

Pertussis 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:	Date	Classification:	Date	LAB TEST INFORMATION:
CASE		CONTACT		Date specimen collected:
<input type="checkbox"/> Confirmed	YYYY / MM / DD	<input type="checkbox"/> Contact	YYYY / MM / DD	YYYY / MM / DD
<input type="checkbox"/> Does Not Meet Case	YYYY / MM / DD	<input type="checkbox"/> Not a Contact	YYYY / MM / DD	Specimen type:
<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Person Under Investigation	YYYY / MM / DD	<input type="checkbox"/> Nasopharyngeal
<input type="checkbox"/> Probable	YYYY / MM / DD			<input type="checkbox"/> Throat
<input type="checkbox"/> Suspect	YYYY / MM / DD			

Disposition:
 FOLLOW UP:

<input type="checkbox"/> In progress	YYYY / MM / DD	<input type="checkbox"/> Complete	YYYY / MM / DD
<input type="checkbox"/> Incomplete - Declined	YYYY / MM / DD	<input type="checkbox"/> Not required	YYYY / MM / DD
<input type="checkbox"/> Incomplete - Lost contact	YYYY / MM / DD	<input type="checkbox"/> Referred - Out of province	YYYY / MM / DD
<input type="checkbox"/> Incomplete - Unable to locate	YYYY / MM / DD	(specify where)	

REPORTING NOTIFICATION Name of Attending Physician or Nurse:	Location:
Physician/Nurse Phone number:	Date Received (Public Health): YYYY / MM / DD

Type of Reporting Source: Health Care Facility Lab Report Nurse Practitioner Physician Other _____

Pertussis Data Collection Worksheet

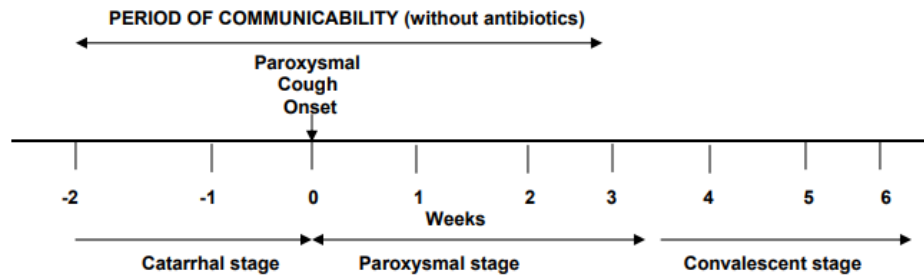
Please complete all sections.

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

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	No	Yes - Date of onset	Description	No	Yes - Date of onset
Apnea		YYYY / MM / DD	Cough – paroxysmal		YYYY / MM / DD
Coryza or rhinitis		YYYY / MM / DD	Cough – with whoop		YYYY / MM / DD
Cough		YYYY / MM / DD	Cough > 2 weeks		YYYY / MM / DD
Cough – with apnea		YYYY / MM / DD	Gagging - infant		YYYY / MM / DD
Cough – with vomiting		YYYY / MM / DD	Gasping - infant		YYYY / MM / DD



D) 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>	

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N –No NA – not asked U - unknown	DESCRIPTION	Yes	N –No NA – not asked U - unknown
Special Population - Pregnancy	YYYY / MM / DD		Setting - Crowded living conditions (>1 person per room excluding bathrooms)		
Contact - Persons with similar symptoms	YYYY / MM / DD		Special Population - Lives in a communal setting		
Contact to a known case (Add'l Info)	YYYY / MM / DD		Travel - Outside of Canada (Add'l Info)	AE/TE YYYY / MM / DD	
Immunocompromised - Related to underlying disease or treatment			Travel - Outside of Saskatchewan, but within Canada (Add'l Info)	AE/TE YYYY / MM / DD	
Maternal Tdap not received between 27 weeks and 2 weeks prior to delivery <i>(For infant cases <1 year)</i>	YYYY / MM / DD				

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F) IMMUNIZATION HISTORY INTERPRETATION SUMMARY

LHN -> INVESTIGATION-> IMMUNIZATION HISTORY INTERPRETATION SUMMARY

Interpretation Date: YYYY / MM / DD	
Interpretation of Disease Immunity:	<input type="checkbox"/> IOM - Fully immunized (for age) <input type="checkbox"/> IOM - Partially immunized
<input type="checkbox"/> IOM – Unimmunized <input type="checkbox"/> IOM - Unclear immunization history	Valid doses received: ____ Doses needed: ____
Reason:	<input type="checkbox"/> IOM - Interpretation of history by investigator

G) TREATMENT

LHN -> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

H) INTERVENTION

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

Intervention Type and Sub Type:				
Assessment:		Immunization:		
<input type="checkbox"/> Assessed for contacts (especially pregnant or < 1 year of age) YYYY / MM / DD Investigator name		<input type="checkbox"/> Eligible immunizations recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization given YYYY / MM / DD Investigator name		
Other Investigation Findings:		Referral:		
<input type="checkbox"/> Investigator Notes <input type="checkbox"/> See Document Management		<input type="checkbox"/> Other (specify) _____ YYYY / MM / DD Investigator name		
Communication:		Testing:		
<input type="checkbox"/> Other communication (see Investigator Notes) YYYY / MM / DD Investigator name <input type="checkbox"/> Letter (See Document Management) YYYY / MM / DD Investigator name		<input type="checkbox"/> Laboratory testing recommended YYYY / MM / DD Investigator name		
General: Investigator name		Treatment:		
<input type="checkbox"/> Disease-Info/Prev-Control YYYY/ MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts YYYY/ MM / DD		<input type="checkbox"/> Treatment not recommended YYYY / MM / DD Investigator name		
Education/counseling: Investigator name				
<input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided YYYY / MM / DD				
Exclusion: Investigator name				
<input type="checkbox"/> Daycare YYYY / MM / DD <input type="checkbox"/> School YYYY / MM / DD		<input type="checkbox"/> Preschool YYYY / MM / DD <input type="checkbox"/> Work YYYY / MM / DD		
Date	Intervention subtype	Comments	Next follow-up Date	Initials
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	
YYYY/MM/DD			YYYY/MM/DD	

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I) OUTCOMES (required for infants <12 months)

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) _____

J) Transmission Events

LHN -> INVESTIGATION-> EXPOSURE SUMMARY -> TRANSMISSION EVENT SUMMARY -> QUICK ENTRY

Transmission Event ID	Exposure Name	Setting type	Date/Time	# of contacts
		<input type="checkbox"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure		
		<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"/> Congregate/Communal living <input type="checkbox"/> Health Care setting <input type="checkbox"/> Type of community contact <input type="checkbox"/> Household Exposure		
	Pertussis Contacts – Inv ID# _____	<input type="checkbox"/> Multiple Settings	YYYY / MM / DD to YYYY / MM / DD	

K) TOTAL NUMBER OF CONTACTS

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

Anonymous contacts: _____ (total number of individuals [including groups that do not require 1:1 follow-up])

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