

Hepatitis A Data Collection Worksheet

Please complete all sections.

Panorama QA complete: Yes No
 Initials: _____

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-> ZOONOTIC & VECTORBORNE 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"/> Blood |
| <input type="checkbox"/> Probable | YYYY / MM / DD | | | <input type="checkbox"/> Stool |
| Disposition: | | | | |
| <i>FOLLOW UP:</i> | | | | |
| <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 | | Location: | | |
| Name of Attending Physician or Nurse: | | | | |
| Physician/Nurse Phone number: | | Date Received (Public Health): YYYY / MM / 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 _____ | | | | |

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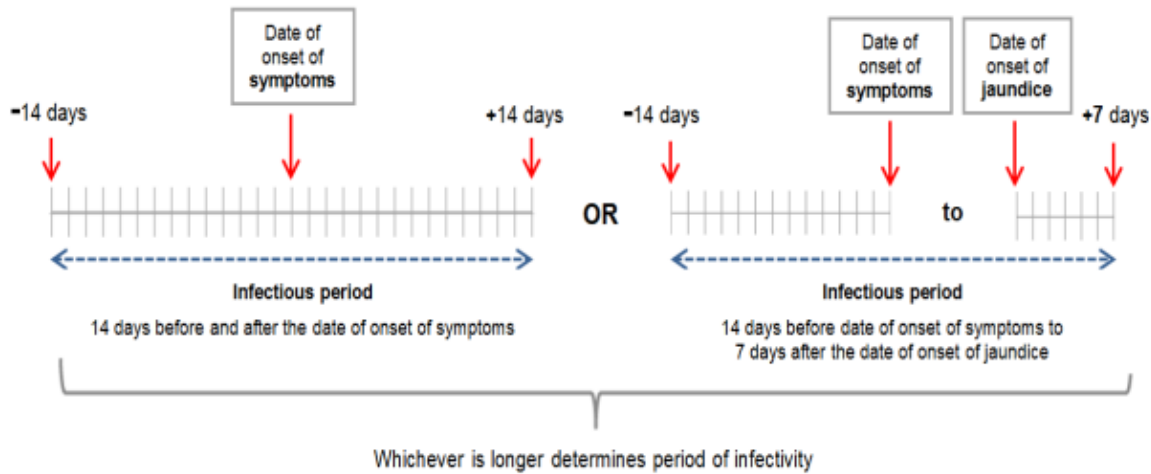
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C) SIGNS & SYMPTOMS (Bold supports confirmed case definition)

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

| Description | No | Yes - Date of onset | Description | No | Yes - Date of onset |
|--|----|---------------------|------------------------------------|----|---------------------|
| Asymptomatic | | YYYY / MM / DD | Loss of appetite (anorexia) | | YYYY / MM / DD |
| Fever | | YYYY / MM / DD | Malaise | | YYYY / MM / DD |
| Jaundice | | YYYY / MM / DD | Nausea | | YYYY / MM / DD |
| Lab - liver enzymes - elevated | | YYYY / MM / DD | Pain - abdominal | | YYYY / MM / DD |
| Other signs and symptoms if applicable | | | Urine - dark | | YYYY / MM / DD |

Figure 6-1. Determining period of infectivity



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 (during risk period) (continued on next page)

LHN-> SUBJECT->RISK FACTORS

| DESCRIPTION | YES | N - No NA - not asked U - Unknown | DESCRIPTION | YES | N - No NA - not asked U - Unknown |
|--|----------------|---|--|----------------------|---|
| Contact - At risk population (international travellers or immigrants) | YYYY / MM / DD | | Special Population - Attends childcare | TE | |
| Contact - Persons with similar symptoms | YYYY / MM / DD | | Special Population - From or residence in an endemic country (Add'l Info) | YYYY / MM / DD | |
| Contact to a known case (Add'l Info) | YYYY / MM / DD | | Travel - Outside of Canada (Add'l Info) | YYYY / MM / DD AE | |
| Immunocompromised - Related to underlying disease or treatment | | | Travel - Outside of Saskatchewan, but within Canada (Add'l Info) | YYYY / MM / DD AE | |
| Occupation - Child Care Worker | TE | | Water - Bottled water (Add'l Info) | | |
| Occupation - Food Handler | TE | | Water - Private well or system (Add'l Info) | | |

