



<u>INSTRUCTIONS</u>		Panorama Data Entry Guidance	
<ul style="list-style-type: none"> This form is confidential when completed. Create investigations for confirmed and probable cases in Panorama/PARIS. Enter as much additional information into Panorama/PARIS as required regionally. Send forms to: Scan the completed form and put in the designated HA folder. Also notify us by sending an email to publichealthvet@bccdc.ca 			
PERSON REPORTING			
Health Authority: <input type="checkbox"/> FHA <input type="checkbox"/> FNHA <input type="checkbox"/> IHA <input type="checkbox"/> NHA <input type="checkbox"/> VCH <input type="checkbox"/> VIHA		Review/update using the links on the top right hand corner: >My Account >>User Profile If entering data on behalf of someone else, record in >Notes > when the investigation is in context. Record date received: >Investigation >>Investigation Details >>>Reporting Notifications as Report Date (Received) Record source of information in: >Investigation >>Investigation Details >>>Links & Attachments >>>>COVID-19 Surveillance Case Investigation Form	
Name: _____ <small style="margin-left: 50px;"><i>Last</i></small> <small style="margin-left: 150px;"><i>First</i></small>	Phone Number: () - ext.		
Email: _____	Fax Number () - ext.		
Date report received by health authority: _____ <small style="margin-left: 200px;"><i>www / mm / dd</i></small>			
Classification (see page 6): <input type="checkbox"/> Confirmed <input type="checkbox"/> Probable			
A. CLIENT PERSONAL INFORMATION			
Panorama Investigation ID: _____ PARIS Client ID: _____		Record or review and update in >Subject >>Client Details >>>Personal Information Select this address as "Client Home Address at Time of Initial Investigation" in >Investigation >>Investigation Details >>>Investigation Information	
Name: _____ <small style="margin-left: 50px;"><i>Last</i></small> <small style="margin-left: 150px;"><i>First</i></small> <small style="margin-left: 250px;"><i>Middle</i></small>			
Date of Birth: _____ <small style="margin-left: 100px;"><i>yyyy / mm / dd</i></small>	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown		
Gender identity: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Non-binary <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> X <input type="checkbox"/> Transgender Male to Female <input type="checkbox"/> Transgender <input type="checkbox"/> Two Spirit <input type="checkbox"/> Unsure/Questioning <input type="checkbox"/> Other			
Health Card Number: _____	Alternate Name(s): _____		
Phone Number (home/work/mobile): () - ext.			
Address: _____ <small style="margin-left: 100px;"><i>Unit #</i></small> <small style="margin-left: 100px;"><i>Street #</i></small> <small style="margin-left: 100px;"><i>Street Name</i></small> <small style="margin-left: 100px;"><i>City</i></small>			
Postal Code: _____	Province: _____		Country of Residence <i>(if not Canada)</i> : _____
B. INDIGENOUS INFORMATION			
Do you self-identify as an Indigenous Person? <input type="checkbox"/> Asked, not provided <input type="checkbox"/> No <input type="checkbox"/> Non-BC Resident <input type="checkbox"/> Yes			Record or review and update in >Subject >> Client Details >>> Indigenous Information
Indigenous Identity: <input type="checkbox"/> First Nations and Inuit <input type="checkbox"/> First Nations and Métis <input type="checkbox"/> First Nations, Inuit and Métis <input type="checkbox"/> Inuit <input type="checkbox"/> Inuit and Métis <input type="checkbox"/> Métis <input type="checkbox"/> Not asked			
First Nations Status: <input type="checkbox"/> Asked, but unknown <input type="checkbox"/> Asked, not provided <input type="checkbox"/> Non-Status Indian <input type="checkbox"/> Not Asked <input type="checkbox"/> Status Indian			
Indigenous Organization: _____			



C. FARM AND ANIMAL EXPOSURES

I. Domestic and Farm Birds

In the 10 days prior to illness onset, was the client:

Exposed¹ to any birds?

Yes No Asked but Unknown Declined to Answer Not Assessed

If yes,

Date of last exposure: _____ (YYYY/MM/DD)

Were the birds sick or dying?

Yes No Asked but Unknown Declined to Answer Not Assessed

Visiting a facility/farm where the bird(s) were kept?

Yes No Asked but Unknown Declined to Answer Not Assessed

Was the exposure to:

Domestic/farm bird(s) Wild bird(s) Other, Specify _____ Asked but Unknown Declined to Answer

Not Assessed

If the exposure was to a wild bird, skip to section II

What was the setting where exposure to bird(s) occurred?

Commercial farm Backyard flock Processing setting Unknown Other, Specify _____

If the exposure was at a commercial farm, backyard flock or processing setting then,

Premise name: _____

Premise number if known: _____

Street address: _____

What activities did the client engage in at the premise?

