3/12/2004

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 510-883-6015

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 >38º C (>100.4º 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 ☐ 2º 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: ________________________________
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
Departure Date: ____/____/____ Departure City/Country: ________________________________
Arrival Date: ____/____/____ Arrival City/Country: ________________________________
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
Departure Date: ____/____/____ Departure City/Country: ________________________________
Arrival Date: ____/____/____ Arrival City/Country: ________________________________
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:______________________

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 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: ____

Section 10. Contact Information

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 and Celia Woodfill at (510) 540-2065 or Duc Vugia and Jon Rosenberg at (510) 540-2566.

Section 11. Submitted by

Last Name: _____________________________ First Name: _____________________________ Phone: (____)_____________________

Affiliation: _____________ County: _______________________Fax:____________________ E-mail: ______________________________

Section 12. Additional Comments

Section 13. (To be filled out by DHS 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)