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| DESCRIPTION | YES | N – No NA – not asked U - Unknown | DESCRIPTION | YES | N – No NA – not asked U - Unknown |
|---|----------------|---|--|-----|---|
| Occupation - Health Care Worker IoM Risk Factor | TE | | Water - Public water system (Add'l Info) | | |
| Occupation - Personal Care Worker | TE | | Water - Untreated water | | |
| Sexual Behaviour - MSM | YYYY / MM / DD | | Water (Recreational) - Pond, stream, lake, river, ocean | | |
| Sexual Behaviour - Oral-anal | YYYY / MM / DD | | Water (Recreational) – Private (swimming pool/whirlpool) | TE | |
| Sexual Behaviour - Sex with a person from endemic Country (Add'l Info) | YYYY / MM / DD | | Water (Recreational) - Public (swimming/paddling pool/whirl pool) | TE | |

F) USER DEFINED FORM (SEE ATTACHED)

LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> HEPATITIS A FORM

G) COMPLICATIONS

LHN-> INVESTIGATION->COMPLICATIONS

| Description | Yes Date of onset | Description | Yes Date of onset |
|-----------------------|----------------------|---------------------|----------------------|
| Hepatitis - fulminant | YYYY / MM / DD | Other complications | YYYY / MM / DD |

H) 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 - Unimmunized <input type="checkbox"/> IOM - Unclear immunization history | <input type="checkbox"/> IOM - Partially immunized Valid doses received: _____ Doses needed: _____ <input type="checkbox"/> IOM - Interpretation of history by investigator |

I) INTERVENTIONS

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

| Intervention Type and Sub Type: | | | | |
|---|----------------------|--|---------------------|----------|
| Assessment: <input type="checkbox"/> Assessed for contacts Investigator name: _____ YYYY / MM / DD | | Exclusion: Investigator name <input type="checkbox"/> Daycare YYYY / MM / DD <input type="checkbox"/> Preschool YYYY / MM / DD <input type="checkbox"/> School YYYY / MM / DD <input type="checkbox"/> Work YYYY / MM / DD | | |
| Communication: <input type="checkbox"/> Other communication (See Investigator Notes) Investigator name: _____ YYYY / MM / DD <input type="checkbox"/> Letter (See Document Management) Investigator name: _____ YYYY / MM / DD | | Public Health Order: YYYY / MM / DD <input type="checkbox"/> Other (specify) Investigator name: _____ | | |
| General: Investigator name <input type="checkbox"/> Disease-Info/Prev-Control YYYY / MM / DD <input type="checkbox"/> Disease-Info/Prev-Cont/Assess'd for Contacts YYYY / MM / DD | | Referral: YYYY / MM / DD <input type="checkbox"/> Canadian food inspection agency <input type="checkbox"/> Consultation with MHO <input type="checkbox"/> Primary care provider Investigator name: _____ | | |
| Education/counseling: Investigator name <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided YYYY / MM / DD | | Symptom monitoring: YYYY / MM / DD <input type="checkbox"/> Symptom monitoring indirect, passive – (contacts as well as cases) Investigator name: _____ | | |
| Environmental health: YYYY / MM / DD <input type="checkbox"/> Restaurant Inspection <input type="checkbox"/> Water system inspection Investigator name: _____ | | Immunization: Investigator name <input type="checkbox"/> Eligible Immunization recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization recommended YYYY / MM / DD <input type="checkbox"/> Disease-specific immunization given YYYY / MM / DD <input type="checkbox"/> Immunization nurse notified YYYY / MM / DD | | |
| Other Investigation Findings: <input type="checkbox"/> Investigator notes <input type="checkbox"/> Document Management | | | | |
| Date | Intervention subtype | Comments | Next follow-up Date | Initials |
| YYYY / MM / DD | | | | |
| YYYY / MM / DD | | | | |
| YYYY / MM / DD | | | | |

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J) 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) _____

K) 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

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 settings <input type="checkbox"/> Food service establishment <input type="checkbox"/> Health care setting <input type="checkbox"/> Household <input type="checkbox"/> Private Function (Food prep) <input type="checkbox"/> Sexual Exposure <input type="checkbox"/> Type of Community Contact <input type="checkbox"/> Travel | | |
| | | <input type="checkbox"/> Congregate/Communal Living settings <input type="checkbox"/> Food service establishment <input type="checkbox"/> Health care setting <input type="checkbox"/> Household <input type="checkbox"/> Private Function (Food prep) <input type="checkbox"/> Sexual Exposure <input type="checkbox"/> | | |
| | | <input type="checkbox"/> Congregate/Communal Living settings <input type="checkbox"/> Food service establishment <input type="checkbox"/> Health care setting <input type="checkbox"/> Household <input type="checkbox"/> Private Function (Food prep) <input type="checkbox"/> Sexual Exposure <input type="checkbox"/> Type of Community Contact <input type="checkbox"/> Travel | | |
| | Hep A Contacts – Invest ID _____ | <input type="checkbox"/> Multiple Settings | YYYY / MM / DD to YYYY / MM / DD | |

L) 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 / MM / DD |
|-------------------------------------|--|---|