

CALIFORNIA CASE REPORT FORM FOR SUSPECT AVIAN (H5N1) INFLUENZA

NOTE: If case also meets epidemiologic and clinical criteria for severe acute respiratory syndrome (SARS), please fill out the "California Case Report Form for SARS-like Illness" and the **grey-colored sections 2, 3, 5, 6, 7 and 9** of this form. For fatal cases, please attach copy of autopsy report, if available. Please refer to the WHO website at http://www.who.int/csr/disease/avian_influenza/en/ for an updated list of affected countries.

Fax Completed form to:

Riverside County, Department of Public Health: (951) 358-5102 or (951) 358-5446

Date of Initial report to LHD: ____/____/____

State ID# _____

Section 1. Patient Information

Patient's Last Name: _____ First Name: _____ MI: _____

Current Street Address: _____

Current Residence City: _____ State: _____ County: _____

Home telephone: _____ Work telephone: _____

Age at onset: _____ Years Months Date of Birth ____/____/____ Gender: Male Female

Ethnicity: Hispanic/Latino Non-Hispanic/Non-Latino

Race: Native American/Alaskan Native Asian Pacific Islander African American/Black White Other Unk

Nationality/Citizenship: _____ Residency: U.S. Resident Non-U.S. Resident

Specify patient occupation: _____

Is individual a health care worker (a person who has close contact to patients, patient care areas (e.g., patient's room) or patient care items (e.g., linens or clinical specimens)? Yes No Unk

If yes, specify:

Health care worker type: Physician Nurse/ PA Laboratorian Other _____

Place of employment: Hospital Long Term Care Facility Laboratory Ambulatory Care Other _____

Does patient have DIRECT patient care responsibilities?)? Yes No Unk

Section 2. Risk Factors for Influenza Complications

Cardiac disease _____

Chronic lung disease (e.g, asthma) _____

Chronic metabolic/renal disease (e.g., diabetes) _____

Immunosuppression (e.g., HIV, transplant, malignancy, long-term steroids) _____

Child < 18 yrs old on chronic aspirin therapy _____ Hemoglobinopathy (e.g., SCD) _____

Pregnancy in 2nd or 3rd trimester _____ Nursing home resident / institutionalized _____

Other underlying illness (specify): _____

Section 3. Signs and Symptoms

Date of initial symptom onset: ____/____/____

Fever (subjective or objective): Yes No Unk If yes, date of fever onset: ____/____/____

If yes, temperature >38° C (>100.4° F): Yes No Unk

Influenza-associated symptoms: Chills Rigors Myalgias Headache Sore throat Runny nose/congestion

Conjunctivitis Cough Wheezing Shortness of breath Bloody respiratory secretions Ear pain/otitis

Nausea/vomiting Diarrhea Abdominal pain Apnea Lethargy Altered mental status Other: _____

Complications: Encephalitis Myocarditis Seizures Sepsis Multi-organ failure

Reyes Syndrome 2° bacterial pneumonia Other _____

Antiviral medications: Yes No Unk

If yes, specify: Amantadine Rimantadine Oseltamivir Zanamavir Date started: ____/____/____

Received flu vaccine for 2003-2004 season: Yes No Unk If yes, specify date: ____/____/____

Comments:

Section 4. Clinical Status

Date of first clinical evaluation for this illness: ___/___/___

Laboratory results (if available): Platelet count _____ Liver function: AST: _____ ALT: _____

White blood cell count: _____ differential: ___segs ___lymphs ___monos ___baso ___atyp lymph

Was a chest X-ray or chest CAT scan performed? Yes No Unk If yes, date: ___/___/___

If yes, was there evidence of pneumonia or respiratory distress syndrome? Yes No Unk

Comments/interpretation: _____

Was the patient hospitalized for > 24 hours during this course? Yes No Unk

If yes: Name of hospital: _____ Medical Record Number: _____

City: _____ State: _____

Date of admission: ___/___/___ Date of discharge: ___/___/___

Was the patient transferred to or from another facility? Yes No Unk

If yes, facility name: _____

If yes, date of transfer: ___/___/___ (If more, please list on back of page).

