



		Panorama Data Entry Guidance	
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			
Name: <i>Last</i> <i>First</i>		Phone Number: () - ext.	
Email:		Date case report form completed: YYYY / MM / DD	
INSTRUCTIONS			
<ul style="list-style-type: none"> Confidential when completed Report confirmed cases of hepatitis B virus to your MHO Enter confirmed cases into Panorama or PARIS Case definition in Section P, page 5 Shaded areas represent core surveillance variables. Please ensure these are complete and accurate. Complete an Acquisition Event in Panorama if confirmed case is a neonate or blood/tissue/organ recipient Complete a Transmission Event in Panorama if confirmed case is a blood/tissue/organ donor Enter Sections A to G directly into Panorama or PARIS. Enter Sections H to L into the User Defined Form (UDF): Hepatitis B Acute Form. Enter historical immunizations directly into the Panorama Immunization Module. 			
A. PERSONAL INFORMATION FOR THE CASE			
Panorama Client ID:	Panorama Investigation ID:	<input type="checkbox"/> PARIS ID:	(if applicable)
Name: <i>Last</i> <i>First</i> <i>Middle</i>			
Alternate Name(s):		Date of Birth: YYYY / MM / DD	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown		Health Care Number:	
Gender Identity: <input type="checkbox"/> Transgender <input type="checkbox"/> Transgender Female to Male <input type="checkbox"/> Transgender Male to Female			
<input type="checkbox"/> Other <i>Specify Other Gender Identity:</i>			
Phone Number (home/work/mobile): () ext.			
Address*: <i>Unit #</i> <i>Street #</i> <i>Street Name</i> <i>City</i>			
Postal Code:	Province:	Email:	
B. ETHNICITY AND ABORIGINAL INFORMATION			
Ethnicity: <input type="checkbox"/> Arab <input type="checkbox"/> Black <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Korean			
<input type="checkbox"/> Latin American <input type="checkbox"/> South Asian <input type="checkbox"/> Southeast Asian <input type="checkbox"/> West Asian <input type="checkbox"/> White			
<input type="checkbox"/> Other, <i>specify:</i> <input type="checkbox"/> Declined <input type="checkbox"/> Unknown			
Do you wish to self-identify as an Aboriginal Person? <input type="checkbox"/> Asked, not provided <input type="checkbox"/> No			
<input type="checkbox"/> Not asked <input type="checkbox"/> Yes			
Aboriginal Identity: <input type="checkbox"/> Asked, but unknown <input type="checkbox"/> Asked, not provided <input type="checkbox"/> First Nations			
<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			
C. HEALTH CARE PROVIDER (HCP) INFORMATION: PHYSICIAN OR CERTIFIED NURSE			
<i>Only complete when the laboratory result does not come from the BCCDC Public Health Laboratory</i> <i>Note HCP Name is the minimum data requirement when laboratory results are received from labs other than BCCDC Public Health Laboratory</i>			
Ordering HCP Name: <i>LAST</i> <i>FIRST</i>		Phone Number:	
Ordering HCP Practitioner No:		HCP Clinic / Facility Name:	

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.

More details in Section Q, pages 5-6.

These IDs are to be recorded on the hard copy only for record keeping.

>Subject
>>Client Details
>>>Personal Information
*Select this address as "Client Home Address at Time of Initial Investigation" in >Investigation
>>Investigation Details
>>>Investigation Information

