button; which will add a line listing of the Disease
- **Required Fields:**

Diag-Treat Tab		
Field	Description	Business Rule / Comments
Disease Code	From the drop down, select the appropriate disease code.	Entry is based on the case definitions. The organism on the lab report may assist in determining which disease is being reported.  If the individual is co-infected with multiple organisms, add another disease code in the same encounter.
Status	Status of the disease. How the disease was confirmed.	Must match the case definitions as outlined in the CDC Manual. (Lab confirmation may not be the only criteria for a case to be "Confirmed".)  Refer to the most current <a href="#">Case Status Guidance document</a> for details and definitions.

		<p>If cases are entered in error, the case status should be updated to the most appropriate option as cases must not be deleted.</p> <p>Refer to <a href="#">Attachment – iPHIS Case Status Guidance</a></p>
<p><b>NOTE</b> – The public health investigator (PHN/PHI) must assign case statuses of confirmed, probable, suspect, possible, and does not meet case definition.</p>		
Date / Time	<p>Either select from the calendar the date on which the disease was confirmed, or enter the date in YYYY-MM-DD format. The time will default to the current time in HH:MM:SS format and can be updated if required.</p> <p><b>NOTE:</b> A time stamp may not be included with the date of disease. This is set by each jurisdiction for case tracking and is specific to each module.</p>	<p>Date the case status is assigned as suspect, probable, confirmed, transferred to another HA, etc. This is a system generated date that can be overwritten to the most accurate date.</p>
Etiologic Agent	<p>From the drop-down list, select the etiologic agent.</p> <p><b>NOTE:</b> This field is filtered by disease. It will only show those values relevant for the selected disease.</p> <p><b>NOTE:</b> This field will default if there is only one value in the drop-down list.</p>	<p>Pre-populates with the associated organisms of the disease code chosen.</p>
Subtype	<p>From the drop-down list, select the subtype.</p> <p><b>NOTE:</b> This field is filtered by etiologic agent. It will only show those values relevant for the selected etiologic agent.</p> <p><b>NOTE:</b> This field will default if there is only one value in the drop-down list.</p>	<p>Pre-populates with the associated subtypes of that organism (etiologic agent). The subtype should be chosen based on what the lab report indicates as the subtype. This indicates the species of the organism.</p> <p><b>NOTE</b> - This is not as relevant in STI as for CD.</p>

**Important: DO NOT UPDATE AN HIV CASE TO AIDS**

When a case progresses from HIV to AIDS, A **NEW** case (encounter) must be entered for AIDS.

AIDS Indicative Diseases		NOTE - WHEN CASE PROGRESSES FROM HIV TO AIDS, A NEW CASE MUST BE ENTERED FOR THE AIDS CASE – <b>DO NOT UPDATE THE HIV CASE TO AIDS.</b>
Disease		On the notification form that is received from the physician. Select from the drop down menu.
Earliest Known Start Date		Date on the notification form from the physician.

Treatment		
Formulary	From the drop-down list, select the drug.	Select from the formulary for the drug, route, dose, unit, etc to be pre-populated with the standard values. NOTE – if Formulary is bypassed, the MicroStrategy Treatment report will show a blank/null value.

**Important:** If the formulary field is bypassed, the treatment reports using Microstrategy will display with a blank/null value.  
 If the user has selected a Formulary drug, but chooses to select an alternate Drug value the MicroStrategy Treatment report will show with the Incorrect Formulary/Drug combination.

Drug	From the drop-down list, select the drug. <b>NOTE:</b> This field is filtered by formulary.  If the wrong medication is prepopulated, it can be overwritten	When a Formulary drug is selected, the Drug field will be pre-populated with the standard value. At times, an abbreviation of the medication will be listed in the drug field. If the drug or abbreviated listing is not included in the formulary drop down, select from the list of medications listed. NOTE – if the user bypasses the Formulary, the treatment reports accessed by MicroStrategy will show a blank/null value.
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Route	From the drop-down list, select the route. <b>NOTE:</b> This field is pre-populated based on formulary choice selected.	When selected from the formulary, the route for the medication selected will be pre-populated with the standard value. An alternate value can be selected from the drop down if appropriate
Dose	<b>NOTE:</b> This field is pre-populated based on formulary choice selected.	When selected from the formulary, the dose and dose unit for the medication selected will be pre-populated with the standard value. An alternate value can be selected from the drop down if appropriate
Dose Unit		
Frequency	<b>NOTE:</b> This field is pre-populated based on formulary choice selected.	When selected from the formulary, the frequency, duration and duration unit for the medication selected will be pre-populated with the standard value. An alternate value can be selected from the drop down if appropriate.
Duration		
Duration Unit		
Effective Date	Either select from the calendar the date the treatment was provided, or enter this date in YYYY-MM-DD format.	The date treatment was initiated is to be documented in this field.

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

### Diagnosis & Treatment

Client / ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250) 747-3265  
Client Address At Time Of Encounter No address selected for this case  
Episode Date/Type 2012-04-02 / REPORTED  
Encounter ID/Date/Type/Status/Encounter Created Date 18341 / 2012-04-02 / CONTACT INVESTIGATION / OPEN / 2012-04-02

Exemptions Adverse Contraindication Notes File

client  
Exemption Adverse Contraind Organ/Bld Allergies Alerts Files

encounter  
Encounter Symptoms History Physicians Abx Risks IDU Support Exam Imms/IST  
Lab **Diag-treat** Follow-up Notes Contacts Informant Birth Ctrl Psych Outreach

#### Diagnosis

◆ Disease Code ◆ Status ◆ Date / Time

Etiologic Agent Subtype  
Add

Disease Code	Status	Date / Time	Etiologic Agent	Subtype	
Chancroid	SUSPECT CASE	2012-04-02 08:55:04	HAEMOPHILUS DUCREYI		Update Delete History

#### AIDS Indicative Diseases

◆ Disease

Disease	Earliest Known Start Date	Diagnosis	
			Add

#### Allergies

Allergen/Drug	Adverse Event(s) Details	Severity	Date Reported	Accurate	Medically Verified
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#### Treatment

Drug Formulary

◆ Drug ◆ Route ◆ Dose ◆ Dose Unit ◆ Frequency ◆ Duration ◆ Duration Unit ◆ Effective Date

Drug	Route	Dose	Dose Unit	Frequency	Duration	Duration Unit	Effective Date	
							2012-04-02	Add

Comments

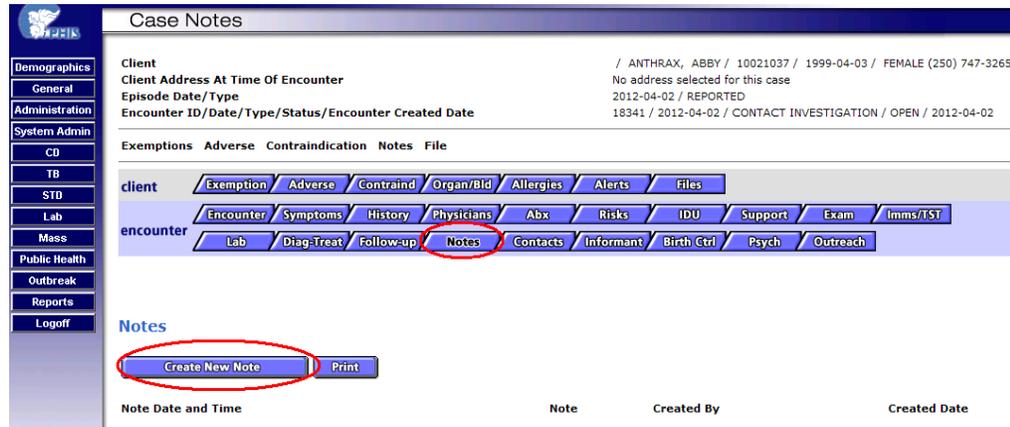
Save

m) Follow-up

- Documenting in this tab is not mandatory

n) Notes

- Click the Create New Note button



- Complete the require fields and click Save

**Important:** To the extent possible, the **Symptoms and Risks** should be documented in the designated field in iPHIS. Notes is reserved for documentation of information for which a designated field does not exist.

- **Required Fields:**

Notes Tab (if applicable)		* Notes can not be edited or deleted
Field	Description	Business Rule / Comments
Note Date and Time	Either select from the calendar, or enter this date in YYYY-MM-DD format	
Note	Free text field. This is a field that would be equivalent to the health care providers notes in a client's medical chart.	This allows for a narrative description of additional details relevant to the history, investigation, interventions, etc. This is accessed frequently by the Ministry when reviewing cases that may be related to an outbreak or when cases are of particular public health significance. This is where

Notes Tab (if applicable)		* Notes can not be edited or deleted
Field	Description	Business Rule / Comments
		additional details requested by the Ministry can be documented such as immunization history as relevant.  If an error is apparent within a note, a new note should be created as amendment to the note with the error.

**Important: Do not Delete Notes for Quality Assurance**  
 If an error is apparent within a note, a new note should be created as an amendment to the note with the error.

The screenshot shows the 'Case Notes' interface. On the left is a navigation menu with options like Demographics, General, Administration, System Admin, CD, TB, STD, Lab, Mass, Public Health, Outbreak, Reports, and Logoff. The main area displays client information: Client (ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250) 747-3265), Client Address At Time Of Encounter (No address selected for this case), Episode Date/Type (2012-04-02 / REPORTED), and Encounter ID/Date/Type/Status/Encounter Created Date (18341 / 2012-04-02 / CONTACT INVESTIGATION / OPEN / 2012-04-02). Below this are tabs for Exemptions, Adverse, Contraindication, Notes, and File. The 'Notes' tab is active and circled in red. Underneath, there are sub-tabs for client (Exemption, Adverse, Contraind, Organ/Bld, Allergies, Alerts, Files) and encounter (Encounter, Symptoms, History, Physicians, Abx, Risks, IDU, Support, Exam, Imms/TST, Lab, Diag-Treat, Follow-up, Notes, Contacts, Informant, Birth Ctrl, Psych, Outreach). The 'Notes' sub-tab is also circled in red. The 'Note' section has a date and time dropdown set to 2012-04-02 10:40, a text area for the note, and a text area for client comments. At the bottom, it shows 'Created By: VPOLIQUIN' and 'Created Date'. Three buttons are at the bottom: 'Save' (circled in red), 'Delete', and 'Back'.