Was the patient ever in the ICU? Yes No Unk

Was the patient ever placed on mechanical ventilation? Yes No Unk

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

If yes, date of death: ___/___/___

If yes, was an autopsy performed? Yes No Unk If yes, please forward autopsy report.

Section 5. Avian (H5N1) Influenza Epidemiological Risk Factors

In the 10 days prior to symptom onset:

Did the patient travel to an area with documented avian (H5N1) influenza in birds and/or humans? Yes No Unk

If yes, 1. Complete section 6.

2. Did the patient have history of contact with domestic poultry? Yes No Unk

If yes, a. Did the patient come within one meter of any poultry? Yes No Unk

b. Was the poultry sick or dying? Yes No Unk

c. Did the patient touch any live poultry? Yes No Unk

d. Did the patient touch any recently butchered poultry? Yes No Unk

Did the patient come in close contact or stay in the same household with a known or suspected human case of H5N1?

Yes No Unk (If YES to exposure to ill traveler, please fill out source case information in SECTION 9)

Did the patient come in close contact or stay in the same household with anyone with pneumonia or severe flu-like illness?

Yes No Unk

Section 6. Travel History

Complete if travel to foreign or domestic area with documented or suspected recent local transmission of avian (H5N1) influenza cases in birds or humans. List each portion or leg of the trip in the space below. Copy or use additional pages if necessary.

Leg 1

Departure Date: ___/___/___ Departure City/Country: _____

Arrival Date: ___/___/___ Arrival City/Country: _____

Leg 2

Departure Date: ___/___/___ Departure City/Country: _____

Arrival Date: ___/___/___ Arrival City/Country: _____

Leg 3

Departure Date: ___/___/___ Departure City/Country: _____

Arrival Date: ___/___/___ Arrival City/Country: _____

Please complete Annex 1 to provide more detailed travel history

Section 7. Local Hospital/Outpatient/Public Health Laboratory Results

Date of first specimen collection: ____/____/____

Blood culture: Not done Neg Pos Unk Organism isolated: _____ Collection Date: ____/____/____

Respiratory culture: Not done Neg Pos Unk Organism isolated: _____ Collection Date: ____/____/____

If done, specimen type: nasopharyngeal swab nasopharyngeal wash oropharyngeal swab endotracheal asp
 sputum bronchoalveolar lavage pleural fluid

Rapid influenza test: Not done Neg Pos Unk Collection Date: ____/____/____

If done, specimen type: nasopharyngeal swab nasopharyngeal wash oropharyngeal swab endotracheal asp
 sputum bronchoalveolar lavage pleural fluid

Rapid RSV test: Not done Neg Pos Unk Collection Date: ____/____/____

If done, specimen type: nasopharyngeal swab nasopharyngeal wash oropharyngeal swab endotracheal asp
 sputum bronchoalveolar lavage pleural fluid

Other hospital/outpatient tests: Test: _____ Result: _____ Collection date: ____/____/____
 Test: _____ Result: _____ Collection date: ____/____/____

Local public health lab results (if available):

If done, specimen type: nasopharyngeal swab nasopharyngeal wash oropharyngeal swab endotracheal asp
 sputum bronchoalveolar lavage pleural fluid

Results: _____

Section 8. Alternative Diagnosis

Was an alternative respiratory pathogen detected for the patient? Yes No Unk

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.*)

Section 9. Source Case and Contact Information

Please complete **Annex 2** to provide source case information for a patient with any history of contact with a known or suspected human case of **influenza A (H5N1)** within 10 days of symptom onset.

In contrast to source case information, contact information in this section refers to those individuals the patient has had contact with **since** becoming ill. Unless otherwise specified, CDHS will not routinely request the information you collect on "trace-forward" contacts, but you may want to maintain a list in case of laboratory confirmation for H5N1. If you would like to consult with a member of the avian influenza team at CDHS, please call Janice Louie or Carol Glaser (510) 307-8585, Duc Vugia (510) 620-3434, Howard Backer or Trevor Shoemaker (510) 620-3737.

