

Novel Influenza A such as H5N1

_____ COUNTY

FOR STATE USE ONLY

___/___/___ case report confirmed
 presumptive
___/___/___ interstate suspect

CASE IDENTIFICATION

Name _____ Phone(s) _____
LAST, first, initials (a.k.a.) indicate home (H); work (W); message (M)

Address _____
Street City Zip

_____ e-mail address _____

ALTERNATIVE CONTACT: Parent Spouse Household Member Friend _____

Name _____ Phone(s) _____
indicate home (H); work (W); message (M)

Address _____
Street City Zip

SOURCES OF REPORT (check all that apply)

Lab Infection Control Practitioner
 Physician _____

Name _____

Phone _____ Date ___/___/___
(first report)

Primary M.D. _____
(if different)

Phone _____ OK to talk to patient?

DEMOGRAPHICS

SEX
 female male

HISPANIC yes no unknown

RACE

White American Indian
 Black Asian/Pacific Islander
 unknown refused to answer
 other _____

DATE OF BIRTH ___/___/___
m d y

or, if unknown, AGE _____

Worksites/school/day care center _____

Occupations/grade _____

EPIDEMIOLOGICAL RISK FACTORS

Is the patient part of a health care worker cluster of severe unexplained respiratory illness? yes no unk

Is the patient a laboratory or health care worker with potential exposure to avian influenza (H5N1)? yes no unk

In the 10 days prior to symptom onset:

Did the patient travel to an area with documented avian influenza (H5N1) in birds or humans? yes no unk

(see: http://www.oie.int/download/AVIAN%20INFLUENZA/A_AI-Asia.htm for outbreaks in poultry,
and: <http://www.who.int/csr/disease/avian-influenza/en/index.html> for information on human cases)

TRAVELERS

If yes,

1. Complete travel history on page 5 of this form. yes no unk

2. Did the patient have close contact (within 1 meter) with live or dead domestic poultry (e.g., visited a poultry farm, a household raising poultry or a live bird market) or wild birds? yes no unk

3. Did the patient touch any raw, butchered poultry? yes no unk

4. Did the patient visit, travel with or stay in the same household with anyone with severe respiratory illness or severe flu-like illness? yes no unk

NONTRAVELERS

For patients who **did not** travel outside the U.S.:

1. In the 10 days prior to illness onset, did the patient visit or stay in the same household with a traveler returning from a country with H5N1 in poultry or humans who developed severe respiratory illness or severe flu-like illness? yes no unk

If yes, CDC ID _____ State ID _____

2. Did the patient have close contact (3 feet) with anyone with severe respiratory or flu-like illness?

If yes, provide information on contact:

Name _____ Address _____ Phone number _____

CDC ID _____ State ID _____

CLINICAL DETAILS

Date of symptom onset: ____/____/____
m d y

Did the person have a fever (subjective or objective)? yes no unk

If yes, Date of fever onset: ____/____/____
m d y

Was temperature >38° C (100.4° F)? Yes No Unk

Highest measured temperature _____

Influenza associated symptoms:

- | | | | | |
|-----------------------------------|--|---|--|---|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Lethargy |
| <input type="checkbox"/> Rigors | <input type="checkbox"/> Runny nose/congestion | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Altered mental status |
| <input type="checkbox"/> Myalgias | <input type="checkbox"/> Conjunctivitis | <input type="checkbox"/> Cough productive of sputum | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Cough | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Apnea | |

Complications:

- | | | | | |
|--------------------------------------|---------------------------------------|--------------------------------------|--|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Myocarditis | <input type="checkbox"/> Sepsis | <input type="checkbox"/> Reye Syndrome |
| <input type="checkbox"/> Diaphoresis | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Renal failure | <input type="checkbox"/> Bacterial pneumonia |
| | | | | <input type="checkbox"/> Other specify _____ |

Have antiviral medication been administered: Yes No Unk

If yes, specify: Amantadine Rimantadine Oseltamivir Zanamavir

Date : ____/____/____
m d y

Received flu vaccine for current season? Yes No Unk

Date : ____/____/____
m d y

Was patient hospitalized during course? Yes No Unk

If yes: Name of Hospital: _____
 City: _____ State: _____
 Unit: _____ Floor: _____ Room: _____
 Medical Record #: _____
 Date of Hospitalization: ____/____/____
m d y
 Date of Discharge: ____/____/____
m d y

Was patient transferred to or from another facility? Yes No Unknown

If yes, facility name: _____

If yes, date of transfer: ____/____/____
m d y

Was patient ever admitted to the intensive care unit (ICU)? Yes No Unk

Did patient die as a result of this illness? Yes No Unk

Date of death: ____/____/____
m d y

Was an autopsy performed? Yes No Unk

Was pathology consistent with pneumonia or ARDS? Yes No Unk

Date of first clinical evaluation for this illness: ____/____/____
m d y

If hospitalized, highest measures within 48 hours of hospitalization: Platelet count _____ Liver function: AST _____ ALT _____

White blood cell count _____
 differential: _____%segs _____%lymphs _____%monos _____%baso _____%atyp lymph

If hospitalized, lowest measures within 48 hours of hospitalization: Platelet count _____ Liver function: AST _____ ALT _____

White blood cell count _____
 differential: _____%segs _____%lymphs _____%monos _____%baso _____%atyp lymph

If not hospitalized, highest measures within 48 hours of hospitalization: Platelet count _____ Liver function: AST _____ ALT _____

White blood cell count _____
 differential: _____%segs _____%lymphs _____%monos _____%baso _____%atyp lymph

If not hospitalized, lowest measures within 48 hours of hospitalization: Platelet count _____ Liver function: AST _____ ALT _____