- After saving the note users are returned to the main note screen where another note can be added or the existing ones edited

Case Notes

Client / ANTHRAX, ABBY / 10021037 / 1999-04-03 / FEMALE (250) 747-3265  
Client Address At Time Of Encounter  
Episode Date / Type 2012-04-02 / REPORTED  
Encounter ID / Date / Type / Status / Encounter Created Date 18341 / 2012-04-02 / CONTACT INVESTIGATION / OPEN / 2012-04-02

Exemptions Adverse Contraindication Notes File

client Exemption Adverse Contraind Organ/Bld Allergies Alerts Files  
encounter Encounter Symptoms History Physicians Abx Risks IDU Support Exam Imms/TST  
Lab Diag-Treat Follow-up Notes Contacts Informant Birth Ctrl Psych Outreach

Notes

Create New Note Print

Note Date and Time	Note	Created By	Created Date
2012-04-02 10:40	Client says they will not do needle drugs again	VPOLIQUIN	2012-04-02 10:53

Update

- o) Contacts**
  - Refer to [Creating/Maintaining Contacts](#) for details.
- p) Informant**
  - Documenting in this tab is not mandatory
- q) Birth control**
  - Documenting in this tab is not mandatory
- r) Psych**
  - Documenting in this tab is not mandatory
- s) Outreach**
  - This tab has been inactivated in iPHIS

Exposure Setting	Rationale/Guidance
STI - Unprotected Sex	This speaks to the type of risky behaviour the individual participates in. This applies to all types of barrier methods of protection including dental dams, etc...Intended to be used as yes if the case never uses condoms/protection or uses condoms/protection inconsistently.
STI - Condom failure	This is intended to be used for slippage or breakage.
STI - Infant born to infected mother	When a case of congenital syphilis or neonatal/congenital herpes is reported, it is to be reported in the STI Module. This is the only risk that would apply to these cases.
STI - Sexual assault	The actual risk for a Sexual Assault relates to the increased risk for transmission because of the potential for trauma at the site. This may be compounded by the source being unknown to the victim. Additional interventions may be required for individuals who have been assaulted (such as additional counselling, emergency contraception counselling, and additional follow-up testing for HIV, Hep B and Hep C). NOTE: Hepatitis B and C are reported in the CD Module of iPHIS.
HIV - Occupationally exposed to HIV contaminated blood or body fluids	Exposure to HIV contaminated blood or body fluids, or concentrated virus in an occupational setting. This is intended to be used for cases that have been exposed to a <u>confirmed HIV source</u> in their occupational setting. If the source is <u>probable HIV source</u> , the answer should be documented as "NO" but a note of clarification should be documented in the comments field at the bottom of the screen. For example "occupationally exposed to a probable HIV case".
HIV - Non medical exposure (e.g., tattoo, aggravated contact with blood) Please Specify	The risk for disease transmission in a Non-medical exposure is not necessarily greater than it is for the other risks; however the risk for these individuals is dependent on the type of exposure they encountered. For example tattoos can be a significant source of infection if done in an unsterile environment or with shared equipment. It is useful to monitor non-medical exposures to be able to describe the epidemiology of HIV in Saskatchewan. Aggravated contact with blood is inclusive of fights and bites. Community needle sticks are to be included here.
HIV - Perinatal Transmission	The transmission of HIV from a woman infected with HIV to her infant either in utero, during childbirth, or through breastfeeding. If breastfed, indicate in text box.

Exposure Setting	Rationale/Guidance
HIV - From endemic country (please specify)	This is intended to be used for individuals who were born in a country where HIV is endemic. See list of endemic countries. An HIV-endemic country is defined as having an adult (ages 15-49) prevalence of HIV that is 1.0% or greater and one of the following: 50% or more of HIV cases attributed to heterosexual transmission; a male to female ratio of 2:1 or less; or, HIV prevalence greater than or equal to 2% among women receiving prenatal care.
DO NOT USE - Sexual Contact with confirmed case	

Medical Risk Factors	Rationale/Guidance
HIV - Medical exposure (e.g. surgery, dental, oscopy) Please Specify	This is intended to be used for individuals who have been exposed to HIV while undergoing a medical procedure. This is inclusive of exposure through contaminated instruments or exposure from a positive source.
HIV - Received blood or blood components after 1985	Received transfusion of whole blood or blood components, such as packed red cells, plasma, platelets or cryoprecipitate; Received pooled concentrates of clotting factor VIII or IX for treatment of hemophilia/coagulation disorder after 1985. Trace back by Canadian Blood Services will be required. Receiving transfusions prior to 1985 are not to be included.
DO NOT USE - Received Pooled Concentrates of Factor VIII or IX for Treatment of Blood Disorder	
Behavioural/Social Factors	Rationale/Guidance
STI - Alcohol/Drug use	It is known that people engage in risky behaviour when under the influence of drugs/alcohol. It reduces inhibitions and studies show that recreational drug use can enhance the sexual experience.

STI - Casual sex while travelling outside Canada	The relevance is related to anonymous partnering or sex with a partner whose history may not be known, or sex with a partner in a country where a strain of STI may be endemic. It is known that people engage in riskier behaviour when they are on vacation. This is of most significance when the disease is a resistant strain. For example, AMR-GC is not endemic in Saskatchewan at this time. It is important to monitor cases related to travel outside of Canada to fully understand the epidemiology of STI in Saskatchewan.
STI - Injection Drug Use	Injection Drug use is not a typical mode of transmission for STIs, but it can be a marker for those who are at risk for HIV or are engaged in other high risk behaviours and therefore should be monitored to determine interventions for the individual and to monitor the epidemiology of STIs in Saskatchewan. For example, IDU has been a common behaviour of individuals with syphilis in particular outbreaks in Saskatchewan in the past.
STI - Internet partnering (specify which website)	Individuals who do not know their partners' histories are at greater risk of STIs. It is useful to monitor Internet Partnering to fully describe the epidemiology of STIs in Saskatchewan and determine if interventions can target this risk. Unknown/Anonymous partnering should also be answered as applicable as they may use the internet to hook up with known partners. Documenting which websites the case meets partners will assist in determining if targeting messaging on specific websites is a useful way to notify contacts.
STI - Unprotected sex with the same sex	Outbreaks of Syphilis in Saskatchewan in 2006 and 2008 were primarily among the MSM population. It is important to monitor Sex with the Same Sex risk to fully describe the epidemiology of STIs in Saskatchewan and to provide information for a response to STIs in Saskatchewan.
STI - More than two partners in the last three months	Risk increases with the number of partners, as described above. This can provide an opportunity for education and individual intervention (such as offering immunizations for Hep B if they have not received previously). This is intended to be used for understanding the risk behaviour of individuals and to understand the epi of STIs in Saskatchewan. This can be used to determine if interventions can target this risk.
STI - New partner within the last three months	People participating in serial monogamy can be at risk for STI because they may not know enough about their partner before engaging in a sexual relationship. This is intended to be used for understanding the risk behaviour of individuals and to understand the epi of STIs in Saskatchewan. This can be used to determine if interventions can target this risk.

STI - Previous STI	Risk for HIV and STI transmission may be increased when the case or their sexual partner has had an STI. This should be answered yes if the case has a history of STIs. This may be most significant if the case has a history of a recurrent ulcerative STI (i.e. herpes). Behavioural risks, access to condoms and addressing barriers to safer sex should be explored with clients who have previously had a STI.
STI - Sex with a known STI case	This identifies the source of the disease. Although this is the risk for acquiring the disease, other risks should still be asked to determine risky behaviour and risk for further transmission. It is important to be able to fully describe the epidemiology of STIs in Saskatchewan.
STI - Sex Trade Worker	The actual risk for transmission is no greater than it is for other risks; however sex trade workers are considered a vulnerable population. It is important to monitor sex trade risks to fully describe the epidemiology of STIs in Saskatchewan and to provide contextual information for planning a response to STIs in Saskatchewan. This includes providing sex for food, money, drugs, shelter, etc.
STI - Sex with a sex trade worker	The actual risk for transmission is no greater than it is for other risks; however sex trade workers are considered a vulnerable population. It is important to monitor sex trade risks to fully describe the epidemiology of STIs in Saskatchewan and to provide contextual information for planning a response to STIs in Saskatchewan. This includes providing someone with food, money, drugs, shelter, etc... In exchange for sex.
STI - Sex with a transgender partner	
STI - Street Involved/Homeless	These individuals are considered a vulnerable population. It is important to monitor street involved/homeless to fully describe the epidemiology of STIs in Saskatchewan and to determine if interventions can target this risk.
STI - Unknown/Anonymous Partner	The risk for these individuals is considered greater because they do not know their partners. This variable is intended to be used in tandem with Internet Partnering if applicable, or alone if the "hook up" was not done through the internet. It is useful to monitor Unknown/Anonymous Partnering to fully describe the epidemiology of STIs in Saskatchewan and determine if interventions can target this risk. Broader prevention measures may be required in managing outbreak situations and to notify others at risk.
HIV - Injection Drug Use (Current or past history)	IDU is a risk for HIV Transmission. If client is a current IDU or has a history of IDU the risk should be responded to as yes. This includes illicit drug use, steroid use. This is used in conjunction with sexual exposures to determine if MSM/IDU is a risk. MSM with an IDU is considered a risk category unto itself.
HIV - Sexual contact with confirmed/suspected HIV/AIDS (MSM or Heterosexual)	Risk for transmission of HIV is increased when there has been sexual contact (with same or other sex partner) with a confirmed case of HIV/AIDS.

HIV - Heterosexual contact with an IDU	The hierarchy of risks for heterosexual sex is higher for those who have sex with an injection drug user.
HIV - Heterosexual contact of a bisexual male	The hierarchy of risks for heterosexual sex is higher for those who have sex with a bisexual male.
HIV - Heterosexual contact with a person from an HIV endemic Country	This is intended to be used for individuals who have heterosexual sex with someone who was born in a country where HIV is endemic. See list of endemic countries. An HIV-endemic country is defined as having an adult (ages 15-49) prevalence of HIV that is 1.0% or greater and one of the following: 50% or more of HIV cases attributed to heterosexual transmission; a male to female ratio of 2:1 or less; or, HIV prevalence greater than or equal to 2% among women receiving prenatal care.
HIV - Sex with a partner of the same sex	This is intended to capture MSM and WSW. This will have to be used in conjunction with the client gender. This may be protected or unprotected. Since protection is often partial (example, condom not used in foreplay but used later) this variable is intended to be used for any sex with the same sex partner, regardless if a condom/protection is used or not.
HIV - Heterosexual contact (no other risk)	This is intended to capture the situations when a heterosexual individual has responded "no" to all other risks. Heterosexual transmission is considered low on the hierarchy of transmission for HIV, however remains a risk indicator when no other risks are identified.
HIV - Past history of sexually transmitted infection (STI)	Risk for virus transmission is increased when the case or their sexual partner has an STI. Past STI may mean there is a history of risky behaviour.
HIV - Sex Trade Worker	The risk for transmission for a Sex Trade Worker is no greater than it is for the other risks; however the risk for these individuals is because they are considered a vulnerable population. It is important to monitor Sex Trade risks to fully describe the epidemiology of HIV in Saskatchewan. Includes sex trade for food, money, drugs, shelter, etc.
HIV - Unable to obtain history	Where the history of exposure to HIV through any of the modes listed is unknown, or there is no reported history. This exposure category may include people whose exposure history is incomplete because they died, declined to be interviewed or were lost to follow-up; and people who cannot identify any mode of transmission. This is intended to be answered as YES when there is no history available.
DO NOT USE - Sex with men	
DO NOT USE - Sex with woman	

## Purpose:

- This chapter describes the iPHIS technical functionality and business processes for entering Laboratory data.
- Laboratory evidence is typically a requirement for meeting confirmed case definitions (Refer to [Appendix 2 – Criteria for confirmed cases](#)). It is the purpose of this chapter to outline the steps and business rules to enter laboratory data.
- Red diamonds  to left of some fields indicate they are system required fields.
- Fields for some sections are hidden and can be expanded by clicking  sign.

