



INSTRUCTIONS			
<ul style="list-style-type: none"> • This form is confidential when completed. • Enter laboratory-confirmed and probable COVID-19 cases into Panorama or PARIS. • Case definitions for COVID-19 surveillance are provided in Section M, page 5. • Vancouver Coastal and Fraser Health Authorities: Save a copy of this case report form in the shared folder or fax it to the BCCDC Influenza and Emerging Respiratory Pathogens team at 604-707-2516. • Submit updates to BCCDC by case report form or entry into Panorama. • Notify BCCDC about out-of-province cases or contacts requiring public health follow-up. • BCCDC Communicable Diseases and Immunization Service phone number: 604-707-2510 • Priority data items are indicated with an asterisk (*) 			<p>Panorama Data Entry Guidance</p> <p>More details in Section N, page 6</p>
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: <small>Last</small> _____ <small>First</small> _____		Phone Number: () _____ - _____ ext.	
Email: _____		Fax Number () _____ - _____ ext.	
Date report received by health authority*: _____ <small>YYYY / MM / DD</small>			
Source(s) of information: <input type="checkbox"/> Patient/family interview <input type="checkbox"/> Attending clinician <input type="checkbox"/> Hospital record <input type="checkbox"/> Other, <i>specify</i> : _____			
A. CLIENT PERSONAL INFORMATION			
Panorama Investigation ID*:		BC COVID Case Number: _____	
PARIS Client ID: _____			
Name*: <small>Last</small> _____ <small>First</small> _____ <small>Middle</small> _____			
Date of Birth*: _____ <small>YYYY / MM / DD</small>	Gender*: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Undifferentiated <input type="checkbox"/> Unknown		
Health Card Number*:		Alternate Name(s): _____	
Phone Number (home/work/mobile): () _____ ext.			
Address: <small>Unit #</small> _____ <small>Street #</small> _____ <small>Street Name</small> _____ <small>City*</small> _____			
Postal Code*: _____	Province*: _____	Country of Residence (if not Canada) *: _____	
B. INDIGENOUS INFORMATION			
Do you wish to 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"/> Not asked <input type="checkbox"/> Yes	
Indigenous Identity:		<input type="checkbox"/> First Nations <input type="checkbox"/> Inuit	
<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 and Métis	<input type="checkbox"/> Métis	<input type="checkbox"/> Not asked	
First Nations Status:		<input type="checkbox"/> Non-Status Indian	
<input type="checkbox"/> Not Asked		<input type="checkbox"/> Status Indian	
Indigenous Organization: _____			

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

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

Record or review and update in
 >Subject
 >> Client Details
 >>> Indigenous Information



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C. RISK FACTORS							
Risk Factor	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed	Record in > Subject >> Risk Factors When the investigation is in context, the preset list of COVID-19 risk factors will display, and newly recorded risk factors will be set as pertinent to the investigation. Follow PPHIS guidance to ensure previously-recorded risk factors are marked as pertinent to the investigation.	
Chronic cardiac disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Malignancy/cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic respiratory/pulmonary condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Chronic neurological or neuromuscular disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Immunocompromised	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pregnancy <i>If yes, gestational age (weeks): _____</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Post-partum (≤6 weeks) at time of symptom onset	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other, <i>specify:</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
D. EXPOSURES							
Exposure	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed	Record in >Investigation >>Investigation Details >>>Links & Attachments >>>> COVID-19 Surveillance Case Investigation Form	
Is the client a healthcare worker [§] ? <i>If yes, specify:</i> <input type="checkbox"/> long term care <input type="checkbox"/> acute care <input type="checkbox"/> other, <i>specify:</i> _____ <i>Specify Work Place(s):</i> _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the client have laboratory exposure to biological materials known to contain SARS-CoV-2?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Does the client work in or attend a school or daycare?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Is the client a resident of a long-term care facility?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Did the client travel outside of Canada in the 14 days prior to illness onset? <i>If yes,</i> <i>Specify area:</i> _____ <i>Date left area (yyyy/mm/dd)*:</i> ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Was the client in close contact [§] with a probable [§] or confirmed [§] case of COVID-19 within 14 days prior to illness onset?*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
<i>If yes, complete the following:</i>							
Panorama Investigation ID or Case identifiers* <small>(e.g., name, PHN)</small>	First Contact Date* <small>(yyyy/mm/dd)</small>	Last Contact Date* <small>(yyyy/mm/dd)</small>	Contact Setting*		Comments*		
	Or sustained contact (no specific contact date): <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UK		<input type="checkbox"/> Household <input type="checkbox"/> Workplace <input type="checkbox"/> Health care <input type="checkbox"/> Unknown <input type="checkbox"/> Other, <i>specify:</i> _____				
	Or sustained contact: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> UK		<input type="checkbox"/> Household <input type="checkbox"/> Workplace <input type="checkbox"/> Health care <input type="checkbox"/> Unknown <input type="checkbox"/> Other, <i>specify:</i> _____				