Section 10. Submitted by

Last Name: _____ First Name: _____ Phone: (____) _____
 Affiliation: _____ County: _____ Fax: _____ E-mail: _____

Section 11. Additional Comments

Annex 1.

Supplemental Travel History

Complete if provided a more detailed travel history to foreign or domestic areas with documented or suspected recent local transmission of avian (H5N1) influenza cases in birds or humans. Copy or use additional pages if necessary.

Leg 1
Transport type: Airline Train Auto Cruise Bus Tour group Other _____
Transport company: _____ **Transport number:** _____
Residence at arrival city (e.g., hotel, relative's home): _____ **Purpose/activities:** _____

Leg 2
Transport type: Airline Train Auto Cruise Bus Tour group Other _____
Transport company: _____ **Transport number:** _____
Residence at arrival city (e.g., hotel, relative's home): _____ **Purpose/activities:** _____

Leg 3
Transport type: Airline Train Auto Cruise Bus Tour group Other _____
Transport company: _____ **Transport number:** _____
Residence at arrival city (e.g., hotel, relative's home): _____ **Purpose/activities:** _____

Annex 2.

Source Case Information

This section should be filled out if the patient reported any history of contact with a known or suspected human case of influenza A (H5N1) within 10 days of symptom onset. Please be sure to submit a case report form for the source case as well. If the source case is not a resident of your county or not a California resident, please collect as much information as possible about the source case and contact a member of the state avian (H5N1) influenza team so they may contact appropriate individuals for follow-up.

If the patient lists more than two possible source cases, please use additional pages or space below.

Source Case 1:
Name: _____ **Age:** _____ Years Months **Gender:** Male Female

Address: _____
City: _____ **County:** _____ **State:** _____

Telephone (h): (____) _____ **Telephone (w):** (____) _____

Nature of contact: Household Co-worker Health care Other

Please describe the nature of the contact:

Date of patient's last exposure to source case: ____/____/____

Has a case report form been completed on source case? Yes No Unk In Progress

If yes, date of completion: ____/____/____

If known, source case's CDC ID#: _____ **CDHS#:** _____ **Local ID #:** _____

Did the ill contact recently travel to a country with documented H5 infected poultry or human cases? ? Yes No Unk

If yes, list countries: _____

Source Case 2:

Name: _____ **Age:** _____ Years Months **Gender:** Male Female

Address: _____

City: _____ **County:** _____ **State:** _____

Telephone (h): (____) _____ **Telephone (w):** (____) _____

Nature of contact: Household Co-worker Health care Other

Please describe the nature of the contact:

Date of patient's last exposure to source case: ____/____/____

Has a case report form been completed on source case? Yes No Unk In Progress

If yes, date of completion: ____/____/____

If known, source case's CDC ID#: _____ **CDHS#:** _____ **Local ID #:** _____

Did the ill contact recently travel to a country with documented H5 infected poultry or human cases? ? Yes No Unk

If yes, list countries: _____

Annex 3.

(To be filled out by DIHS personnel)

VRDL Results (if available):

Date of specimen: ___/___/___

Specimen type: nasopharyngeal swab nasopharyngeal wash oropharyngeal swab endotracheal asp
 sputum bronchoalveolar lavage pleural fluid

Results: _____

CDC Results (if available):

Date of specimen: ___/___/___

Specimen type: nasopharyngeal swab nasopharyngeal wash oropharyngeal swab endotracheal asp
 sputum bronchoalveolar lavage pleural fluid

Results: _____

CDC Contact (if further laboratory testing required):

Last Name: _____ First Name: _____ Phone: (____) _____

E-mail: _____ Date reported to CDC: ___/___/___ CDC ID#: _____

Case Classification:

- Case under investigation Epidemiologic/clinical investigation completed, lab results pending
- Suspect H5 case (investigation completed, no lab results available) Influenza A (human subtype H1, H3)
- Ruled out case Other etiology (list) _____ H5 case (laboratory confirmed)