The case definitions for each chapter outline the laboratory requirements. In addition to supporting the case definitions, documentation of laboratory findings creates context to the clinical picture of the case.

**IMPORTANT** – As a quality control measure, iPHIS only allows a Placer Requisition ID to be used once within the system.

**Recommendation** – Standard processes are required among all iPHIS users to prevent delays in data entry due to this feature of the system that prevent duplicates.

**IMPORTANT** – Before setting up a lab requisition, a case or encounter must be created so the lab report can be assigned to the case!

Refer to [Section 10-30: How to Create/Maintain a CD Case](#) or [Section 10-40: How to Create/Maintain an STI Encounter](#).

## Index:

1. [Searching for a Requisition](#)
2. [Creating a Requisition](#)
  - a. [New Requisition](#)
3. [Add a test to a Requisition](#)
4. [Adding Results for a test](#)

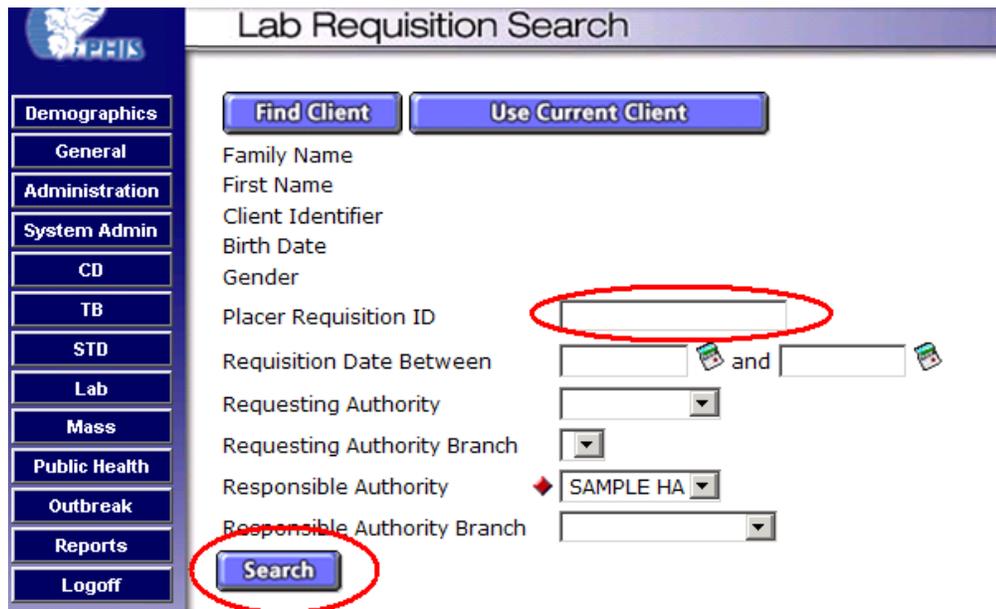
## 1. Search for a Requisition

- Click on the Lab button in the left had Navigation bar and select Lab Requisition Search



- Enter the Requisition number and click Search to see if the requisition has been entered in iPHIS already.
  - If you search for the requisition within the context of a client, the search is limited to requisitions of that client.
  - If you search for the requisition without a client in context, a matching requisition will be searched for from within the entire system.
- You can use the % to do wild card searches (see Create Client for information on wildcard searches)
- **Note** – laboratory requisitions are case sensitive.

**Recommendation** – Search for a requisition without a client in context as this will search the entire system for the requisition. When creating a new requisition, a client will have to be in context. If creating a requisition that is already in the system, an error will be displayed indicating that this function cannot be completed.



## 2. Create a Requisition

- If the requisition already exists and you want to add a test and/or results click the Details button and follow the steps in section 2 or 3 to add tests or results.



Lab Requisition Search Result					
Placer Requisition ID	Filler ID	Client Name	Ordering Provider	Physician Billing #	Requisition Date
EXT2246		PERTUSSIS, FREDDIE			2006-11-21

- If the requisition does not exist click the New button

Lab Requisition Search Result

Search Again **New**

Placer Requisition ID      Filler ID      Client Name      Ordering Provider      Physician Billing #      Requisition Date

**a) New Requisition**

- Enter the required fields and click Save
- Required Fields:

Lab Requisition Details Screen		
Field	Description	Business Rule / Comments
Placer Requisition ID	Free text field, enter requisition number	The system will not allow duplicate Place Requisition ID numbers. If a lab was entered in one health region in error, they will have to delete their lab requisition before another region will be able to enter the lab details.
Lab	From the drop-down list, select the Lab	
Requisition Date	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format	This date represents the Specimen Collected Date from the laboratory report. See Reference Card to choose the appropriate date.

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

Lab Requisition Details

**Client Information**

Client Name      ANTHRAX, ABBY      Birth Date      1999-04-03  
 Gender      FEMALE      Health Area      SAMPLE HA

**Find Client**

**Requisition Information**

Placer Requisition ID            **Search**

Responsible Authority      SAMPLE HA

\* Enter External Source Type and either Source Name or City for filter

External Source Type      Source Name      City      **Filter**

Ordering Provider     

Billing #     

Comments     

Lab     

Requisition Date     

**Save**      **New**      **Delete**

### 3. Add a Test to a Requisition

- After saving a requisition the Add Test button will show
- Click the Add Test button to get to the Lab Test Details screen

Lab Requisition Details

---

**Client Information**

Client Name	ANTHRAX, ABBY	Birth Date	1999-04-03
Gender	FEMALE	Health Area	SAMPLE HA

---

**Requisition Information**

Placer Requisition ID

Responsible Authority

\* Enter External Source Type and either Source Name or City for filter

External Source Type <input type="text"/>	Source Name <input type="text"/>	City <input type="text"/>	<input type="button" value="Filter"/>
---	----------------------------------	---------------------------	---------------------------------------

Ordering Provider

Billing #

Comments

Lab

Requisition Date

---

**Test and Result Summary**

Program Area  Test Panel

Set ID	Specimen Type	Specimen ID	Def.	Body Site	Test Name	Test Result Status	Collection Date	Reported Date	<input type="button" value="Add Test"/>
--------	---------------	-------------	------	-----------	-----------	--------------------	-----------------	---------------	---

- Enter the required fields and click Save
- Required Fields:

Lab Test Details Screen		
Field	Description	Business Rule / Comments
Specimen Type	From the drop-down list, select the specimen type	Create data dictionary to provide guidance on selecting appropriate specimen types
Body Site	From the drop-down list, select the body site	Create data dictionary to provide guidance on selecting appropriate body sites
Test Name	From the drop-down list, select the test name	Create data dictionary to provide guidance on selecting appropriate test names. Selection of the lab test is based on the type of test that was conducted. It need not be the exact name of the test that was used. For example, an antibody or antigen test is the umbrella term that will not change with the name of the test that the laboratory uses.

Test Result Status		Normally set to: 'Final results; results stored and verified. Only changed with a corrected result'.
Collection Date	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format	This date represents the Specimen Collection Date on the laboratory report. Refer to the Reference Card.
Reported Date	Either select from the calendar the date that the case was reported to the clinic/branch, or enter the date in YYYY-MM-DD format	This date represents the Date Reported on the laboratory report. Refer to the Reference Card.

**Recommendation** – Selection of the lab test is based on the type of test that was conducted. It need not be the exact name of the test that was used. For example, tests may be looking for the organism (PCR, DNA, RNA, and antigen) or for evidence of infection (antibody).

In general, the drop down will include the types of test (umbrella term) rather than specific test names (trademark or associated with a test kit) in order to document the objective test rather than a trademark name of a test.

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

### Lab Test Details

#### Client Information

Client Name	DOUBLE, ENTRY	Birth Date	1977-01-01
Gender	FEMALE	Health Area	SAMPLE HA
Placer Requisition ID	T200		

[Requisition Details](#)

#### Test Information

Set ID

Specimen Type

Specimen ID

Body Site

Test Name

Test Result Status

Collection Date

Reported Date

Defining Specimen

[Save](#) [New](#) [Delete](#)

#### Result Summary

Set OBX Id	Program Area	Result	Disease/Diagnosis	Resulted Test Code
------------	--------------	--------	-------------------	--------------------

#### 4. Adding Results for a Test

- After saving a Test for the requisition the Add Result button will show
- Click the Add Result button to get to the Lab Result Details screen

**Lab Test Details**

**Client Information**

Client Name	ANTHRAX, ABBY	Birth Date	1999-04-03
Gender	FEMALE	Health Area	SAMPLE HA
Placer Requisition ID	LT0002		

**Requisition Details**

**Test Information**

Set ID: 1

Specimen Type:

Specimen ID:

Body Site:

Test Name:

Test Result Status:

Collection Date:

Reported Date:

Defining Specimen:

**Save** **New** **Delete**

**Result Summary**

<b>Set OBX Id</b>	<b>Program Area</b>	<b>Result</b>	<b>Disease/Diagnosis</b>	<b>Resulted Test Cod</b>	<b>Add Result</b>
-------------------	---------------------	---------------	--------------------------	--------------------------	-------------------

- Fill in the required fields and click Save
- Required Fields:

Lab Result Details Screen		
Field	Description	Business Rule / Comments
Branch	From the drop-down list, select the current status of the case	Is required by the Ministry for FNIHB and NITHA to enter the branch as the health region where the case is geographically located.
Program Area	From the drop-down list, select the current status of the case	One requisition may include tests for infections that are to be documented in either the CD or STI modules and diseases are linked to either of these modules. Selecting the program area will ensure the tests are only accessible by users of the appropriate program area.
Disease/Diagnosis	From the drop-down list, select the appropriate disease that the lab test	By choosing this, it will narrow down the appropriate drop-down items.

	supports the diagnosis of	
Result	From the drop-down list, select the appropriate result.	Refer to Reference Card. Usually set to positive.
Assign result to case	From the drop-down list, select the disease that the lab test result supports.	This is <b>required to link the lab test and associated result to the appropriate case.</b> If the individual has multiple cases or encounters, select the case or encounter that this lab test/result supports.
Observation Value	Free text field, enter observation values	If applicable For HIV: CD4 count, viral load values

**The most important steps in entry of lab tests and results is ASSIGNING THE RESULT TO CASE**

Individuals may have several cases over time or they may have a co-infection. The lab tests/results support a specific diagnosis. The appropriate disease must be selected to connect the lab result to the case/encounter (see below).

When this step is successfully completed, the lab results will be visible within the case or encounter’s lab tab of the CD or STI Modules.

