

Meningococcal Disease (invasive) Data Collection Worksheet

Panorama QA complete: Yes No
 Initials: _____

Please complete all sections.

Panorama Client ID: _____
 Panorama Investigation ID: _____

A) CLIENT INFORMATION

LHN -> SUBJECT -> CLIENT DETAILS -> PERSONAL INFORMATION

Last Name:	First Name: and Middle Name:	Alternate Name (Goes by):
DOB: YYYY / MM / DD Age: _____	Health Card Province: _____ Health Card Number (PHN): _____	Preferred Communication Method: (specify - i.e. home phone, text): Email Address: <input type="checkbox"/> Work <input type="checkbox"/> Personal
Phone #: <input type="checkbox"/> Primary Home: <input type="checkbox"/> Mobile contact: <input type="checkbox"/> Workplace:		
Place of Employment/School:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown	
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____	Address Type: <input type="checkbox"/> No fixed <input type="checkbox"/> Postal Address <input type="checkbox"/> Primary Home <input type="checkbox"/> Temporary <input type="checkbox"/> Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home): Address at time of infection if not the same:	

B) INVESTIGATION INFORMATION

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

Disease Summary Classification: CASE:	Date	Classification: CONTACT:	Date	LAB TEST INFORMATION:																
<input type="checkbox"/> Confirmed	YYYY / MMM / DD	<input type="checkbox"/> Contact	YYYY / MMM / DD	Date specimen collected: YYYY / MMM / DD <input type="checkbox"/> Blood <input type="checkbox"/> Other <input type="checkbox"/> CSF <input type="checkbox"/> Joint fluid <input type="checkbox"/> Pericardial fluid																
<input type="checkbox"/> Does Not Meet Case	YYYY / MMM / DD	<input type="checkbox"/> Not a Contact	YYYY / MMM / DD																	
<input type="checkbox"/> Person Under Investigation	YYYY / MMM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MMM / DD																	
<input type="checkbox"/> Probable	YYYY / MMM / DD																			
Disposition: FOLLOW UP: <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> In progress</td> <td>YYYY / MM / DD</td> <td><input type="checkbox"/> Complete</td> <td>YYYY / MM / DD</td> </tr> <tr> <td><input type="checkbox"/> Incomplete - Declined</td> <td>YYYY / MM / DD</td> <td><input type="checkbox"/> Not required</td> <td>YYYY / MM / DD</td> </tr> <tr> <td><input type="checkbox"/> Incomplete - Lost contact</td> <td>YYYY / MM / DD</td> <td><input type="checkbox"/> Referred - Out of province</td> <td>YYYY / MM / DD</td> </tr> <tr> <td><input type="checkbox"/> Incomplete - Unable to locate</td> <td>YYYY / MM / DD</td> <td colspan="2">(specify where)</td> </tr> </table>					<input type="checkbox"/> In progress	YYYY / MM / DD	<input type="checkbox"/> Complete	YYYY / MM / DD	<input type="checkbox"/> Incomplete - Declined	YYYY / MM / DD	<input type="checkbox"/> Not required	YYYY / MM / DD	<input type="checkbox"/> Incomplete - Lost contact	YYYY / MM / DD	<input type="checkbox"/> Referred - Out of province	YYYY / MM / DD	<input type="checkbox"/> Incomplete - Unable to locate	YYYY / MM / DD	(specify where)	
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<input type="checkbox"/> Incomplete - Unable to locate	YYYY / MM / DD	(specify where)																		
REPORTING NOTIFICATION Name of Attending Physician or Nurse:		Location:																		
Provider's Phone number:		Date Received (Public Health): YYYY / MMM / DD																		
Type of Reporting Source: <input type="checkbox"/> Health Care Facility <input type="checkbox"/> Lab Report <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician <input type="checkbox"/> Other _____																				

C) DISEASE EVENT HISTORY

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

Site / Presentation:	<input type="checkbox"/> Meningitis <input type="checkbox"/> Sepsis <input type="checkbox"/> Unknown
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D) SIGNS & SYMPTOMS *(Bold text = part of case definition)*

LHN-> INVESTIGATION-> SIGNS & SYMPTOMS

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

E) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

Incubation for Case (period for acquisition):	
Earliest Possible Exposure Date: YYYY / MM / DD	Latest Possible Exposure Date: YYYY / MM / DD
<i>Exposure Calculation details:</i>	
Communicability for Case (period for transmission):	
Earliest Possible Communicability Date: YYYY / MM / DD	Latest Possible Communicability Date: YYYY / MM / DD
<i>Communicability Calculation Details:</i>	

F) RISK FACTORS *(RF followed by + impact the Immunization Forecaster)*

LHN-> SUBJECT->RISK FACTORS

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

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YYYY / MM / DD			YYYY / MM / DD
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YYYY / MM / DD			YYYY / MM / DD
YYYY / MM / DD			YYYY / MM / DD
YYYY / MM / DD			YYYY / MM / DD
YYYY / MM / DD			YYYY / MM / DD

K) OUTCOMES LHN-> INVESTIGATION-> OUTCOMES

<input type="checkbox"/> Not yet recovered/recovering	YYYY / MM / DD	<input type="checkbox"/> ICU/intensive medical care	YYYY / MM / DD	<input type="checkbox"/> Hospitalization	YYYY / MM / DD
<input type="checkbox"/> Recovered	YYYY / MM / DD	<input type="checkbox"/> Intubation /ventilation	YYYY / MM / DD	<input type="checkbox"/> Unknown	YYYY / MM / DD
<input type="checkbox"/> Fatal	YYYY / MM / DD	<input type="checkbox"/> Other _____	YYYY / MM / DD		

Cause of Death: (if Fatal was selected) _____

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

Acquisition Event ID: _____

Exposure Name: _____

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

Location Name: _____

Setting Type

Travel Health care setting Public facilities Recreational facilities Most likely source

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

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

N) TOTAL NUMBER OF CONTACTS LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> TE HYPERLINK -> UNKNOWN/ANONYMOUS CONTACTS

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

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