White blood cell count _____
 differential: _____%segs _____%lymphs _____%monos _____%baso _____%atyp lymph

Was a chest X-ray or CAT scan performed? Yes No Unknown If yes, date: ____/____/____
m d y

If yes, Did the patient have radiographic evidence of pneumonia or acute respiratory distress syndrome (ARDS)? Yes No Unknown

Comments & interpretation:

Laboratory Evaluation

List all clinical specimens submitted for laboratory evaluation

Specimen 1
Lab name _____
Collection Date: ___/___/___
m d y

- Clinical material
 - Extracted RNA
 - Virus isolate
- Source**
- serum (acute)
 - serum (convalescent)
 - NP swab
 - NP aspirate
 - BAL
 - OP swab
 - tracheal aspirate
 - tissue
 - other _____

Test Type:

- Viral culture
- Direct fluorescent antibody (DFA)
- RT-PCR
- Rapid antigen test*

*Name of rapid antigen test:

other _____

Sent to OSPHL? yes no

Sent to CDC? yes no

Carrier:
Tracking #:

RESULTS:

Specimen 2
Lab name _____
Collection Date: ___/___/___
m d y

- Clinical material
 - Extracted RNA
 - Virus isolate
- Source**
- serum (acute)
 - serum (convalescent)
 - NP swab
 - NP aspirate
 - BAL
 - OP swab
 - tracheal aspirate
 - tissue
 - other _____

Test Type:

- Viral culture
- Direct fluorescent antibody (DFA)
- RT-PCR
- Rapid antigen test*

*Name of rapid antigen test:

other _____

Sent to OSPHL? yes no

Sent to CDC? yes no

Carrier:
Tracking #:

RESULTS:

Specimen 3
Lab name _____
Collection Date: ___/___/___
m d y

- Clinical material
 - Extracted RNA
 - Virus isolate
- Source**
- serum (acute)
 - serum (convalescent)
 - NP swab
 - NP aspirate
 - BAL
 - OP swab
 - tracheal aspirate
 - tissue
 - other _____

Test Type:

- Viral culture
- Direct fluorescent antibody (DFA)
- RT-PCR
- Rapid antigen test*

*Name of rapid antigen test:

other _____

Sent to OSPHL? yes no

Sent to CDC? yes no

Carrier:
Tracking #:

RESULTS:

Specimen 4
Lab name _____
Collection Date: ___/___/___
m d y

- Clinical material
 - Extracted RNA
 - Virus isolate
- Source**
- serum (acute)
 - serum (convalescent)
 - NP swab
 - NP aspirate
 - BAL
 - OP swab
 - tracheal aspirate
 - tissue
 - other _____

Test Type:

- Viral culture
- Direct fluorescent antibody (DFA)
- RT-PCR
- Rapid antigen test*

*Name of rapid antigen test:

other _____

Sent to OSPHL? yes no

Sent to CDC? yes no

Carrier:
Tracking #:

RESULTS:

Call **971-673-1111**

for guidance on handling and submission of specimens to the
Oregon State Public Health Laboratory

PATIENT'S NAME >

CASE NOTES

ALTERNATE DIAGNOSIS

Was an alternative respiratory pathogen detected from this patient? Yes No Unknown

If yes, indicate which pathogen(s): _____(e.g., influenza A/B, RSV, rhinovirus, adenovirus, human parainfluenza virus, human metapneumovirus, *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Mycoplasma pneumoniae*, *Chlamydia pneumoniae*, *Legionella* sp.)

--

Travel History and Details

List all legs of recent foreign and domestic travel, including destination(s). List all travel by public conveyance (airplane, train, or others).
Include all travel in 10 days prior to symptom onset, and until placed in isolation.

Trip or portion (1)				Transport type:
Departure date: ____/____/____ <small>m d y</small>	Departure city:	Arrival date: ____/____/____ <small>m d y</small>	Arrival city:	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Cruise <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport company:		Transport no:		
Comments:				

Trip or portion (2)				Transport type:
Departure date: ____/____/____ <small>m d y</small>	Departure city:	Arrival date: ____/____/____ <small>m d y</small>	Arrival city:	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Cruise <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport company:		Transport no:		
Comments:				

Trip or portion (3)				Transport type:
Departure date: ____/____/____ <small>m d y</small>	Departure city:	Arrival date: ____/____/____ <small>m d y</small>	Arrival city:	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Cruise <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport company:		Transport no:		
Comments:				

Trip or portion (4)				Transport type:
Departure date: ____/____/____ <small>m d y</small>	Departure city:	Arrival date: ____/____/____ <small>m d y</small>	Arrival city:	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Cruise <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport company:		Transport no:		
Comments:				

Trip or portion (5)				Transport type:
Departure date: ____/____/____ <small>m d y</small>	Departure city:	Arrival date: ____/____/____ <small>m d y</small>	Arrival city:	<input type="checkbox"/> Airline <input type="checkbox"/> Train <input type="checkbox"/> Bus <input type="checkbox"/> Cruise <input type="checkbox"/> Auto <input type="checkbox"/> Tour Group <input type="checkbox"/> Other
Transport company:		Transport no:		
Comments:				

Notes

PLEASE FAX FORMS TO: 971-673-1100
OREGON STATE PUBLIC HEALTH ACUTE & COMMUNICABLE DISEASE

CASE-CONTACT MANAGEMENT AND FOLLOW UP

Identify people who had close contact (within 3 feet) with the case for the 24-hour period prior to symptom onset, or until case was placed in isolation.

name	age	relation to case	address	telephone number	dates of contact	with case
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___
_____	_____	_____	_____	_____	___/___/___	to ___/___/___

Comments