### Lab Result Details

<b>Name</b>	* PERTUSSIS, FREDDIE	<b>Birth Date</b>	1981-05-12	<b>Reported Date</b>	2014-09-02	
<b>Client ID</b>	10002795	<b>Gender</b>	MALE	<b>Episode Date</b>	2014-09-01	
<b>Client Address at Time of Case</b>	No address selected for this case				<b>Episode Date Type</b>	SPECIMEN
<b>PHN</b>	456997717	<b>Age At</b>	33yr 3mo	<b>Case ID</b>	118107	
<b>Disease</b>	Pneumococcal-invasive					

Exemptions	Adverse	Contraindic	118107, 2014-09-02, B95.3, Pneumococcal-invasive
			116903, 2014-06-23, A92.3, West Nile virus
			83686, 2014-06-10, J11.1, SRI
			116698, 2014-06-09, J80, SARS
			112535, 2013-11-28, A98.5, Hantavirus
			111031, 2013-09-10, A06, Ameobiasis
			111030, 2013-09-10, A07.1, Giardiasis
			109431, 2013-06-13, A49.8, Aeromonas
			104464, 2012-09-25, B17.1, Hepatitis C
			103532, 2012-08-07, A81.0, Creutzfeldt-Jakob disease
			103404, 2012-07-30, A00, Cholera
			98084, 2011-09-29, A04.0, Verotoxigenic Escherichia coli infections
			95653, 2011-05-03, P36.0, Streptococcal B-neonatal
			94378, 2011-02-17, A15, Tuberculosis-respiratory
			91881, 2010-09-09, A36, Diphtheria
			89092, 2010-03-22, A37, Pertussis
			89044, 2010-03-17, B95.0, Streptococcal A-invasive
			88198, 2010-01-19, A32, Listeriosis
			88197, 2010-01-19, ,
			88196, 2010-01-19, ,
			84940, 2009-09-30, A06, Ameobiasis
			84178, 2009-08-13, J11.1, SRI
			83529, 2009-07-10, J10, Influenza
			82584, 2009-06-10, J10, Influenza
			77317, 2008-07-23, B01, Chickenpox
			71966, 2007-10-03, A49.2, H. influenza-invasive
			69542, 2007-07-26, A92.3, West Nile virus
			68148, 2007-04-11, A82, Rabies
			61793, 2006-01-19, Z22.5, Hepatitis B-carrier
			61139, 2005-11-17, A02.0, Salmonellosis
			118107, 2014-09-02, B95.3, Pneumococcal-invasive

**Result Information**

Set OBX Id

Health Area

Branch

Program Area

Disease/Diagnosis

Resulted Test Group Code

Result

Assign result to case

Observation Value

IMPORTANT

All cases associated with the individual will display allowing the user to select the case the lab result supports. In this case, it is the pneumococcal – invasive case reported on 2014-09-02

Communicable Disease Control Manual


 Government  
 of  
 Saskatchewan  
Ministry of Health

## **Rabies on iPHIS – Comprehensive Guidelines for Data Entry Effective August 1, 2010**

### **Background:**

There are a number of potential exposures to rabies that are investigated each year in Saskatchewan. The Ministry of Health requires reports of incidents where Rabies post-exposure prophylaxis (RPEP) has been administered. A consistent approach to reporting is necessary to be able to interpret information in a reliable way.

Some regions had been fulfilling their reporting requirements by entering into the integrated Public Health Information System (iPHIS). A number of health authorities expressed an interest/desire on this method of reporting as long as the information entered could be accessed for reports. Efforts were placed into determining if reports could be created. We have now determined that rabies information entered into iPHIS can be retrieved.

A working group was created including Ministry of Health, health region and First Nations Inuit Health representation to:

- Identify the reports that would be helpful at a local level so they could be developed and made available to regions/jurisdictions;
- Provide feedback on the data elements that will be requested in an effort to standardize the information that is collected through the investigation and subsequently reported in iPHIS. Ideally, the options from iPHIS should be included on local report/investigation forms;
- Provide feedback on a rabies investigation worksheet that is synchronized with iPHIS which health authorities can use or adapt for local use; and,
- Establish guidelines/standards for data entry into the various fields of iPHIS so information is being recorded/reported consistently so reports that are generated will be meaningful.

Beginning August 1, 2010 all incidents with exposure dates of January 1, 2010 and onward for which RPEP has been administered are to be entered into iPHIS. It is however, the decision of the Health Authorities if they want to enter all other animal bite investigations.

**The following are the guidelines based on the recommendations of the working group:**

The Health Authority who provides follow-up of the individual will report the case, regardless of residence of the case. If follow-up of the animal is being done by another health authority, details of the animal (including the Unique Animal ID Number) will be shared with the health authority following the case so all required details of the animal can be completed in the case record. Refer to Animal Services Incident Number in the charts below for details about generating Unique Animal ID Numbers.

Note – Fields that are shaded in grey are required fields for reporting incidents where RPEP was administered to the Ministry.

Demographic information is for the individual who has been provided RPEP or who it is being considered for.

Rabies is not entered as a CD case – this is reserved for Human Rabies Cases, not Rabies incident investigations.

To navigate to the screen for entering Rabies incidents:

- Create or select a client in the demographics screen.
- Click on the CD hotlink on the side bar.
- Choose “Client Rabies Incident Summary”.

If the incident has not previously been entered, enter as “New Incident”

**Incident:**

The screenshot shows the iPHIS web application interface. The top navigation bar includes links for Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, and Logoff. The left sidebar contains a menu with categories like Demographics, General, Administration, System Admin, and various medical conditions (CD, TB, STD, Lab, Mass, Public Health, Outbreak, Reports, Logoff). The main content area is titled 'Incident' and displays the following information:

- Name:** \* PERTUSSIS, FREDDIE
- Client ID:** 10002795
- Birth Date:** 1981-05-12
- Gender:** MALE
- Client Address At Time Of Incident:** No address selected for this case
- Age At:** 23yr 3mo
- PHN:** 456997717
- Reported Date:** 2004-09-01
- Animal Species:**

Below this information are tabs for Exemptions, Adverse, Contraindication, and File. The 'Incident' tab is active, showing:

- Incident Number:** 212
- Health Area:** SAMPLE HA
- Reported Date:** 2004-09-01
- General Comments:** (Empty text area)
- Status:** OPEN

The 'Client Details' section includes a search filter for Physician Filters with fields for Source Name and City, and buttons for Filter, Attending Physician, Physician Telephone, and Client Address At Time Of Incident.

**Data Elements:**

Reported Date	The date the health region started the follow-up
General Comments	Not required by the Ministry, but for case management you may want to include a summary of the incident here
Status – <i>iPHIS mandatory field</i>	Open: if follow-up is being done. Closed: Once follow-up is complete Unresolved: if lost to follow-up (cannot reach the client to finish follow-up)

**Incident – Client**

**Details:**

The screenshot shows the iPHIS Application interface in Microsoft Internet Explorer. The browser address bar displays 'https://phis.health.gov.sk.ca - iPHIS Application - Microsoft Internet Explorer'. The top navigation bar includes links for Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, and Logoff. The main content area is titled 'Incident' and displays client information for a case named 'PERTUSSIS, FREDDIE'. The client's details include: Client ID 10002795, Birth Date 1981-05-12, Gender MALE, Client Address At Time Of Incident (No address selected for this case), Age At 23yr 3mo, PHN 456997717, and Reported Date 2004-09-01. Below the client information, there are tabs for 'client' (Exemption, Adverse, Contraind, Allergies) and 'incident' (Incident, Exposure, Animal, Imms/TST). The 'client' tab is selected, and the 'Status' is set to 'OPEN'. The 'Client Details' section contains various input fields: Physician Filters (Source Name and City), Attending Physician (dropdown), Physician Telephone (dropdown), Client Address At Time Of Incident (dropdown), Bleeding/Breaks To Skin (dropdown), Previously Immunized (dropdown), Immunization Date (text field), Vaccine Type (dropdown), Client Weight At Time Of Incident (text field with 'KG' unit), and Prophylaxis Indicated (dropdown). 'Save' and 'Delete' buttons are located at the bottom of the form.

Attending Physician	Not required by the Ministry, but for case management you may want to complete
Client Address at Time of Incident	Not required by the Ministry, but for case management you may want to complete
Bleeding/Breaks to Skin	Choose as appropriate from drop down
Previously Immunized	Choose as appropriate from drop down: Yes – only for those who completed a series. No – for those who have not had a series or for those where a series was not completed

	Unknown -
Immunization Date	<p>Only one date can be entered. Only include for those where Previously Immunized response was YES</p> <p>The following is the criteria for what date to enter for those who completed a series:</p> <ul style="list-style-type: none"> <li>• Choose actual date of last dose if known, <b>OR</b></li> <li>• Choose 1<sup>st</sup> day of the month (for the appropriate year) if this is known, <b>OR</b></li> <li>• Choose the 1<sup>st</sup> day of Jan for the appropriate year if month unknown.</li> </ul>
Vaccine Type	<p>Include the type of vaccine that the client has received previously – Immune Globulin is irrelevant in this situation as it has no bearing on post-exposure immunization requirements whereas the vaccine if given as pre-exposure or as a completed post-exposure series will eliminate the need for RIG and the additional doses of HDCV).</p>
Client Weight at time of incident	<p>Important for determining RIG dosage. Include for case management</p>
Prophylaxis Indicated	<p>Choose as appropriate from drop down –</p> <p>Yes – if RPEP is recommended</p> <p>No – if RPEP is not recommended</p> <p>Unknown – not applicable in this instance</p>

Save Changes

## Exposure

The screenshot shows a web browser window with the URL <https://phis.health.gov.sk.ca>. The page title is "Exposure". The client information is as follows:

Name	* PERTUSSIS, FREDDIE	Birth Date	1981-05-12	
Client ID	10002795	Gender	MALE	
Client Address At Time Of Incident	No address selected for this case		Age At	23yr 3mo
PHN	456997717	Reported Date	2004-09-01	
Animal Species				

Below the client information, there are tabs for "Exemption", "Adverse", "Contraind", and "Allergies". Under the "incident" section, there are tabs for "Incident", "Exposure", "Animal", and "Imms/TST". The "Exposure" tab is selected, and the form contains the following fields:

- Date Of Exposure: 2004-08-29
- Place Of Exposure: THIS PROVINCE - RURAL
- Proximity To River/Rural: YES
- Details: (Empty text area)
- Type Of Exposure: BITE
- Wound Location: ANKLE/FOOT
- Wound Description: (Empty text area)

A "Save" button is located at the bottom left of the form.

