

## Amoebiasis 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-> ENTERIC ENCOUNTER GROUP ->CREATE INVESTIGATION

Disease Summary Classification:	Date	Classification:	Date	LAB TEST INFORMATION:
<b>CASE</b>		<b>CONTACT</b>		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 Definition	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"/> Intestinal Fluid <input type="checkbox"/> Stool
<b>Disposition:</b>				
<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)		
<b>REPORTING NOTIFICATION</b>		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 _____				

### C) DISEASE EVENT HISTORY

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

Site / Presentation:	<input type="checkbox"/> Anogenital	<input type="checkbox"/> Extraintestinal	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Other
Staging:	<input type="checkbox"/> Acute	<input type="checkbox"/> Carrier		

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### D) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Asymptomatic		YYYY / MMM / DD	Abdominal - discomfort		YYYY / MMM / DD
Chills		YYYY / MMM / DD	Fever		YYYY / MMM / DD
Constipation		YYYY / MMM / DD	Lesion - genital		YYYY / MMM / DD
Dehydration		YYYY / MMM / DD	Lesion - perianal - ulcer		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea - bloody		YYYY / MMM / DD	Weight loss		YYYY / MMM / DD
Diarrhea - mucousy		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

### E) INCUBATION AND COMMUNICABILITY

LHN-> INVESTIGATION->INCUBATION & COMMUNICABILITY

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

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
<b>Contact</b> - At risk population (international travellers or immigrants)	YYYY / MM/DD		
<b>Contact</b> - Daycare			
<b>Contact</b> - Persons with diarrhea/vomiting	YYYY / MM/DD		
<b>Occupation</b> - Child Care Worker			
<b>Occupation</b> - Food Handler	YYYY / MM/DD		
<b>Sexual Behaviour</b> - Oral-anal			
<b>Special Population</b> - From or residence in an endemic country (add'l info)			
<b>Travel</b> - Outside of within Canada (Add'l Info)	YYYY / MM/DD AE		
<b>Travel</b> - Outside of Saskatchewan, but within Canada (add'l info)	YYYY / MM/DD AE		
<b>Water</b> - Bottled water (specify)			
<b>Water</b> - Private well or system (Add'l Info)			
<b>Water</b> - Public water system (Add'l Info)			
<b>Water</b> - Untreated water (Add'l Info)			
<b>Water (Recreational)</b> - Pond, stream, lake, river, ocean (Add'l Info)	YYYY / MM/DD		
<b>Water (Recreational)</b> - Private (swimming pool/whirl pool) (Add'l Info)	YYYY / MM/DD		
<b>Water (Recreational)</b> - Public (swimming pool/paddling pool/whirl pool) (Add'l Info)	YYYY / MM/DD		

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### G) COMPLICATIONS

INVESTIGATION->COMPLICATIONS

Description	Yes Date of onset	Description	Yes Date of onset
Abscess - brain	YYYY / MMM / DD	Disseminated infection	YYYY / MMM / DD
Abscess - liver		Hemorrhage - Intestinal	
Abscess - lung		Intussusception	
Ameboma (amebic granulomata)	YYYY / MMM / DD		
Other complications			

### H) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

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

### I) INTERVENTION

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>Immunization:</b> Investigator name <input type="checkbox"/> Eligible immunizations recommended YYYY / MM / DD			
<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>Public Health Order:</b> <input type="checkbox"/> Order (specify) _____ YYYY / MM / DD Investigator name			
<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 Investigator name <input type="checkbox"/> Primary care provider YYYY/ MM / DD Investigator name <input type="checkbox"/> Consultation with MHO YYYY / MM / DD Investigator name			
<b>Education/counseling:</b> <input type="checkbox"/> Prevention/Control measures YYYY / MM / DD <input type="checkbox"/> Disease information provided YYYY / MM / DD Investigator name	<b>Testing:</b> Investigator name <input type="checkbox"/> Stool testing recommended (e.g. contacts) YYYY / MM / DD <input type="checkbox"/> Laboratory testing recommended (contacts) YYYY / MM / DD			
<b>Exclusion:</b> 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	<b>Other Investigation Findings:</b> <input type="checkbox"/> Investigator Notes <input type="checkbox"/> Document Management Notes			
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	

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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"/> Other           | YYYY / MM / DD |
| <input type="checkbox"/> Fatal                        | YYYY / MM / DD | <input type="checkbox"/> Unknown                    | _____          |  |                |

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	Date/Time	# of contacts
		<input type="checkbox"/> Household <input type="checkbox"/> Public Facility		
		<input type="checkbox"/> Household <input type="checkbox"/> Public Facility		
		<input type="checkbox"/> Household <input type="checkbox"/> Public Facility		
		<input type="checkbox"/> Household <input type="checkbox"/> Public Facility		
	Amoebiasis Contacts – Inv 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 exposed)

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