>Subject
>> Client Details
>>> Personal Information

>Subject
>> Client Details
>>> Aboriginal Information

>Investigation
>>Investigation Details
>>>External Sources



						Panorama Data Entry Guidance	
HEALTH CARE PROVIDER (HCP) INFORMATION: PHYSICIAN OR CERTIFIED NURSE <i>continued</i>							
Address: <i>Unit #</i> <i>Street #</i> <i>Street Name</i>			City		>Investigation >>Investigation Details >>>External Sources		
Postal Code:			Province:				
Follow-up HCP Name: <i>LAST</i> (if different from Ordering HCP)			<i>FIRST</i>				Phone Number :
D. CLASSIFICATION							
<input type="checkbox"/> Confirmed <i>See Section P, page 5 for case definition.</i>						>Investigation >>Disease Summary	
E. STAGING							
<input type="checkbox"/> Acute <i>See Section P, page 5 for case definition.</i>						>Investigation >>Investigation Details >>>Disease Summary	
F. SIGNS AND SYMPTOMS							
Enter ONSET DATE if the case has symptoms compatible with acute hepatitis B: • <i>Onset date = earliest date of any of the symptoms listed below that are reported by the case</i> • <i>Do not enter onset date if the case does not report symptoms</i>					YYYY / MM / DD		>Investigations >>Signs & Symptoms
Specific symptoms can be recorded below for case management but are not required for surveillance.							
Sign / Symptom	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed	Record in >Investigation >>Signs and Symptoms Do Not select "Set as Onset" for any of the signs/symptoms.	
Asymptomatic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Abdominal Discomfort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Dark Urine	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Malaise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pale Stool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
G. OUTCOME AT TIME OF REPORTING							
<input type="checkbox"/> Fully Recovered <input type="checkbox"/> Not yet recovered/recovering <input type="checkbox"/> Death <i>If died, date of death:</i> YYYY/MM/DD <input type="checkbox"/> Other, <i>specify below</i> <input type="checkbox"/> Unknown <input type="checkbox"/> Permanent disability, <i>specify below</i>						>Investigation >> Outcome (Section Q)	
Specify other outcome / permanent disability: _____							
H. REASON FOR TESTING							
<i>Check all that apply.</i>							
<input type="checkbox"/> Recent risk event or exposure		<input type="checkbox"/> Symptomatic		<input type="checkbox"/> Diagnosed with another infection (e.g. STI, TB, HIV)			
<input type="checkbox"/> Exposure to medical procedure (e.g. surgery, dialysis, endoscope, vaccinations, dental procedure, etc.)		<input type="checkbox"/> Screening at correctional facility		<input type="checkbox"/> Elevated liver enzymes			
<input type="checkbox"/> Prenatal screening		<input type="checkbox"/> Blood donation (e.g. Canadian Blood Services)		<input type="checkbox"/> Self-referral / patient request			
<input type="checkbox"/> Not known		<input type="checkbox"/> Declined to answer		<input type="checkbox"/> Other <i>Please specify</i>			
I. LABORATORY INFORMATION							
<i>Enter lab information only if current/previous serology were <u>not</u> performed at BCCDC Public Health Laboratory.</i>						>Investigation >>Investigation Details >>Links & Attachments >>>UDF - Hepatitis B Acute Form	
Specimen collection date:			YYYY/MM/DD				
Does the case have a previous negative HBsAg test result? (identified by the case, in provincial lab system, from private lab, or another province/territory)			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Not Applicable				
If yes, provide the date of last negative:			YYYY/MM/DD				
						If available, attach histopathology reports in >Investigation >>Investigation Details >>>Links & Attachments Record Causative Agent in >Investigation >>Investigation Details >>>Disease Summary	



J. EXPOSURE INFORMATION

In the 6 months prior to diagnosis, what were the possible routes of HBV transmission for this case? Check all that apply.
Note: Exposure information is considered part of core surveillance variables. Complete all sections that apply to the investigation.
Choose "Not Assessed" if there was no opportunity to evaluate exposures.

Answer the following questions about exposures in the last 6 months prior to diagnosis.	Yes in Canada	Yes outside Canada	Specify the country	No	Asked but Unknown	Declined to Answer	Not Assessed	Record this section in >Investigation >>Investigation Details >>>UDF - Hepatitis B Acute Form	
BEHAVIOURAL									
Does the case have a history of injection drug use?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Provide referrals to harm reduction and education to the case when drug use is listed.	
Has the case shared injection drug use equipment? (e.g. needles, syringes, cooker)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Has the case shared non-injection drug use equipment? (e.g. smoking, snorting paraphernalia)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
OTHER PERCUTANEOUS EXPOSURE									
Did the case have acupuncture or get any tattoos, piercings (ear & other), and/or scarification? Provide the facility name if available: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	*Person at high risk includes individuals with a history of injection drug use, sex trade workers, etc. Obtain and list sexual and household contacts for case management follow-up. (Refer to Section N to record contacts)	
SEXUAL									
How many sex partners has the case had? _____									
Was the case a sexual contact of a known case or person at high risk*?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Has the case had sex with a person of the same sex?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Has the case worked in the sex trade? (e.g. sex work, transactional or exchange sex)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
HOUSEHOLD CONTACTS									
Does the case have household contact(s) and/or family member(s) that are known to be hepatitis B positive?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
BLOOD/TRANSPLANT RECIPIENT									
Was the case a recipient of blood/blood product, tissue or organ?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Record additional information in >Investigation >>Exposure Summary as an Acquisition Event (Section Q)	
MEDICAL (Provide facility name(s) if available: _____)									
Has the case had surgery? (e.g. Major → abdominal, Minor → stitches, or Oral)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Record in >Investigation >>Investigation Details >>>UDF - Hepatitis B Acute Form	
Has the case had kidney dialysis? (e.g. hemodialysis or peritoneal dialysis)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Has the case had a medical procedure? (e.g. reuse of syringes, colonoscopy, endoscopy, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Has the case had dental work?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
OCCUPATIONAL EXPOSURE									
Did the case have an occupational needle stick injury?	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
INCARCERATION									
Does the case have a history of incarceration > 24 hours?	<input type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
OTHER Please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
UNKNOWN - Risk unable to be determined	<input type="checkbox"/>								



