Government of Saskatchewan

Legionellosis Data Collection Worksheet

PANORAMA

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: ☐ Work ☐ Personal
Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:		
Place of Employment/School:	Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown	
Alternate Contact: _____ Relationship: _____ Alt. Contact phone: _____	Address Type: ☐ No fixed ☐ Postal Address ☐ Primary Home ☐ Temporary ☐ Legal Land Description Mailing (Postal address): Street Address or FN Community (Primary Home): Address at time of infection if not the same:	

B) INVESTIGATION INFORMATION

LHN-> SUBJECT SUMMARY-> ENTERIC ENCOUNTER GROUP ->CREATE INVESTIGATION

Disease Summary Classification: CASE	**Date**	**Classification: CONTACT**	**Date**	**LAB TEST INFORMATION:**
☐ Confirmed	YYYY / MM / DD	☐ Contact	YYYY / MM / DD	Date specimen collected: YYYY / MM / DD
☐ Does Not Meet Case Definition	YYYY / MM / DD	☐ Not a Contact	YYYY / MM / DD	Specimen type: ☐ Blood ☐ Urine ☐ Respiratory Secretions
☐ Person Under Investigation	YYYY / MM / DD	☐ Person Under Investigation	YYYY / MM / DD	
☐ Probable	YYYY / MM / DD			

Disposition:

FOLLOW UP:

☐ In progress	YYYY / MM / DD	☐ Complete	YYYY / MM / DD
☐ Incomplete - Declined	YYYY / MM / DD	☐ Not required	YYYY / MM / DD
☐ Incomplete – Lost contact	YYYY / MM / DD	☐ Referred – Out of province (specify where)	YYYY / MM / DD
☐ Incomplete – Unable to locate	YYYY / MM / DD		

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

Type of Reporting Source: ☐ Health Care Facility ☐ Lab Report ☐ Nurse Practitioner ☐ Physician ☐ Other_____

C) DISEASE EVENT HISTORY

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

Site Description: ☐ Legionnaires' disease ☐ Pontiac fever ☐ Other

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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
Loss of appetite (anorexia)		YYYY / MMM / DD	Headache		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Malaise		YYYY / MMM / DD
Confusion			**Myalgia (muscle pain)**		
Cough		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	**Pneumonia**		YYYY / MMM / DD
Fever		YYYY / MMM / DD	Respiratory distress		YYYY / MMM / DD

E) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

Incubation for Case(period for acquisition):
Earliest Possible Exposure Date: YYYY / MM / DD **Latest Possible Exposure Date**: YYYY / MM / DD

Exposure Calculation details:

F) RISK FACTORS N—No, NA–Not asked, U–Unknown

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Chronic Medical Condition - Malignancies/Cancer+			
Immunocompromised - Related to underlying disease or treatment			
Immunocompromised - Transplant Candidate or Recipient - Solid Organ/Tissue+			
Travel - Outside of within Canada (Add'l Info)	YYYY / MM/DD AE		
Travel - Outside of Saskatchewan, but within Canada (add'l info)	YYYY / MM/DD AE		
Water - Aerosol - Air conditioning unit	YYYY / MM/DD		
Water - Aerosol - Other (add'l info)	YYYY / MM/DD		
Water - Aerosol - Room/central humidifier	YYYY / MM/DD		
Water - Aerosol - Shower head	YYYY / MM/DD		

G) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication *(Panorama = Other Meds) :* _____

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

H) INTERVENTION

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

Intervention Type and Sub Type:

Assessment: Investigator name
☐ Assessed for contacts (individuals exposed to same source) YYYY / MM / DD

Immunization: Investigator name
☐ Eligible immunizations recommended YYYY / MM / DD

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

Referral:
☐ Infection Prevention and Control YYYY / MM / DD
Investigator name
☐ Consultation with MHO YYYY / MM / DD
Investigator name

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

Other Investigation Findings:
☐ Investigator Notes
☐ Document Management Notes

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

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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	

I) OUTCOMES

LHN-> INVESTIGATION-> OUTCOMES

☐ Not yet recovered/recovering YYYY / MM / DD ☐ ICU/intensive medical care YYYY / MM / DD ☐ Hospitalization YYYY / MM / DD
☐ Recovered YYYY / MM / DD ☐ Intubation /ventilation YYYY / MM / DD ☐ Other YYYY / MM / DD
☐ Fatal YYYY / MM / DD ☐ Unknown _____

Cause of Death: (if Fatal was selected) _____

J) EXPOSURES

Acquisition Event

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

Acquisition Event ID:_____

Exposure Name: _____

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

Location Name: _____

Setting Type

☐ Travel ☐ Exposure or consumption of potentially contaminated food or water ☐ Most likely source

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