[§] Definitions are available in Section M.



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G. SIGNS AND SYMPTOMS cont.

Sign / Symptom	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed
Fever <i>If yes, specify the highest temperature recorded: ____°C</i>	<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"/>
Hypotension (low blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<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"/>
Nausea	<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"/>
Rhinorrhoea (runny nose)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizure	<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"/>
Tachypnea (rapid breathing)	<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"/>
Weakness	<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"/>

Record in
>Investigation
>>Signs and
Symptoms

Record temperature as
Observation Value
under "Details Exist"

H. CLINICAL EVALUATIONS, COMPLICATIONS AND DIAGNOSES

	Yes	No	Asked but Unknown	Declined to Answer	Not Assessed
Abnormal lung auscultation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Altered mental status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
O ₂ saturation <95%	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharyngeal exudate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Renal failure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sepsis	<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"/>

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

⁸ Definitions are available in Section M.



		Panorama Data Entry Guidance
I. HOSPITALIZATION		
Admitted to hospital [§] ?: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		Record in >Investigation >>>Investigation Details >>>>Links & Attachments >>>>> COVID-19 surveillance Case Investigation Form
If yes, admission date (yyyy/mm/dd)*: ____/____/____		
Discharge date (yyyy/mm/dd)*: ____/____/____		
Admitted to an intensive care unit [§] ?* <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, admission date (yyyy/mm/dd)*: ____/____/____		
Discharge date (yyyy/mm/dd)*: ____/____/____		
Required intubation/ventilation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
Was a chest X-ray performed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
If yes, chest X-ray summary:		
Physician diagnosis at time of this report: <input type="checkbox"/> Pneumonia / bronchitis <input type="checkbox"/> Other, specify: _____		
J. OUTCOME AT TIME OF REPORTING*		
<input type="checkbox"/> Fully Recovered [§] <input type="checkbox"/> Not yet recovered/recovering <input type="checkbox"/> Fatal <i>If died, date of death:</i> _____		Record in >Investigation >> Outcome If fatal outcome, see Section K for data standards.
<input type="checkbox"/> Permanent disability <input type="checkbox"/> Unknown <input type="checkbox"/> Other, specify: _____		
<i>If died, cause of death:</i> <input type="checkbox"/> Contributed but wasn't underlying cause <input type="checkbox"/> Did not contribute to death/incidental		
<input type="checkbox"/> Underlying cause of death <input type="checkbox"/> Unknown		
<input type="checkbox"/> Other, specify: _____		
K. CLASSIFICATION*		
<input type="checkbox"/> Confirmed <input type="checkbox"/> Probable		Record/Update in >Investigation >>Disease Summary
<input type="checkbox"/> Person Under Investigation <input type="checkbox"/> Not a Case		
Case definitions are available in Section M.		
L. NOTES		
		Record in >Notes In order to have the note linked to the investigation, ensure the investigation is in context when creating the note.

[§] Definitions are available in Section M.