						Panorama Data Entry Guidance
K. TRANSMISSION RISK						Record pregnancy in >> Subject >>> Risk Factors Set as pertinent to the investigation. >> Subject >>> Client Warnings (Section Q) Record partner pregnant & blood, tissue & organ donors in, >> Investigation >>> Investigation Details >>>> Links & Attachments >>>>> UDF - Hepatitis B Acute Form For blood, tissue & organ donors, go to >> Investigation >>> Exposure Summary as a Transmission Event (Section Q)
	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed	
Is the case pregnant? → Create a client warning for post-natal follow up of infant.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Is the case's partner pregnant? → If partner is pregnant, add partner as a contact in the case's record & record pregnancy & warning in her record. Note this is flexible to RHA workflow for HBV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
In the last 6 months, has the case donated blood, tissue or organ(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
L. CONSULTATION AND REFERRALS						
<i>Complete the following questions when data is available at the time of reporting.</i>						
Is the case aware of the diagnosis? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						Note: this section is not part of the core surveillance variables. Answer the questions for which information is available. Record in >> Investigation >>> Investigation Details >>>> Links & Attachments >>>>> UDF - Hepatitis B Acute Form
Has education for hepatitis B disease been completed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
Who completed the education? <input type="checkbox"/> Family Physician <input type="checkbox"/> Ordering health care provider <input type="checkbox"/> Public Health <input type="checkbox"/> Other: <i>Please specify (if different from Family Physician)</i>						
Did the case receive a hepatitis B information package? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
Has the case been referred to other services? <i>Check all that apply.</i>						
<input type="checkbox"/> Nutritional Consultation <input type="checkbox"/> Housing support <input type="checkbox"/> Mental Health <input type="checkbox"/> Drug dependency/addictions <input type="checkbox"/> Distribution sites for harm reduction supplies <input type="checkbox"/> Alcohol dependency <input type="checkbox"/> Supervised injection facilities <input type="checkbox"/> Opioid substitution <input type="checkbox"/> Liver transplant <input type="checkbox"/> Legal Support <input type="checkbox"/> Financial Support (e.g. Social Assistance) <input type="checkbox"/> Other: <i>please specify</i>						
M. HISTORICAL IMMUNIZATION INFORMATION						
Vaccine	Date(s) of Immunization				Record or review and update immunization information in the Immunization Module. Documented immunizations: > Immunizations >> Record & Update Imms Undocumented immunizations: > Immunizations >> Special Considerations (Section Q) Definition : undocumented immunization – immunizations not entered into information system (i.e. given at physician office)	
	Dose 1	Dose 2	Dose 3	Dose 4		
Hepatitis A:	YYYY/MM/DD	YYYY/MM/DD				
Hepatitis B:	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD	YYYY/MM/DD		
HBVg:	YYYY/MM/DD					
Pneumococcal	YYYY/MM/DD	YYYY/MM/DD				
Influenza	YYYY/MM/DD					
Un-documented immunizations received (for the vaccines listed above): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown						
If Yes, provide available details: _____						
Hepatitis A Immunity: <input type="checkbox"/> Immune, previous disease <input type="checkbox"/> Immune, lab evidence <input type="checkbox"/> Susceptible, lab evidence <input type="checkbox"/> Unknown						Record on hard copy only.



	Panorama Data Entry Guidance
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N. CONTACT TRACING

Contact tracing is not required for surveillance.
How contact tracing occurs & the use of this section is at the discretion of the Regional Health Authorities.

