Government of Saskatchewan

Cyclosporiasis 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: _____	Preferred Communication Method: (specify - i.e. home phone, text):
Phone #: ☐ Primary Home: ☐ Mobile contact: ☐ Workplace:	Health Card Number (PHN): _____	Email Address: ☐ Work ☐ Personal
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: ☐ Biopsy ☐ Intestinal Fluid ☐ Stool
☐ 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_____

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C) SIGNS & SYMPTOMS

LHN-> INVESTIGATION->SIGNS & SYMPTOMS

Description	Yes Date of onset	Date of recovery	Description	Yes Date of onset	Date of recovery
Abdominal - bloating or distension		YYYY / MMM / DD	Fever - low grade		YYYY / MMM / DD
Cardiac - endocarditis		YYYY / MMM / DD	Flatulence		YYYY / MMM / DD
Asymptomatic		YYYY / MMM / DD	Loss of appetite (anorexia)		YYYY / MMM / DD
Constipation		YYYY / MMM / DD	Nausea		YYYY / MMM / DD
Diarrhea		YYYY / MMM / DD	Pain - abdominal		YYYY / MMM / DD
Diarrhea - watery		YYYY / MMM / DD	Vomiting		YYYY / MMM / DD
Lethargy (fatigue, drowsiness, weakness, etc)		YYYY / MMM / DD	Weight loss		YYYY / MMM / DD
Fever		YYYY / MMM / DD			YYYY / MMM / DD
Other Signs & Symptoms if applicable					

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

Exposure Calculation details:

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

LHN-> SUBJECT->RISK FACTORS

DESCRIPTION	Yes Start date	N, NA, U	Add'l Info
Contact - At risk population (international travellers or immigrants)	YYYY / MM/DD		
Contact - Persons with diarrhea/vomiting	YYYY / MM/DD		
Contact to a known case (add'l info)			
Immunocompromised - Related to underlying disease or treatment			
Special Population - From or residence in an endemic country (add'l info)			
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 – Bottled water (specify)			
Water - Private well or system (Add'l Info)			
Water - Public water system (Add'l Info)			
Water - Untreated water (Add'l Info)			
Water (Recreational) - Pond, stream, lake, river, ocean (Add'l Info)	YYYY / MM/DD		
Water (Recreational) - Private (swimming pool/whirl pool) (Add'l Info)	YYYY / MM/DD		
Water (Recreational) - Public (swimming pool/paddling pool/whirl pool) (Add'l Info)	YYYY / MM/DD		

F) TREATMENT

LHN-> INVESTIGATION-> MEDICATIONS->MEDICATIONS SUMMARY

Medication ***(Panorama = Other Meds)*** **:** _____

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

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Please complete **all** sections

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Panorama Investigation ID: _____

G) INTERVENTION

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

Intervention Type and Sub Type:

Assessment: Investigator name
☐ Assessed for contacts 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

Public Health Order:
☐ Order (specify)_____ 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

Referral:
☐ Canadian food inspection agency YYYY / MM / DD
Investigator name
☐ Primary care provider YYYY/ MM / DD
Investigator name
☐ Consultation with MHO YYYY / MM / DD
Investigator name

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

Testing: Investigator name
☐ Stool testing recommended (e.g. contacts) YYYY / MM / DD
☐ Laboratory testing recommended (contacts) YYYY / MM / DD

Exclusion: Investigator name
☐ Daycare YYYY / MM / DD ☐ Preschool YYYY / MM / DD
☐ School YYYY / MM / DD ☐ Work YYYY / MM / DD

Other Investigation Findings:
☐ Investigator Notes
☐ 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	

H) 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) _____

I) 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