M. DEFINITIONS	
Healthcare worker	Health Care Workers (HCWs) include persons who provide health care to patients or work in institutions that provide patient care (e.g., physicians, nurses, emergency medical personnel, dental professionals, laboratory technicians; medical, dental, nursing and laboratory technician students; hospital volunteers; and administrative, housekeeping and other support staff in health care institutions).
Hospitalization [†]	Any person admitted to a hospital for at least an overnight stay ^{††}
ICU admission [†]	Any person admitted to an intensive care unit (ICU) bed for at least an overnight stay
Death [†]	A death (from any cause) occurring in any person with no period of complete recovery between illness and death.
Person under investigation	A person with fever and/or cough who meets the exposure criteria and for whom a laboratory test for COVID-19 has been or is expected to be requested.



M. DEFINITIONS cont.	
Probable case	<p>A person with fever (over 38 degrees Celsius) and/or new onset of (or exacerbation of chronic) cough AND who meets the COVID-19 exposure criteria AND in whom laboratory diagnosis of COVID-19 is</p> <ul style="list-style-type: none"> • inconclusive, • negative (if specimen quality or timing is suspect), or • positive but not confirmed by the National Microbiology Laboratory (NML) or a provincial public health laboratory by nucleic acid amplification tests (NAAT). <p>¹ Inconclusive is defined as a positive test on a single real-time PCR target without sequencing confirmation or a positive test with an assay that has limited performance data available.</p>
Confirmed case	<p>A person with laboratory confirmation of infection with the virus that causes COVID-19 is performed at a reference laboratory (NML or a provincial public health laboratory), and consists of positive nucleic acid amplification tests (NAAT) on at least two specific genome targets or a single positive target with nucleic acid sequencing.</p> <p>Positive laboratory tests at a non-reference laboratory require additional testing at a reference laboratory for confirmation.</p>
Exposure criteria	<p>In the 14 days before onset of illness, a person who:</p> <p>Traveled to an affected area OR</p> <p>Had close contact with a confirmed or probable case of COVID-19 OR</p> <p>Had close contact with a person with acute respiratory illness who has been to an affected area within 14 days prior to their illness onset OR</p> <p>Had laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19.</p> <p>Factors that raise the index of suspicion should also be considered.</p> <p>Note: Other exposure scenarios not specifically mentioned here may arise and may be considered at MHO discretion (e.g. history of being a patient in the same ward or facility during a nosocomial outbreak of COVID-19*).</p>
Affected areas	<p>Affected areas are defined by the Public Health Agency of Canada and are subject to change (https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/covid-19-affected-areas-list.html). Consult the MHO for the most up-to-date information.</p>
Close contact	<p>A close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact or who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill.</p>
Another Epi-link	<p>Exposure to known clusters or a known exposure event in a communal setting (e.g., facility outbreaks, cruise ship outbreaks, airplane clusters). These may not involve close contact with a specifically identified case in the cluster/exposure setting.</p>
Unknown Exposure	<p>The source of the client's infection is unknown. The client has not reported international travel, close contact with a confirmed or probable case or an epi link to a cluster in the 14 days prior to onset.</p>
Recovered	<p>Resolution of symptoms followed by two negative tests at least 24 hours apart.</p>
High-risk contact	<p>Includes close contacts (defined above) and airline contacts (within a 2 meter radius of the case per BC Public Health Management interim guidance - http://www.bccdc.ca/health-professionals/clinical-resources/novel-coronavirus-(covid-19)#Case-management).</p>
<p>[†] The hospitalization, ICU admission, or death does not have to be attributable to COVID-19; a positive laboratory test for SARS-CoV-2 is sufficient for provincial surveillance reporting.</p> <p>^{††} Includes persons admitted to hospital but without transfer to a ward/unit.</p>	

N. PANORAMA DATA ENTRY DETAILS	
<p>If the client is pregnant, record as a Risk Factor (under Subject in the left hand navigation).</p> <p>Risk Factor: Special Population - Pregnancy Relevant to Disease Investigation Additional information: Record expected due date Response: Yes Additional Information: record gestational age</p>	
<p>If the outcome is fatal, record as follows.</p> <p>Outcome: Fatal Outcome Date: Date of death Cause of Death: <select appropriate option></p> <p>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.</p> <p>Note: If the outcome is not fatal, the outcome date is the date public health was made aware of the outcome.</p>	

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