

## Listeriosis, 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 same:	

### B) INVESTIGATION INFORMATION

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

Disease Summary Classification:	Date		Date	LAB TEST INFORMATION:
<input type="checkbox"/> Confirmed	YYYY / MMM / DD	<input type="checkbox"/> Does Not Meet Case	YYYY / MMM / DD	Date specimen collected: YYYY / MMM / DD Specimen Type
<input type="checkbox"/> Person Under Investigation	YYYY / MMM / DD			
<b>Disposition:</b> FOLLOW UP: <input type="checkbox"/> In progress    YYYY / MMM / DD <input type="checkbox"/> Complete    YYYY / MMM / DD <input type="checkbox"/> Incomplete - Declined    YYYY / MMM / DD <input type="checkbox"/> Not required    YYYY / MMM / DD <input type="checkbox"/> Incomplete – Lost contact    YYYY / MMM / DD <input type="checkbox"/> Referred – Out of province    YYYY / MMM / DD <input type="checkbox"/> Incomplete – Unable to locate    YYYY / MMM / DD    (Specify where)				
<b>REPORTING NOTIFICATION</b>		Location:		
Name of Attending Physician or Nurse:				
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 Description:	<input type="checkbox"/> Congenital Listeriosis	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Sepsis	<input type="checkbox"/> Other	<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
Abortion - spontaneous (miscarriage)		YYYY / MMM / DD	<b>Meningoencephalitis</b>		YYYY / MMM / DD
Birth of infected infant		YYYY / MMM / DD	Myalgia (muscle pain)		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Neurologic - delerium		YYYY / MMM / DD
Fetal death - stillbirth		YYYY / MMM / DD	Pain - back		YYYY / MMM / DD
<b>Fever</b>		YYYY / MMM / DD	Pneumonia		YYYY / MMM / DD
Gastrointestinal symptoms		YYYY / MMM / DD	Premature delivery (mother)		YYYY / MMM / DD
<b>Headache</b>		YYYY / MMM / DD	Premature labour (may not mean premature delivery)		YYYY / MMM / DD
Meningeal irritation <i>(severe unrelating headaches, irritability, nausea and vomiting, fever and chills and generalized muscle aches and pains)</i>		YYYY / MMM / DD	Prematurity (infant)		YYYY / MMM / DD
<b>Meningitis</b>		YYYY / MMM / DD	<b>Sepsis (e.g. bactremia, septicemia, etc.)</b>		YYYY / MMM / DD

### E) INCUBATION

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

<b>Incubation for Case (period for acquisition):</b>	
<b>Earliest Possible Exposure Date:</b> YYYY / MMM / DD	<b>Latest Possible Exposure Date:</b> YYYY / MMM / DD
<i>Exposure Calculation details:</i>	

### F) RISK FACTORS (provide a response for ALL Risk Factors)

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes	N, NA, U	Add'l Info
<b>Chronic Medical Condition</b> Cardiac Disease			
<b>Chronic Medical Condition</b> Liver disease			
<b>Chronic Medical Condition</b> Lung disease			
<b>Chronic Medical Condition</b> Malignancies/Cancer			
<b>Chronic Medical Condition</b> Other (Add'l Info)			
<b>Chronic Medical Condition</b> Renal disease			
<b>Immunocompromised</b> due to underlying disease or treatment (Add'l Info)			
<b>Special Population</b> Infant born to an infected mother			
<b>Special Population</b> Pregnancy			
<b>Travel</b> – Outside of Canada (Add'l Info)	YYYY / MM/DD		
<b>Travel</b> –Outside of Saskatchewan, but within Canada (Add'l Info)	YYYY / MM/DD		

### G) USER DEFINED FORM (SEE ATTACHED)

LHN-> INVESTIGATION-> INVESTIGATION DETAILS -> LINKS AND ATTACHMENTS -> LISTERIOSIS FORM

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### H) COMPLICATIONS

LHN-> INVESTIGATION->COMPLICATIONS

Description	Yes Date of onset	Description	Yes Date of onset
Abscesses	YYYY / MMM / DD	Coma	YYYY / MMM / DD
Cardiac - endocarditis	YYYY / MMM / DD	Granulomatosis infantisepticum	YYYY / MMM / DD
Other complications			

### I) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

### J) INTERVENTIONS

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

Intervention Type and Sub Type:				
<b>Assessment:</b> Investigator name <input type="checkbox"/> Assessed for contacts      YYYY / MM / DD	<b>Environmental Health:</b> YYYY / MM / DD <input type="checkbox"/> Environmental sampling <input type="checkbox"/> Restaurant inspection <input type="checkbox"/> Food/Water sampling Investigator name			
<b>Communication:</b> <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	<b>Other Investigation Findings:</b> <input type="checkbox"/> Investigator Notes      YYYY / MM / DD <input type="checkbox"/> Document Management Notes      YYYY / MM / DD			
<b>General:</b> 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	<b>Referral:</b> <input type="checkbox"/> Canadian food inspection agency      YYYY / MM / DD <input type="checkbox"/> Consultation with MHO      YYYY / MM / DD <input type="checkbox"/> Physician      YYYY / MM / DD			
<b>Education/counselling:</b> <input type="checkbox"/> Prevention/Control measures      YYYY / MM / DD <input type="checkbox"/> Disease information provided      YYYY / MM / DD Investigator name				
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	

### K) OUTCOMES

LHN-> INVESTIGATION-> OUTCOMES

<input type="checkbox"/> Not yet recovered/recovering      YYYY / MM / DD <input type="checkbox"/> Recovered      YYYY / MM / DD <input type="checkbox"/> Fatal      YYYY / MM / DD	<input type="checkbox"/> ICU/intensive medical care      YYYY / MM / DD <input type="checkbox"/> Intubation /ventilation      YYYY / MM / DD <input type="checkbox"/> Other _____      YYYY / MM / DD	<input type="checkbox"/> Hospitalization      YYYY / MM / DD <input type="checkbox"/> Unknown      YYYY / MM / DD
Cause of Death: (if Fatal was selected) _____		

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