Date of Exposure	The date the client was exposed (choose the first date if ongoing exposure). If ongoing exposure to a family pet that tested positive for rabies, choose the date that the animal's behaviour/health started to change.
Place of Exposure	Choose the name of the town/First Nations community or the name of the RM – this is important for tracking rabies incidents in the province and will be mapped along with rabid animal map.
Proximity to River/Rural	Not required by Ministry -
Details	Not required by the Ministry, but for case management you may want to include additional information about the exposure here.
Type of	Choose as appropriate from drop down (see options and definitions

Exposure	<p>below).</p> <p><b>Note: Occupational Exposure options should be used if the exposure was due to an occupational incident. This would involve veterinarians, conservation officers, etc. Choose the appropriate one based on the type of exposure.</b></p> <ul style="list-style-type: none"> <li>• Bite – Teeth penetrated the skin or scratched the skin</li> <li>• Scratch – scratch on the skin by the animals claw</li> <li>• Saliva on mucous membranes – such as “animal kisses”</li> <li>• Saliva on existing lesion - this would include licks to non-intact skin</li> <li>• Saliva on intact skin</li> <li>• Occupational Exposure Bite – Teeth penetrated the skin or scratched the skin</li> <li>• Occupational Exposure Scratch – scratch on the skin by the animals claw</li> <li>• Occupational Exposure Saliva on mucous membranes – such as “animal kisses”</li> <li>• Occupational Exposure Saliva on existing lesion - this would include licks to non-intact skin</li> <li>• Occupational Exposure Saliva on intact skin</li> <li>• No known contact – for example bat found in the room, or family pet that is positive and family member cannot report if there was contact with the animal</li> </ul>
Wound location	<p>Choose as appropriate from drop down</p> <p>Head/Neck; Face; Arm; Hand/finger; Torso; Leg;, Foot/toe; Mucosa; Unknown;</p>
Wound Description	<p>Not required by the Ministry, but for local follow-up/case management you may want to include more details here</p>

Save Changes

## Animal – Owner Info

https://phis.health.gov.sk.ca - iPHIS Application - Microsoft Internet Explorer

Home • Client Search • Wait Queue • Scheduling • Outstanding Referrals • Lab • Site Map • Help • About • Logoff

**Owner/Animal**

Name	* PERTUSSIS, FREDDIE	Birth Date	1981-05-12
Client ID	10002795	Gender	MALE
Client Address At Time Of Incident	No address selected for this case	Age At	23yr 3mo
PHN	456997717	Reported Date	2004-09-01
Animal Species			

Exemptions Adverse Contraindication File

client **Exemption** Adverse Contraind Allergies

incident Incident Exposure **Animal** Imms/TST

**Owner Info**

Find Client Create Client Reset Owner Info

Family Name  First Name  Gender  Birth Date

Owner Address

OR

Street 1

Street 2

City

Province

Country

Postal Code

**Animal Info**

Animal Species

Animal Type

Owner information is not required by the Ministry, except in instances where the owner is out of province and we have to forward the information onto another jurisdiction so follow-up can be provided. Data entry of owner information is a regional decision.

### E-mail Communication Requirement:

Owner information is to be provided to the Ministry when the owner will be followed up in another jurisdiction (province). This will best be communicated via e-mail to the ministry at [cdc@health.gov.sk.ca](mailto:cdc@health.gov.sk.ca) rather than including in iPHIS. Details that must be provided to facilitate follow-up include:

- Name of owner
- Phone numbers

- Address
  - Details of the animal (name, type, etc)
  - Summary of the incident
  - Contact number of the individual following the victim so the animal investigator can relay animal observation results directly.
- NOTE:** E-mail from within the Global System is considered secure. If e-mail communication is from outside global, the message should be encrypted or it can be sent to the confidential fax at (306)787-9576.

### Animal - Animal Info

The screenshot shows the IPHIS Application web interface in Microsoft Internet Explorer. The browser address bar shows 'https://phis.health.gov.sk.ca - IPHIS Application - Microsoft Internet Explorer'. The navigation menu includes: Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, and Logoff. The main content area is titled 'Owner/Animal' and displays client information for '\* PERTUSSIS, FREDDIE'. The information includes Client ID (10002795), Birth Date (1981-05-12), Gender (MALE), Client Address At Time Of Incident (No address selected for this case), Age At (23yr 3mo), PHN (456997717), and Reported Date (2004-09-01). Below this, there are tabs for 'client' (Exemption, Adverse, Contraind, Allergies) and 'incident' (Incident, Exposure, Animal, Imms/TST). The 'Animal Info' form is active, showing fields for Animal Species, Animal Type, Animal Description, Animal Vaccinated, Vaccination Date, Animal Healthy, Observation Following Exposure, Brain Sent For Testing, FA Result, Tissue Culture, Date Sent For Testing, and FA Result Date. A 'Comments' field is also present at the bottom of the form. The Windows taskbar at the bottom shows the Start button, several open applications, and the system clock at 3:29 PM on 8/2/2010.

Animal Species	Choose as appropriate from drop down (see options below) Dog↑ Cat↑ Bat↑ Cow↑ Horse↑ Hog↑ Skunk↑ Raccoon↑ Fox↑ Coyote□ Ferret□ Mouse/gopher□ Hamster□ Other□ Unknown□
Animal Type	<ul style="list-style-type: none"> <li>• Pet (indoor) – pet that does not go outside unaccompanied</li> <li>• Pet (outdoor) – pet that does not come into the house</li> <li>• Pet (Indoor/Outdoor) – pet that spends time inside as well as outside unaccompanied</li> <li>• Outdoor Farm Animal – for example barn cats, livestock</li> <li>• Wild – would include any animal that is not domestic (fox, skunk, etc...)</li> <li>• Stray – domestic animal that is feral</li> <li>• Unknown</li> </ul>
Animal Description	Not required by the Ministry, but for case management you may want to include information here. An example of when you use this may be when it is a stray/unknown and you include a physical description
Animal Vaccinated	Choose as appropriate from drop down
Vaccination Date	Not required by the Ministry, but for case management you may want to include this information
Animal Healthy	Choose as appropriate from drop down based on the health of the animal at the time of the incident. If “No”, complete the symptoms field.
Observation Following Exposure	Choose as appropriate from drop down. – this is an important field for reporting as is used for filtering of some reports
Brain sent for testing	Will be used in generating reports
Date sent for testing	Indicate the date the specimen was sent for testing
FA Result	The preliminary result recorded here.
FA Result Date	Date the results were reported to the RHA/FN jurisdiction
Tissue Culture	For complete record, it is beneficial to add this, however it is not required at the ministry.

**Animal - Animal Info cont'd**

Rabies Status	Not required by the Ministry, but follow these guidelines for use of this field. Choose as appropriate from drop down (see options below) Positive – only to be used for those confirmed positive Negative – use for animals who were well after observation period or whose results returned as negative Unknown – use for escaped animals or those who were destroyed and not available for testing
Animal Retention Method	Not required by the Ministry, but for case management you may want to include information here.
Retention Method	Not required by the Ministry, but for case management you may want to include information here.

Comments	
Retention Method From ... To	Dates animal is to be under observation for (start date and end date) Not required by the Ministry, but for case management you may want to include information here.
Animal Retention Results	Choose as appropriate from drop down based on the status of the animal during/after the observation period. This field is only mandatory for reporting when observation following exposure was documented as “YES” <ul style="list-style-type: none"> <li>• Became ill – appeared to be healthy at the time of the incident but became ill during the observation period</li> <li>• Released – was well after the observation period and has been released</li> <li>• Natural Death – the animal succumbed due to illness</li> <li>• Destroyed –</li> </ul>
Family Vet Name	Not required by the Ministry, but for case management you may want to include information here.
Vet Phone	Not required by the Ministry, but for case management you may want to include information here.
Animal Services Notified	Choose as appropriate from drop down - Not required by the Ministry, but for case management you may want to include information here.
Animal Services Incident Number	This field will be used for the Unique Animal ID Number. This must be used in each case report on iPHIS that involves the same animal in the following format (no spaces included in this sequence): <i>&lt;health region 3-4 letter acronym&gt;-&lt;four digit calendar year&gt;-&lt;R to indicate Rabies&gt;-&lt;three digit sequential number beginning at 001&gt;</i> (e.g. SCHR-2007-R-001)  <b>Rationale:</b> this is an important element to be incorporated as it helps to determine the number of animals involved in incidents - for example it would be misleading if the same animal that rabies results were positive for was counted 5 times because 5 people were exposed the family pet.  The region where the animal is being followed will generate the Unique Animal ID Number. Animal information must be included in the victim’s iPHIS record therefore, communication between case and animal investigators is important for quality of data and prevention of duplicate reporting.

Save

**Animal - Animal Info Cont'd**

Symptoms – iPHIS mandatory field	Choose as appropriate from drop down if “animal healthy” response was “NO”
--	--

**Immunization/TST:**

The screenshot shows the iPHIS application interface. The top navigation bar includes links for Home, Client Search, Wait Queue, Scheduling, Outstanding Referrals, Lab, Site Map, Help, About, and Logoff. The left sidebar contains a menu with categories like Demographics, Administration, System Admin, and various medical conditions (CD, TB, STD, Lab, Mass, Public Health, Outbreak, Reports, Logoff). The main content area is titled 'Immunizations' and displays client information for 'PERTUSSIS, FREDDIE'. Below this, there are tabs for 'Exemption', 'Adverse', 'Contraind', and 'Allergies'. The 'Immunizations' tab is selected, showing a search filter for '2004-09-01' and a 'Filter' button. The form includes fields for 'Provider/Personnel', 'Professional Status', 'Where Administered', 'Agent Formulary', 'Agent', 'Lot Number (Expiry Date)', 'Site', 'Route', 'Dosage', 'Dosage Units', and 'Informed Consent'.

**NOTE:** The Saskatchewan Immunization Management System (SIMS) houses the complete immunization record for individuals and entry into SIMS should be considered.

Immunization Date - <i>iPHIS mandatory field</i>	Date immunization provided. It is best practice and provides a complete record when all doses of rabies post-exposure prophylaxis (immune globulin and vaccine) are documented. This is required for analysis of RPEP in Saskatchewan.
Provider/Personnel - <i>iPHIS mandatory field</i>	Not required by the Ministry, but is a mandatory field for data entry and may be useful for case management.
Where	Not required by the Ministry, but for case management you may want

Administered	to include information here.
Agent Formulary	Not required by the Ministry,
Agent - <i>iPHIS mandatory field</i>	Choose as appropriate from drop down.
Lot Number/Expiry - <i>iPHIS mandatory field</i>	This is a drop-down list and must be pre-populated by eHealth. A process has been established at the Ministry to try to ensure that when new Lot Numbers for the vaccine is received, it will be forwarded to eHealth for inclusion in the drop-down list. If not in the drop-down, forward the information to <a href="mailto:ServiceDesk@eHealthsask.ca">ServiceDesk@eHealthsask.ca</a> . "Unknown" has been included as an option for instances where the series has been started in another province/country and the information will not be available. This option should be used infrequently.
Site - <i>iPHIS mandatory field</i>	Choose as appropriate from drop down.
Dosage/Dosage Units	Not required by the Ministry.
Dose Number	All doses must be entered for a complete record. Each dose will be numbered sequentially in the series.
Informed Consent - <i>iPHIS mandatory field</i>	Not required by the Ministry. Mandatory field for data entry.