Slaughtering Feeding Egg collection Direct exposure to contaminated surfaces

Collecting dead poultry Handling live poultry Cleaning and disinfecting premises

Unknown Other, specify: _____

Was appropriate PPE always used during potential exposure?

Yes No Asked but Unknown Declined to Answer Not Assessed

If yes, specify PPE always used:

Gloves:	Face Masks	Eye protection (face shield, goggles):	Other, specify:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	

¹ See page 6 for exposure definition



II. Wild birds

Was the client exposed to wild birds?

Yes No Asked but Unknown Declined to Answer Not Assessed

Where did the exposure to wild birds occur?

Date of last exposure: _____ (YYYY/MM/DD)

How did the exposure occur?

Feeding Hunting Collecting dead birds Rescuing/Rehabilitating Other, Specify: _____

Was appropriate PPE always used during potential exposure?

Yes No Asked but Unknown Declined to Answer Not Assessed

If yes, specify PPE always used:

Gloves:	Face Masks	Eye protection (face shield, goggles):	Other, specify:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	

III. Exposed² to other animals?

Exposed² to pigs/swine?

Yes No Asked but Unknown Declined to Answer Not Assessed

Location: _____

Date of last exposure: _____ (YYYY/MM/DD)

Was appropriate PPE always used during potential exposure?

Yes No Asked but Unknown Declined to Answer Not Assessed

If yes, specify PPE always used:

Gloves:	Face Masks	Eye protection (face shield, goggles):	Other, specify:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	_____
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	<input type="checkbox"/> Unknown	

IV. Exposed² to wild animals?

Yes No Asked but Unknown Declined to Answer Not Assessed

If yes,
Type of wild animal _____

² See page 6 for exposure definition



Date of last exposure: _____ (YYYY / MM / DD)

Was the animal sick or dying?
 Yes No Asked but Unknown Declined to Answer Not Assessed

If yes,
 How does the exposure occur?
 Hunting Field dressing Butchering Wildlife rehab
 Feeding Other, Specify: _____

Was appropriate PPE always used during potential exposure?
 Yes No Asked but Unknown Declined to Answer Not Assessed

If yes, specify PPE always used:
 Gloves: Face Masks Eye protection (face shield, goggles): Other, specify:
 Yes Yes Yes _____
 No No No
 Unknown Unknown Unknown

D. OTHER OCCUPATIONAL EXPOSURES

Is the client a healthcare worker or works in a hospital/clinic setting? Yes No Asked but Unknown Declined to Answer Not Assessed

What is your role as a HCW?
 Doctor Nurse Other Service Provider, Specify _____

What is the address of the facility where HCW worked?

Record in
>Investigation
>>Investigation Details
>>>Links & Attachments
>>>> COVID-19 Surveillance Case Investigation Form
§ Definitions are available in Section M

Is the client a laboratory worker? Yes No Asked but Unknown Declined to Answer Not Assessed

If yes, in the 10 days prior to illness onset did the client have exposure to samples being tested for influenza A:
 Yes No Asked but Unknown Declined to Answer Not Assessed

Date of exposure: _____ (YYYY / MM / DD) Location of exposure: _____

Details: _____

If yes to any of the above questions in this section:
 Was appropriate PPE always used during potential exposure?
 Yes No Asked but Unknown Declined to Answer Not Assessed

If yes, specify PPE always used:
 Gloves: Face Masks Eye protection (face shield, goggles): Other, specify:
 Yes Yes Yes _____
 No No No

E. OTHER EXPOSURES



<p>Did the client travel outside of Canada in the 10 days prior to illness onset?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to answer <input type="checkbox"/> Not Assessed</p> <p><i>If yes, specify country/location: _____</i></p> <p>If yes, Did the client have exposure³ to dead or sick birds?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p> <p>Did the client visit any farms?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p> <p><i>If yes, specify: _____</i></p>	
<p>Did the client travel within Canada in the 10 days prior to illness onset?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p> <p><i>If yes, specify province/territory/city: _____</i></p> <p>Did the client have exposure³ to dead or sick birds?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p> <p>Did the client visit any farms?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p> <p><i>If yes, specify: _____</i></p>	
<p>Did the client have known exposure³ to an individual(s) experiencing influenza-like symptoms in the 10 days prior to illness onset? <i>(see section L for influenza-like symptoms definition)</i></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p>	
<p>Did the client have known exposure³ to an individual(s) who tested positive for influenza in the 10 days prior to illness onset?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not Assessed</p>	
F. VACCINES AND PROPHYLAXIS AGAINST INFLUENZA	
<p>Did the client receive the current season's influenza vaccine?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to answer <input type="checkbox"/> Not Assessed <input type="checkbox"/> Unknown</p> <p>If yes, vaccination date: _____ <i>yyyy / mm</i></p>	
<p>During the 10 days prior to the onset of symptoms did the client take any antiviral medication (oseltamivir, zanimivir, amantadine)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Asked but Unknown <input type="checkbox"/> Declined to Answer <input type="checkbox"/> Not</p>	<p>Record in >Investigation >>Investigation Details</p>