Contacts from BC

Contact Name	Type of Contact	Date of last known contact	Other Details
	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> IDU/NIDU		
	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> IDU/NIDU		
	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> IDU/NIDU		
	<input type="checkbox"/> Sexual <input type="checkbox"/> Household <input type="checkbox"/> IDU/NIDU		

Method of recording is at the discretion of Regional Health Authorities.

IDU = injection drug use
NIDU = non-injection drug use

O. NOTES

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

P. CASE DEFINITIONS

Hepatitis B Virus - Refer to IVES007 Support Bulletin for more information and full list of hepatitis B case definitions.		Reportable?
<p>Hepatitis B - Acute</p> <p>Enter as</p> <p>Classification: Case - Confirmed</p> <p>Staging: Acute</p>	<p>Clinical Criteria:</p> <ul style="list-style-type: none"> Acute clinical illness is characterized by a discrete onset of symptoms and jaundice or elevated serum aminotransferase levels. <p>Laboratory Criteria:</p> <ul style="list-style-type: none"> Hepatitis B surface antigen (HBsAg) and immunoglobulin M antibody to hepatitis B core antigen (anti-HBc IgM) positive in the context of a compatible clinical history or probable exposure; OR Clearance of HBsAg in a person who was documented to be HBsAg positive within the last six months in the context of a compatible clinical history or probable exposure. 	Yes

Q. PANORAMA DATA ENTRY DETAILS

If the **client is pregnant**, record as a Risk Factor (under Subject in the left hand navigation).

Risk Factor: Special Population - Pregnancy Relevant to Disease Investigation
Additional Information: Record expected due date

Response: Yes

Start Date: Estimated date of conception. If unknown, use the first day of the estimated month of conception.

End Date: Date when public health was made aware that the client is no longer pregnant

If required for regional follow-up related to the pregnancy: (1) record contact information for the professional providing perinatal care (e.g. physician, midwife) under >Subject >>Client Details >>>Health Services, (2) record other additional details related to the pregnancy (e.g. delivery hospital) in a clearly identified client note.

Add a Client Warning "Communicable Disease Alert- See Note" and create a Note.

Subject: CD Alert- Post Natal Follow Up

Note Content: Initiate post-natal CD follow up for baby.

Training Materials (<https://panoramacst.gov.bc.ca>): [Client Warnings-Quick Steps-Shared Services](#), [Risk Factors-Quick Steps-Shared Services](#)

System Guidelines (<https://panoramacst.gov.bc.ca>): [Pregnancy- Data Capture Guideline-Investigations](#),

Data Standards (<https://panoramacst.gov.bc.ca>): [Risk Factors-Data Standard-Shared Services](#)

Record details about **historic immunizations** in the Panorama Immunization Module.

If the agent(s) and the complete date(s) (day/month/year) are known, enter the dose(s) using the Add Historic Immunization screen, specifying the agent(s) and date(s) administered. If additional information (e.g. lot number, site, route, trade name, manufacturer, dosage) is known, record it in the designated field(s).

If the agent is known and the year and month, but no day, is known, enter the dose(s) using the Add Historic Immunization screen, specifying the agent. Record the date as the last day of month. Select the Estimated flag. If additional information (e.g. lot number, site, route, trade name, manufacturer, dosage) is known, record it in the designated field(s).

If a series is reported as complete, but is missing information to identify the product received (i.e., missing trade name and generic name and abbreviation) OR missing month/year of immunization, use the Special Considerations screen to create an Exemption with the reason of "Client Reports Undocumented Immunizations". If a booster dose will be required in the future, the exemption should be future end-dated for when the client will become eligible for the booster.

Record refusals to immunization as Exemptions.

The clinician conducting the case follow-up will then review the data entered in the Immunization and Special Considerations Screens, determine cases immune status and



record a summary assessment in the disease-specific User Defined Form.

Training Materials (<https://panoramacst.gov.bc.ca>): [Add Historical Immunization-Quick Steps-Immunization](#), [Special Consideration-Quick Steps-Immunization](#), [User Defined Forms-Reference Guide-Investigations](#)

Data Standards (<https://panoramacst.gov.bc.ca>): [Historic Immunizations-Data Standard-Immunization](#), [Special Considerations-Data Standard-Immunization](#)

To report a **transfusion transmissible infection** in a **transfusion recipient**, create an Acquisition Event on the Exposure Summary screen (under Investigation on the left hand navigation) using the Acquisition Event Details screen.