## Immunization/TST

The screenshot shows the PHIS Application web interface. The browser address bar displays "https://phis.health.gov.sk.ca - iPHIS Application - Microsoft Internet Explorer". The navigation menu includes "Home", "Client Search", "Wait Queue", "Scheduling", "Outstanding Referrals", "Lab", "Site Map", "Help", "About", and "Logout". The main content area is titled "Immunizations".

**Client Information:**

Name	* PERTUSSIS, FREDDIE	Birth Date	1981-05-12	
Client ID	10002795	Gender	MALE	
Client Address At Time Of Incident	No address selected for this case		Age At	23yr 3mo
PHN	456997717	Reported Date	2004-09-01	
Animal Species				

**Exemptions Adverse Contraindication File**

**client** | Exemption | Adverse | Contraind | Allergies

**incident** | Incident | Exposure | Animal | Imms/TST

**Animal** sub-tab is active. Fields include:

- Provider/Personnel: [dropdown]
- Professional Status: [dropdown]
- Recorded By: [dropdown]
- Where Administered: [dropdown]
- Agent Formulary: [dropdown]
- Agent: [dropdown]
- Lot Number (Expiry Date): [dropdown]
- Site: [dropdown]
- Dosage: [text input]
- Dose #: [text input]
- Route: [dropdown]
- Dosage Units: [dropdown]
- Informed Consent: [dropdown]
- Reason For Immunization: [dropdown]
- Source of Information: [dropdown] Accurate
- Comments: [text area]

Buttons: Save, Delete, New

Reason for Immunization	Choose as appropriate from drop down.
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## Rabies on iPHIS – Quick Reference Guidelines for Data Entry – August 1, 2010

The Ministry of Health requires reports of incidents where Rabies post-exposure prophylaxis (RPEP) has been administered. A consistent approach to reporting is necessary to be able to interpret information in a reliable way. Beginning August 1, 2010 all incidents with exposure dates of January 1, 2010 onward for which RPEP has been administered are to be entered into iPHIS. It is however, the decision of the health authority if they want to enter all other animal bite investigations.

The Health Authority who provides follow-up of the individual will report the case, regardless of residence of the case. If follow-up of the animal is being done by another health authority, details of the animal (including the Unique Animal ID Number) will be shared with the health authority following the case so all required details of the animal can be completed in the case record. Refer to Animal Services Incident Number in the charts below for details about generating Unique Animal ID Numbers.

Note – Fields that are shaded in grey are required fields for reporting incidents where RPEP was administered to the Ministry.

Demographic information is for the individual who has been provided RPEP or it is being considered for.

**Client Info:**

PHN	This is the Unique Individual Identification Number and must be reported
Family name - <i>iPHIS mandatory field</i>	Enter details
First name – <i>iPHIS mandatory field</i>	
Birth Date - <i>iPHIS mandatory field</i>	
Gender - <i>iPHIS mandatory field</i>	
Address/Telephone number	Not required by the Ministry, but for case management you may want to include a summary of the incident here

Rabies is not entered as a CD case – this is reserved for Human Rabies Cases, not Rabies incident investigations.

To get to the screen for entering Rabies incidents:

- Create or select a client in the demographic screen
- Click on the CD hotlink on the side bar
- Choose “Client Rabies Incident Summary”

If not previously entered, enter as “New Incident”.

**Incident:**

Reported Date	The date the health region started the follow-up
General Comments	Not required by the Ministry, but for case management you may want to include a summary of the incident here. Please indicate here if the case was referred out of province for completion of series.
Status - <i>iPHIS mandatory field</i>	Open: if follow-up is being done. Closed: Once follow-up is complete Unresolved: if lost to follow-up (cannot reach the client to finish follow-up)

**Incident – Client Details:**

Attending Physician	Not required by the Ministry, but for case management you may want to include
Client Address at Time of Incident	Not required by the Ministry, but for case management you may want to include
Bleeding/Breaks to Skin	Choose as appropriate from drop down
Previously Immunized	Choose as appropriate from drop down: Yes – only for those who completed a series. No – for those who have not had a series or for those where a series was not completed. Unknown -
Immunization Date	Only one date can be entered. Only include for those where Previously Immunized response was YES The following is the criteria for what date to enter for those who completed a series:

	<ul style="list-style-type: none"> <li>Choose actual date of last dose if known, <b>OR</b></li> <li>Choose 1<sup>st</sup> day of the month (for the appropriate year) if this is known, <b>OR</b></li> <li>Choose the 1<sup>st</sup> day of Jan for the appropriate year if month unknown.</li> </ul>
Vaccine Type	Include the type of vaccine that the client has received previously – Immune Globulin is irrelevant in this situation as it has no bearing on post-exposure immunization requirements whereas the vaccine if given as pre-exposure or as a completed post-exposure series will eliminate the need for RIG and will reduce the number of additional doses of HDCV.
Client Weight at time of incident	Important for determining RIG dosage. Include for case management
Prophylaxis Indicated	Choose as appropriate from drop down – Yes – if RPEP is recommended No – if RPEP is not recommended Unknown – not applicable in this instance

Save Changes

**Exposure:**

Date of Exposure	The date the client was exposed (choose the first date if ongoing exposure). If ongoing exposure to a family pet that tested positive for rabies, choose the date that the animal's behaviour/health started to change.
Place of Exposure	Choose the name of the town/First Nations community or the name of the RM – this is important for tracking rabies incidents in the province and will be mapped along with rabid animal map.
Proximity to River/Rural	Not required by Ministry -
Details	Not required by the Ministry, but for case management you may want to include additional information about the exposure here
Type of Exposure	Choose as appropriate from drop down (see options below). Definitions on accompanying page.

	<p>Note: Occupational Exposure options should be used if the exposure was due to an occupational incident. This would involve veterinarians, conservation officers, etc. Choose the appropriate one based on the type of exposure.</p> <p>Bite; Scratch; Saliva on mucous membranes; Saliva on existing lesion; Saliva on intact skin; Occupational Exposure Bite; Occupational Exposure Scratch; Occupational Exposure Saliva on mucous membranes; Occupational Exposure Saliva on existing lesion; Occupational Exposure Saliva on intact skin; No known contact.</p>
Wound location	<p>Choose as appropriate from drop down</p> <p>Head/Neck; Face; Arm; Hand/finger; Torso; Leg; Foot/toe; Mucosa; Unknown</p>
Wound Description	<p>Not required by the Ministry, but for local follow-up/case management you may want to include more details here.</p>

**Animal – Owner Info:**

Owner information is not required by the Ministry, except in instances where the owner is out of province and we have to forward the information onto another jurisdiction so follow-up can be provided. Data entry of owner information is a regional decision.

**E-mail Communication Requirement:**

Owner information is to be provided to the Ministry when the owner will be followed up in another jurisdiction (province). This will best be communicated via e-mail to the ministry at [cdc@health.gov.sk.ca](mailto:cdc@health.gov.sk.ca) rather than including in iPHIS. Details that must be provided to facilitate follow-up include:

- Name of owner
- Phone numbers
- Address
- Details of the animal (name, type, etc)
- Summary of the incident
- Contact number of the individual following the victim so the animal investigator can relay animal observation results directly

**NOTE:** E-mail from within the Global System is considered secure. If e-mail communication is from outside global, the message should be encrypted or it can be sent to the confidential fax at (306)787-9576.

**Animal - Animal Info:**

Animal Species	Choose as appropriate from drop down (see options below) Dog; Cat; Bat; Cow; Horse; Hog; Skunk; Raccoon; Fox; Coyote; Ferret; Mouse/gopher; Hamster; Other; Unknown
Animal Type	Important for assessing biting incidents in Saskatchewan Pet (indoor); Pet (outdoor); Pet (Indoor/Outdoor); Outdoor Farm Animal; Wild; Stray; Unknown
Animal Description	Not required by the Ministry, but for case management you may want to include information here. An example of when this might be used is when it is a stray/unknown and you include a physical description. Please provide a note in this field if there were multiple victims involved in this incident.
Animal Vaccinated	Choose as appropriate from drop down
Vaccination Date	Not required by the Ministry, but for case management you may want to include this information.
Animal Healthy	Choose as appropriate from drop down based on the health of the animal at the time of the incident. If "NO", complete the symptoms field.
Observation Following Exposure	Choose as appropriate from drop down. – This is an important field for reporting as is used for filtering of some reports.
Brain sent for testing	Choose as appropriate from drop down. Will be used in generating reports.
Date sent for testing	Indicate the date the specimen was sent for testing – Not required by the Ministry.
FA Result	The preliminary result recorded here.
FA Result Date	Date the results were reported to the RHA/FN jurisdiction.
Tissue Culture	Enter for complete record.
Rabies Status	Not required by the Ministry, but follow these guidelines for use of this field. Choose as appropriate from drop down (see options below) Positive – only to be used for those confirmed positive

	<p>Negative – use for animals who were well after observation period or whose results returned as negative</p> <p>Unknown – use for escaped animals or those who were destroyed and not available for testing</p>
Animal Retention Method	Not required by the Ministry, but for case management you may want to include information here.
Retention Method Comments	Not required by the Ministry, but for case management you may want to include information here.
Retention Method From ... To	<p>Dates animal is to be under observation for (start date and end date)</p> <p>Not required by the Ministry, but for case management you may want to include information here.</p>
Animal Retention Results	<p>Choose as appropriate from drop down based on the status of the animal during/after the observation period. This field is only mandatory for reporting when observation following exposure was documented as “YES”</p> <p>Became ill; Released; Natural Death; Destroyed</p>
Family Vet Name	Not required by the Ministry, but for case management you may want to include information here.
Vet Phone	Not required by the Ministry, but for case management you may want to include information here.
Animal Services Notified	Choose as appropriate from drop down - Not required by the Ministry, but for case management you may want to include information here.
Animal Services Incident Number	<p>This field will be used for the Unique Animal ID Number. This must be used in each case report on iPHIS that involves the same animal in the following format (no spaces included in the sequence):</p> <p><i>&lt;health region three to four acronym&gt;-&lt;four digit calendar year&gt;-&lt;R to indicate Rabies&gt;-&lt;three digit sequential number beginning at 001&gt; (e.g. SCHR-2007-R-001)</i></p> <p><b>Rationale:</b> this is an important element to be incorporated as it helps to determine the number of animals involved in incidents - for example it would be misleading if the same animal that rabies results were positive for was counted five times because five people were exposed the family pet.</p> <p>The region where the animal is being followed will generate the Unique</p>

	<p>Animal ID Number. Animal information must be included in the victim's iPHIS record therefore, communication between investigators is important for quality of data and prevention of duplicate reporting.</p> <p>If there are multiple animals and one victim, only one animal will be documented. Additional details should be added to the Animal Description field.</p> <p>NOTE – a new number will be issued for animals in new exposures (if the same animal bites again in 2011, a new number would be issued for this animal).</p>
Symptoms - <i>iPHIS mandatory field</i>	Choose as appropriate from drop down if “animal healthy” response was NO.