³ See page 6 for exposure definition



If yes: Name: _____ Dosage: _____ Dates administered: _____
yyyy mm/dd

>>>Links & Attachments
>>>> COVID-19 Surveillance Case Investigation Form
§ Definitions are available in Section M

G. LABORATORY INFORMATION

Indication for testing: Symptomatic Asymptomatic – high risk exposure
 Symptomatic – high risk exposure

Record in >>>Links & Attachments >>>> COVID-19 Surveillance Case Investigation Form

Test type	Collection Date (YYYY/MM/DD)	Testing Laboratory	Result			
Influenza A	-----	-----	<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending
Subtype			<input type="checkbox"/> H5N1 <input type="checkbox"/> H5N2 <input type="checkbox"/> H5N6 <input type="checkbox"/> Other, Specify: _____			
H5 RT-PCR			<input type="checkbox"/> Positive	<input type="checkbox"/> Negative	<input type="checkbox"/> Indeterminate	<input type="checkbox"/> Pending

Receive through E-Lab inbox, or record in >Investigation >>Lab >>>Lab Quick Entry NOTE: the lab test in Panorama starts with "Human coronavirus..." Record Causative Agent in >Investigation >>Disease Summary

H. SIGNS AND SYMPTOMS

Earliest onset of symptoms: / / /
YYYY MM DD

Sign / Symptom	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acute respiratory distress syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conjunctivitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever ≥ 38 °C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meningo-encephalitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Multi-organ failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myalgia (muscle pain)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharyngitis (sore throat)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rhinorrhea (runny nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath / breathing difficulty	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



I. HOSPITALIZATION

Was the client admitted to hospital? Yes No Unknown

If yes, admission date (yyyy/mm/dd): ____/____/____ Discharge date (yyyy/mm/dd): ____/____/____

Record in
>Investigation
>>Investigation
Details
>>>Links &
Attachments
>>>> COVID-
19 surveillance
Case
Investigation
Form

Admitted to an intensive care unit? Yes No Unknown

If yes, admission date (yyyy/mm/dd): ____/____/____ Discharge date (yyyy/mm/dd): ____/____/____

J. OUTCOME

Outcome at Time of Reporting

Fully recovered Not yet recovered/recovering Fatal *If died, date of death:* _____
yyyy/mm/dd

Permanent disability Unknown Other, Specify

K. NOTES

Record in
>Notes
In order to
have the note
linked to the
investigation,
ensure the
investigation is
in context
when creating
the note.

L. DEFINITIONS

Case definitions for notification to/within public health:

Person under investigation (PUI): An individual with onset of clinical signs/symptoms ^[1] within 10 days of last exposure to a potential source^[2] of avian influenza virus, not otherwise attributed to other known etiology.

Probable: An individual that meets the criteria of a PUI case and has a lab confirmed influenza A infection with subtyping pending.

Confirmed: An individual that has a lab confirmed influenza A H5 infection. The specimen must be confirmed by at least one of the following tests:

- 1) H5 RT-PCR
- 2) Whole genome sequencing

¹ **Clinical signs/symptoms:** conjunctivitis (red eye, discharge from eye) or acute respiratory or influenza-like illness with one or more of cough, sore throat, fever or feverishness, rhinorrhea, fatigue, myalgia, arthralgia, headache. May include mild, moderate (e.g. shortness of breath, difficulty breathing, altered mental status, seizures) or severe manifestations (e.g. pneumonia, respiratory failure, acute respiratory distress syndrome, multi-organ failure, meningo-encephalitis). Gastro-intestinal symptoms may also be present.

² **Exposures of concern:** Close exposure (within 2 meters) to a bird, animal or other human with confirmed avian influenza A virus infection. Exposures can include, but are not limited to: being in the same close airspace, touching or handling infected animals; OR consuming under- or uncooked poultry or egg products; OR direct contact with contaminated surfaces; OR being exposed to manure or litter containing high concentration of virus or being in a contaminated air space or environment; OR visiting a live poultry market with confirmed bird infections or associated with a case of human infection. Where avian influenza test results are not available but there is a high index of suspicion and other exposure criteria are met, also consider testing. If during on-site depopulation of birds, last exposure includes when birds are depopulated and all carcasses are disposed. Unprotected laboratory exposure also qualifies as testing indication.

NOTE: Additional relevant training materials and data standards are available on the Panorama Solution Partner Portal (<https://panoramacst.gov.bc.ca>).