Exposure Name: XXX-TTI-Disease Name *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, FHA, or NHA)*
 Potential Mode of Acquisition: Transfusion transmitted
 Nature of Exposure: *Select most appropriate option*
 Exposure Start: Date of transfusion
 note: when exact date is unknown, enter estimate based on available information and select the "Estimated" flag
 Exposure Location Name: *same as Exposure Name*
 Exposure Setting Type: Facility – non-recreational
 Exposure Setting: Hospital
 Address: Details for hospital where transfusion occurred

To report a **transfusion transmissible infection** in a **blood donor**, create a Transmission Event on the Exposure Summary screen (under Investigation on the left hand navigation) using the Transmission Event Details screen.

Exposure Name: XXX-TTI-Disease Name *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, FHA, or NHA)*
 Mode of Transmission: Transfusion transmitted
 Nature of Transmission: Donated blood/blood products
 Exposure Start: Date donated blood
 note: When exact date is unknown, enter estimate based on available information and select the "Estimated" flag
 Exposure Location Name: *same as Exposure Name*
 Exposure Setting Type: Facility – non-recreational
 Exposure Setting: Canadian Blood Services
 Address: Details for location of Canadian Blood Services clinic where blood donation occurred

Training Materials (<https://panoramacst.gov.bc.ca>): [Exposures-Reference Guide-Investigations](#)

System Guidelines (<https://panoramacst.gov.bc.ca>): [Transfusion Transmissible Infections-Data Capture Guideline – Investigations](#), [Exposures-Data Capture Guideline-Investigations](#)

If recording a **neonatal/congenital infection**, create an Acquisition Event on the Exposure Summary Screen (under Investigation on the left hand navigation) using the Acquisition Event Quick Entry section.

Exposure Name: XXX-Vertical Transmission-Disease Name or XXX-Congenital-Disease Name *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, FHA, or NHA)*
 Exposure Start: The date of onset of the disease in the mother (for congenital infections, if known or can be estimated) or The date of birth of the infant (for vertical transmission or neonatal infections, or congenital infections when the mother's date of onset is unknown)
 Location Name: *same as Exposure Name*
 Setting Type: Vertical Transmission/Congenital

Link the infant's Acquisition Event to the mother's Transmission Event.

Training Materials (<https://panoramacst.gov.bc.ca>): [Exposures-Reference Guide-Investigations](#)

System Guidelines (<https://panoramacst.gov.bc.ca>): [Congenital/Neonatal/Vertical Transmission-Data Capture Guideline - Investigations](#), [Exposures-Data Capture Guideline-Investigations](#)

If the client had **contact with a known case**, create an Acquisition Event on the Exposure Summary Screen (under Investigation on the left hand navigation) using the Acquisition Event Quick Entry section.

Exposure Name: XXX-Contact-Disease Name *where XXX is the Health Authority recording/creating exposure (FNHA, IHA, VIHA, FHA, or NHA)*
 Location Name: *same as Exposure Name*
 Start Date: estimated date of first contact or beginning of known case's communicability period
 End date: most recent contact, or end of known case's communicability period

If the known source case is reported in BC, this Acquisition Event should be linked to a Transmission Event on the known source case's [specify disease] investigation. If the known source case is not reported in BC, the creation of the Acquisition Event for the client is adequate to indicate the epidemiologic link.

Training Materials (<https://panoramacst.gov.bc.ca>): [Exposures-Reference Guide-Investigations](#)

System Guidelines (<https://panoramacst.gov.bc.ca>): [Exposures-Data Capture Guideline-Investigations](#), [Contacts-Data Capture Guideline - Investigations](#)

If the **outcome is death**, record as follows.

Outcome: Death
 Outcome Date: Date of death (if known) or date at which user found out about death outcome (if date of death unknown)
 Cause of Death: Select most appropriate response

After recording the outcome, inactivate the client in the Personal Information screen (under Subject > Client Details on the left hand navigation) following routine procedures/standards.

Note: If the outcome is **not death**, the outcome date is the date public health was made aware of the outcome.

Training Materials (<https://panoramacst.gov.bc.ca>):

Data Standards (<https://panoramacst.gov.bc.ca>):

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