Save changes

#### Immunization/TST:

Immunization Date - <i>iPHIS mandatory field</i>	<p>Date immunization provided. It is best practice and provides a complete record when all doses of RPEP (immune globulin and vaccine) are documented. This is required for analysis of RPEP in Saskatchewan.</p> <p>NOTE: The Saskatchewan Immunization Management System (SIMS) houses the complete immunization record for individuals and entry into SIMS should be considered.</p>
Provider/ Personnel - <i>iPHIS mandatory field</i>	<p>Not required by the Ministry, but is a mandatory field for data entry. We recommend choosing "Public Health Nurse", "Registered Nurse" or "Nurse Practitioner" (or the ordering physician) in this drop-down and entering the detailed information regarding who administered it in the comments field. This will ensure there are no delays in being able to enter the information while waiting for an individuals name to be added to the provider list by HISC. Maintaining the provider list will become cumbersome with staff turnover at the regional level.</p> <p>To get the provider field to pre-populate with RN, PHN or NP, choose “Public Health Nurse” in the <i>professional status filter field</i> and click on</p>

	filter. These options are linked with this professional status and will appear as options. Choose as appropriate and include individual details (if required by regional policy) in the comments field.
Where Administered	Not required by the Ministry, but for case management you may want to include information here.
Agent Formulary	Not required by the Ministry.
Agent - <i>iPHIS mandatory field</i>	Choose as appropriate from drop down.
Lot Number/Expiry - <i>iPHIS mandatory field</i>	This is a drop-down list and must be pre-populated by eHealth. A process has been established at the Ministry to try to ensure that when new Lot Numbers for the vaccine is received, it will be forwarded to eHealth for inclusion in the drop-down list. If not in the drop-down, forward the information to <a href="mailto:ServiceDesk@eHealthsask.ca">ServiceDesk@eHealthsask.ca</a> . “Unknown” has been included as an option for instances where the series has been started in another province/country and the information will not be available. This option should be used infrequently.
Site - <i>iPHIS mandatory field</i>	Choose as appropriate from drop down.
Dosage/Dosage Units	Not required by the Ministry.
Dose Number	All doses must be entered for a complete record. Each dose will be numbered sequentially in the series.
Informed Consent - <i>iPHIS mandatory field</i>	Mandatory field for data entry.
Reason for Immunization	Choose as appropriate from drop down.

Save changes

### Scenarios

1. Case and Animal in Same Jurisdiction
  - No variations required.
  
2. Case and Animal in Different Regions within Saskatchewan
  - The area providing follow-up of the case enters all details as per the iPHIS Guidelines.
  - The area following the animal will generate the Unique Animal ID Number and will share this and all animal follow-up details with the area following the individual for documentation into iPHIS.
  
3. Case exposed out of province/country but follow-up completed in Saskatchewan
  - Enter all information as you would for the situation where the case and animal are followed in your area.
    - Local region will generate the Unique Animal ID Number.
  - Place of exposure would be out of province or out of country as appropriate.
  - Some details about the incident, exposure, and animal may be unknown – document the information that you have.
  
4. Case begins RPEP in one area and completes it in another area
  - The case record should be complete will all details of follow-up.
    - Additional RPEP information should be relayed to the health area where it is reported in iPHIS for documentation.
  
5. Case exposed in Saskatchewan but RPEP provided out of province
  - Documentation of the exposure will be entered by the health area where the incident was reported.
  - Status field will indicate 'Closed' –please indicate in the comments that it was referred out of province.
  - Additional details regarding completion of follow-up are not required.
  
6. Exposure occurs in one authority, the victim resides in second authority and animal is from a third authority
  - Individual – Refer to Scenario #2 and #4.
  - Animal – Refer to Scenario #2.

7. One Victim, Multiple Animals

- Documentation should reflect the primary variable that was considered in the initiation of RPEP.
- We recommend to include some comments in the Animal Description field indicating that more than one animal was involved as well as other relevant details. There will only be one Unique Animal ID Number for this situation.

Examples

- All animals involved in the exposure are of the same species (i.e. pack of dogs).
- What to document:
  - o Species – Dog
  - o Type of animal – choose the appropriate type that best describes why RPEP was provided.
    - Fight between a pet and a stray - the stray would likely be the variable for initiating RPEP.
- Animals in the exposure of different species (i.e. dog and coyote)
- What to document:
  - o Species - choose the appropriate species that best describes why RPEP was provided
    - The owner of a dog is breaking up a fight between his pet and a coyote, the coyote would likely be the variable for initiating RPEP.

### Type of Exposure:

- Bite – Teeth penetrated the skin or scratched the skin.
- Scratch – scratch on the skin by the animals' claw.
- Saliva on mucous membranes – such as “animal kisses”.
- Saliva on existing lesion - this would include licks to non-intact skin.
- Saliva on intact skin.
- Occupational Exposure – use as the default if the exposure was due to an occupational incident. This would involve veterinarians, conservation officers, etc.
- Occupational Exposure Bite – Teeth penetrated the skin or scratched the skin.
- Occupational Exposure Scratch – scratch on the skin by the animals' claw.
- Occupational Exposure Saliva on mucous membranes – such as “animal kisses”.
- Occupational Exposure Saliva on existing lesion - this would include licks to non-intact skin.
- Occupational Exposure Saliva on intact skin.
- No known contact – for example bat found in the room, or family pet that is positive and family member cannot report if there was contact with the animal.

### Animal Tab

#### Animal Type:

- Pet (indoor) – pet that does not go outside unaccompanied.
- Pet (outdoor) – pet that does not come into the house.
- Pet (Indoor/Outdoor) – pet that spends time inside as well as outside unaccompanied.
- Outdoor Farm Animal – for example barn cats, livestock.
- Wild – would include any animal that is not domestic (fox, skunk, etc...).
- Stray – domestic animal that is feral.
- Unknown.

## How to Enter Animal Exposures

Attachment – Definitions for Animal Exposures in iPHIS

Page 2 of 2

2010 06 09

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Animal Retention Result: This drop down list needs to include:

- Became ill – appeared to be healthy at the time of the incident but became ill during the observation period.
- Released – was well after the observation period and has been released.
- Natural Death – the animal succumbed due to illness.
- Destroyed – This seems to be self-explanatory.
- Escaped – This seems to be self-explanatory.

	<b>Saskatchewan iPHIS</b> <b>Case Management</b> <b>Reference Card 6.3</b> <b>For Version 6.5.1.2</b>
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Module	Section	Field	Value / Remarks
Demographics	Client Info	PHN	Personal Health Number, nine digits.
		Validated	User with STD privileges <b>MUST</b> check validated if PHN is entered. If not checked the Client Demographic record will display <b>ONLY</b> for users with STD privileges. CD staff will not be able to view Client Demographic record.
	Addr/Tel	Effective From Date	Approximately 30 days prior to the specimen collection date.
		Street Name	Enter “no permanent address” if client does not have a permanent address.
		Postal Code	Must be a valid Saskatchewan or Lloydminster, AB postal code if entered. (No Spaces)
CD	Case Details	Case Reported Date - <b>UPDATED</b>	It should be the <b>earliest</b> of all of these dates. Date case was reported to <i>public health</i> - This may be a phone call from the referring physician, it may be receipt of a notification form or most commonly is the lab reported date. Note - if this was a referral from HA “A” to HA “B”, the date the original HA received the report (notification, phone call, lab report) should be used.
		Case Closed Date	The date the investigation is closed in the Follow-up Status field.
		Case Status – <b>UPDATED</b>	Note: Saskatchewan adheres to the case definitions for national Notifiable communicable diseases. The case definitions are included in the Saskatchewan CDC Manual and should be referred to and entered as appropriate. <ul style="list-style-type: none"> <li>• Confirmed – meets confirmed case definition for Saskatchewan as in the CDC Manual. Reports for monthly notifiable disease reports are based on confirmed case status. Clinical information must be considered before counting as a new case within disease-specific time periods.</li> <li>• Probable – meets probable case definition in the Sask CDC Manual where available (not all diseases have probable case definitions).</li> </ul>

Module	Section	Field	Value / Remarks
			<ul style="list-style-type: none"> <li>• Suspect – meets suspect case definition in the CDC Manual.</li> <li>• Clinical – meets clinical case definition in the Saskatchewan CDC Manual where available.</li> <li>• Possible – meets possible case definition in the Saskatchewan CDC Manual where available.</li> <li>• Does not meet case definition – does not meet case definition.</li> <li>• Out of province case – case is not a resident of Saskatchewan they are living temporarily (&lt;6 months) in Saskatchewan. Refer to Rules of Residency.</li> <li>• Previously reported – previously reported in Saskatchewan (current or other Health Authority). Common for chronic CD's.</li> <li>• Previously reported out of province – the case was reported outside of Sask. Common for chronic CD's and has moved to Sask. Routine medical care has identified the case.</li> <li>• Transferred and counted in another HA – transferred out of your Health Authority. State in the Notes section of the CD or STD module which authority the case was transferred to.</li> <li>• Person Under Investigation – all cases not yet reviewed by a public health investigator.</li> </ul> <p><b>NOTE:</b> All case status options except Person Under Investigation should be assigned by a public health investigator.</p>
		Case Status Date - <b>UPDATED</b>	Date the case status is assigned (as above [confirmed, probable, etc...]). The user will have to actively update the date to ensure the history of case status is accurate.
		User Responsible	Public Health Worker, who is currently responsible for the case. May change as case progresses.
		Physician	Select as per lab report.
		Further Differentiation	The field(s) appropriate to the organism should be filled out when the information becomes available on the lab result

Module	Section	Field	Value / Remarks
STD	Encounter	Encounter Type	Normally set to notification or Lab Note.
		Encounter Date - <b>UPDATED</b>	It should be the <b>earliest</b> of all of these dates. Date case was reported to public health - This may be a phone call from the referring physician, it may be receipt of a notification form or most commonly is the lab reported date. Note - if this was a referral from HA "A" to HA "B", the date the original HA received the report (notification, phone call, lab report) should be used.
		Encounter Status - <b>UPDATED</b>	Should be open while the investigation is occurring. Should only be closed once the investigation and all reporting requirements have been entered. If closed prior to having all data elements completed, a note must be entered in the Notes screen.
		Care Provider	Public Health Worker, who is currently responsible for the case. May change as case progresses.
		Exam Category	Normally lab note.
	Symptoms	Start Date	If asymptomatic, use lab collection date.
	Diag-Treat	Disease Code	Lab Report: Disease.
		Status - <b>UPDATED</b>	See Case Status in CD above. Must match the case definitions as outlined in the CDC Manual.
		Status Date - <b>UPDATED</b>	Date the case status is assigned as suspect, probable, confirmed, transferred to another HA, etc... This is a system generated date that can be overwritten to the most accurate date.
	LAB	Requisition	Placer Requisition ID

Module	Section	Field	Value / Remarks
		External Source (Ordering provider)	Lab Report: Select physician/personnel. If ordering physician/personnel is not listed choose your MHO and place the name of physician/personnel in the comments field below. Inform eHealth of new physician name using the iPHIS Provider Data Information Form: <a href="https://www.ehealthsask.ca/forms/Forms/iPHIS-PhysicianDataInformationForm.pdf">https://www.ehealthsask.ca/forms/Forms/iPHIS-PhysicianDataInformationForm.pdf</a> .
		Comments	Use this box to place name of physician/personnel not listed in the drop down table. i.e. Nurse in Charge.
		Lab	Choose the lab where lab report is from.
		Requisition Date	Lab Report: Specimen Collected Date.
	Test/Result	Test Result Status	Normally set to: 'Final results; results stored and verified. Only changed with a corrected result'.
		Collection Date	Lab Report: Specimen Collected Date.
		Reported Date	Lab Report: Date Reported on lab result.
	Result Information	Result	Usually set to Positive.
		Program Area	STD or CD depending on case.
		<b>ASSIGN RESULT TO CASE</b>	<b>Link the lab results to the appropriate case. This step is mandatory for security reasons.</b>

The eHealth Service Desk can be reached by calling 306-337-0600 or email to: [servicedesk@ehealthsask.ca](mailto:servicedesk@ehealthsask.ca)

Case status may change over the course of investigation. Several levels of case status may be supported by case definitions. The highest level of certainty is Confirmed case status and is used for surveillance statistics. Case definitions are specific to each notifiable disease. Please refer to the Saskatchewan CDC Manual <http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx> or <http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc> for case status definitions of notifiable diseases.

Status classification	Definition	Business rules
Confirmed	Must meet the Confirmed case definition for Saskatchewan as in the CDC Manual. A positive lab result alone does not necessarily constitute a confirmed case. Confirmed cases are included in all provincial communicable disease statistical reports.	<p>The primary reference for case definitions is the Saskatchewan CDC Manual  <a href="http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx">http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx</a>.            If this is not available, the national case definitions should be referenced.  <a href="http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc">http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc</a>. You will note that certain criteria must be met to classify as a confirmed case.</p> <p>To avoid duplicate case reporting, disease-specific time periods for reinfection must be considered before counting as a new case. Confirmed case status must be designated by the public health investigator (PHI/PHN).</p>
Probable	Must meet the Probable case definition in the Saskatchewan CDC Manual where available ( <a href="#">Appendix A</a> lists the diseases where probable status is required). A positive lab result does not necessarily constitute a probable case. Probable cases may be indicated in provincial communicable disease statistical reports depending on the disease but are not included in aggregate statistics.	<p>The primary reference for case definitions is the Saskatchewan CDC Manual  <a href="http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx">http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx</a>.            If this is not available, the national case definitions should be referenced.  <a href="http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc">http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc</a></p> <p>Probable case status must be designated by the public health investigator (PHI/PHN). As level of certainty increases, the case status must be updated.</p>

Status classification	Definition	Business rules
Suspect	Must meet the Suspect case definition in the Saskatchewan CDC Manual where available. Suspect cases are not included in routine provincial communicable disease statistical reports.	The primary reference for case definitions is the Saskatchewan CDC Manual <a href="http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx">http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx</a> . If this is not available, the national case definitions should be referenced. <a href="http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc">http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc</a> . Suspect case status must be designated by the public health investigator (PHI/PHN). As level of certainty increases, the case status must be updated.
Clinical	Must meet the clinical case definition for Saskatchewan in the CDC Manual. A positive lab result alone does not necessarily constitute a confirmed case. Clinical cases are included in all provincial communicable disease statistical reports.	The primary reference for case definitions is the Saskatchewan CDC Manual <a href="http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx">http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx</a> . If this is not available, the national case definitions should be referenced. <a href="http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc">http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc</a> . <b>NOTE:</b> some cases with clinical symptoms may meet the Confirmed classification if there is contact (epi-link) with a lab-confirmed case. Refer to the disease-specific case definition, especially for vaccine preventable diseases. Clinical case status must be designated by the public health investigator (PHI/PHN). As level of certainty increases, the case status must be updated.
Possible	Must meet the Possible case definition for Saskatchewan in the CDC Manual. Possible cases are not included in routine provincial communicable disease statistical reports.	The primary reference for case definitions is the Saskatchewan CDC Manual <a href="http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx">http://www.ehealthsask.ca/services/manuals/Pages/CDCManual.aspx</a> . If this is not available, the national case definitions should be referenced. <a href="http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc">http://www.phac-aspc.gc.ca/publicat/ccdr-rmtc/09vol35/35s2/index-eng.php#toc</a> . Possible case status must be designated by the public health investigator (PHI/PHN). As level of certainty increases, the case status must be updated.

Status classification	Definition	Business rules
Does Not meet Case definition	Does not meet case definition. Case counts are not included in provincial communicable disease statistical reports.	Cases that upon further investigation, were determined not to be the original disease, case status will be changed to "Does Not Meet Case Definition". The exception would be when the disease they are determined to have is another reportable disease, the disease code would be updated accordingly. Does not meet case definition status must be designated by the public health investigator (PHI/PHN). As level of certainty increases, the case status must be updated.
Out of province case	Case is resident of another province/territory/state/country, temporarily living less than six months in Saskatchewan. Out of province cases are not included in provincial communicable disease statistical reports.	Cases will be referred by Saskatchewan Health to the appropriate jurisdiction and counted in the statistics of their resident province even though the clinical and lab diagnosis and public health follow up may be done in SK. NOTE: Cases living longer than a six month period in SK are not considered out-of-province residents.
Previously reported	The case was reported in SK previously. This classification most often applies to chronic communicable diseases. It also applies to making corrections to duplicate cases that were entered in error. Not included in provincial communicable disease statistical reports.	Before entering cases of syphilis, hepatitis B, hepatitis C or HIV ensure they have not been entered in a previous year or by another health region. You may check by faxing the identifying information to the CD Info Consultant at 306-787-9576 (confidential fax). <b>Do not telephone the information to them.</b> If creating an iPHIS record for any previously reported case, it should be assigned a "Previously reported" case status.  When a case has been entered twice within a region but should only be counted once, the case status should be updated to previously reported. If tracking previously reported in another health region, this category should be used
Previously reported out of province	The case was reported outside of SK (reported when the client resided in another province). This classification most often applies to chronic communicable diseases. Not included in provincial communicable disease statistical reports.	If through the investigation it is determined that the case may have been reported in another province or jurisdiction, check by faxing the identifying information to the CD Info Consultant at 306-787-9576 (confidential fax). It is important to identify the province in which they may have been reported.

Status classification	Definition	Business rules
Transferred and counted in another HA	<p>Transferred to another health region or to a FN authority <u>outside of the health regions' geographic boundaries</u>.</p> <p>Documentation of which authority (RHA/NITHA/FNIH) the case was transferred to should be made in the notes screen of the CD or STD module as appropriate. Not included in provincial communicable disease statistical reports.</p>	<p>This applies to active cases that may have been followed by public health within the health authority.</p> <p>Cases do not need to be entered into iPHIS if public health has not followed the case and only incidentally received a copy of the lab report. Please refer to the Rules of Residency documentation to determine which health authority counts the case.</p>
Person Under Investigation	<p>All cases that have not yet been reviewed by a public health investigator should be entered as under investigation and case status should be updated appropriately to match the disease case definition.</p>	<p>All cases that have not yet been reviewed by a public health investigator should be entered as under investigation and case status should be updated appropriately to match the disease case definition. This case status should be updated as soon as possible and no later than the timeframe as identified in Appendix A in the Saskatchewan CDC Manual. This would be used most commonly for case management purposes when data entry staff is entering cases that have not yet been reviewed by a public health investigator.</p>
Exposed - <b>INACTIVATED</b>	<p>The case has no clinical symptoms and no laboratory diagnosis but there is certainty the case has been exposed to the organism therefore public health intervention is warranted. Exposed cases are not included in routine provincial communicable disease statistical reports.</p>	<p>Recommend inactivating this status. We do not require contacts to be entered as cases that have been exposed. This would only be used in case management.</p>

**Assigning residency to communicable disease clients**

**Preamble:** The practice described in this document is intended for public health surveillance purposes. This guidance provides standardization of practice to ensure useful and interpretable surveillance data.

In special situations, jurisdictions may need to determine between themselves to whose jurisdiction the case should be attributed.

The attribution of cases is based on a client's permanent residence at the time of testing/diagnosis of a communicable disease. The document provides clarification on what constitutes the residency of transient and incarcerated clients.

This practice is modeled after the national surveillance practice of attributing cases which has been in place for decades. It was formally operationalized in Saskatchewan in 1999 in response to devolution of public health to health districts.

**Residency in Saskatchewan for public health surveillance purposes**

Saskatchewan residents are defined as:

- People who live in Saskatchewan the longer part of the year, that is, six months or longer.
- People who have recently moved to Saskatchewan with the expectation of staying over six months (e.g. university students, military service people, the incarcerated).
- Students studying out of province who return to their permanent Saskatchewan residence for the summer months if a communicable disease is acquired here during that time.

Those not considered as Saskatchewan residents:

- Short term workers, visitors or transients who are in Saskatchewan for less than six months are not considered a Saskatchewan resident and are referred back to the province of residence for counting there.

**Residency in Saskatchewan Health Regions/Jurisdictions for public health surveillance purposes**

The rules as noted above translate to residency in health regions. Health authority residents are:

- People living in a health authority for longer than six months.
- People who have recently relocated to a health authority with the expectation of staying over six months. They will be counted in the health authority to which they have relocated unless the client presents a clear history of having become infected while living in the jurisdiction from which they moved.
- Students studying in another health region who return to their permanent Saskatchewan residence or to another RHA for the summer months and there is a clear history that a communicable disease was acquired there during that time.

**Attributing clients in correctional facilities**

- If incarcerated over six months, count them in the jurisdiction of the correctional facility unless it has been established they already have been reported elsewhere (eg. within the province, in another province).
- If incarcerated under six months, count them in their normal place of residence, unless it is determined the infection was acquired in the correctional facility then count them in the jurisdiction of the correctional facility.

**Attributing transient clients**

- transient individuals are counted in the region/jurisdiction where they are tested
- non-transient individuals are counted in their usual region/jurisdiction of residency

Definitions:

Transient individuals: people who have no permanent domicile. These would be people frequently moving domicile (including foster children), street people, foster children who change domiciles frequently.

Non-transient individuals: people who have a permanent domicile though they may live there only for short periods of time because of work, eg. two weeks in, two weeks out. They return to their permanent domicile on a regular basis (truckers, pipeline workers, mine workers).

**Revision History**

Date	Changes/Comments
September 9, 1999	Developed
August 2006	Reviewed – No change
April 2009	Reviewed – No change
April 2013	Reviewed – Added guidance for transient and incarcerated individuals developed by sub-working group of iPHIS User Advisory Group
November 2015	Reviewed – Added clarification that the use of this guidance document is for standardization of communicable disease <u>surveillance</u> and that attribution of a client’s residence is based on where they are located at time of testing.
Jan 2015	Reformatted and incorporated into Documentation Section of CDC Manual