Novel Influenza A

Agency:

Investigator: Phone number:

FOR STATE USE ONLY
Status: ☐ Confirmed ☐ Probable ☐ Suspect ☐ Not a case
Reviewer initials:
Referred to another state:

CASE

Last name: First and middle name: Maiden name: Suffix: Address line: Zip: City: State: County: Phone: ( )- - Type: Long-term care resident: ☐ Yes ☐ No ☐ Unknown Facility name:

Date of Birth: / / Estimated? ☐ Age:
Gender: ☐ Female ☐ Male ☐ Other
Pregnant: ☐ Yes ☐ No ☐ Unk Est. delivery date: / /
Marital status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Parent with partner ☐ Widowed
Race: ☐ American Indian or Alaskan Native ☐ Unknown ☐ Black or African American ☐ White ☐ Hawaiian or Pacific Islander ☐ Asian
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown
Parent/Guardian name:
Parent/Guardian phone: ( )- - Type:

EVENT

Diagnosis date: / / Onset date: / /
Event outcome: ☐ Survived this illness ☐ Died from this illness ☐ Died unrelated to this illness ☐ Unknown
Outbreak related: ☐ Yes ☐ No ☐ Unknown
Outbreak name:
Exposure setting:
Epi-linked: ☐ Yes ☐ No ☐ Unk To whom:
Location acquired: ☐ In USA, in reporting state ☐ In USA, outside reporting state ☐ Outside USA ☐ Unknown
State: Country:

Healthcare provider information

Last name:
First name:
Provider title: ☐ ARNP ☐ MD ☐ DO ☐ NP ☐ PA
Facility name:
Address line 1:
Address line 2:
Zip code: City:
State: County:
Phone : ( )- - Type:

LABORATORY FINDINGS

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Influenza virus Subtype:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Influenza virus Subtype:

Laboratory: Accession #: Collection date: / /
Date received: / / Specimen source: Test type:
Result type: ☐ Preliminary ☐ Final Result date: / / Result: ☐ Positive ☐ Negative
Organism: Influenza virus Subtype:

OCCUPATIONS

Interpret 'occupation' very loosely and consider every person to have at least one 'occupation'.

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

Occupation type: _____ Job title: _____

Worked after symptom onset: ☐ Yes ☐ No ☐ Unknown Facility name: _____

Date worked from: / / Address: _____

Date worked to: / / Zip code: _____

Removed from duties: ☐ Yes ☐ No ☐ Unknown City: _____ State: _____ County: _____

Date removed: / / Phone: ( )- - Type:

Handle food: ☐ Yes ☐ No ☐ Unknown
Attend or provide child care: ☐ Yes ☐ No ☐ Unknown
Attend school: ☐ Yes ☐ No ☐ Unknown
Work in a lab setting: ☐ Yes ☐ No ☐ Unknown
Work in a health care setting: ☐ Yes ☐ No ☐ Unknown
Direct patient care duties in lab or health care setting: ☐ Yes ☐ No ☐ Unknown
Health care worker type:

HOSPITALIZATIONS

Was the case hospitalized? ☐ Yes ☐ No ☐ Unknown

Hospital: _____ Isolated at entry: ☐ Yes ☐ No ☐ Unk Isolation type (entry): _____

Admission date: / / Discharge date: / / Days hospitalized: _____

Currently isolated: ☐ Yes ☐ No ☐ Unk Current isolation type:

CLINICAL INFO & DIAGNOSIS

Fever ☐ Yes ☐ Feverish, but temp not taken ☐ No ☐ Unk Highest known fever: ___ °F/C

Cough ☐ Yes ☐ No ☐ Unk
Sore throat ☐ Yes ☐ No ☐ Unk
Runny nose ☐ Yes ☐ No ☐ Unk
Conjunctivitis ☐ Yes ☐ No ☐ Unk
Diarrhea ☐ Yes ☐ No ☐ Unk
Seizures ☐ Yes ☐ No ☐ Unk
Headache ☐ Yes ☐ No ☐ Unk
Shortness of breath ☐ Yes ☐ No ☐ Unk
Vomiting ☐ Yes ☐ No ☐ Unk

Other symptoms (specify) _____

Other complications (specify) _____

Was the patient admitted to the intensive care unit? ☐ Yes ☐ No ☐ Unk

Did the patient require mechanical ventilation? ☐ Yes ☐ No ☐ Unk

Did the patient have a chest x-ray or CAT scan performed? ☐ Normal ☐ Abnormal ☐ Test not performed ☐ Unknown

If abnormal: Was there evidence of pneumonia? ☐ Yes ☐ No ☐ Unk

Did this patient have acute respiratory distress syndrome? ☐ Yes ☐ No ☐ Unk

Did the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting? ☐ Yes ☐ No ☐ Unk

OTHER LAB FINDINGS

Leukopenia (white blood cell count <5,000 leukocytes/mm3) ☐ Yes ☐ No ☐ Unk

Lymphopenia (total lymphocytes <800/mm3 or lymphocytes <15% of total WBC) ☐ Yes ☐ No ☐ Unk

Thrombocytpenia (total platelets <150,000/mm3) ☐ Yes ☐ No ☐ Unk

Were specimen sent to the Centers for Disease Control and Prevention (CDC)?

Date sent	Specimen type	CDC Lab Specimen ID	CDC (lab) unique ID

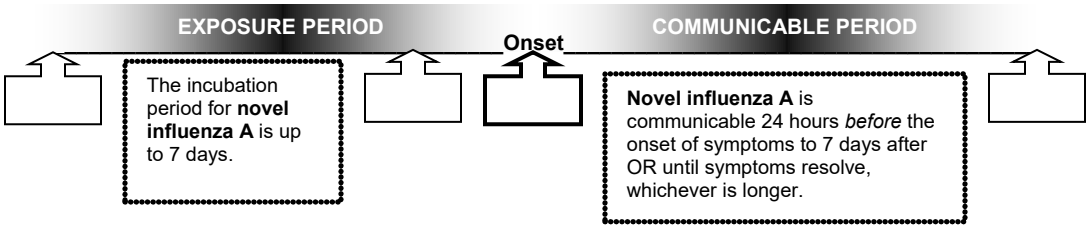
TREATMENT

Antivirals prescribed: ☐ Yes ☐ No ☐ Unknown

Antiviral:	Antiviral:	Antiviral:
Date started: / /	Date started: / /	Date started: / /
Discontinued: / /	Discontinued: / /	Discontinued: / /
Dose:	Dose:	Dose:
Unit: ☐ mg ☐ ml ☐ IU # of days:	Unit: ☐ mg ☐ ml ☐ IU # of days:	Unit: ☐ mg ☐ ml ☐ IU # of days:
# of times a day: Route:	# of times a day: Route:	# of times a day: Route:

INFECTION TIMELINE

Enter onset date in dark-line box. Enter dates for start of exposure period and start and end of communicable period.



RISK FACTORS/TRAVEL

Vaccinated with for SEASONAL influenza: ☐ Yes ☐ No ☐ Unknown

Date vaccinated: / /	Date vaccinated: / /	Date vaccinated: / /
Lot #:	Lot #:	Lot #:
Vaccine:	Vaccine:	Vaccine:
Manufacturer:	Manufacturer:	Manufacturer:
Type: ☐ Inactivated ☐ Live attenuated ☐ Unknown	Type: ☐ Inactivated ☐ Live attenuated ☐ Unknown	Type: ☐ Inactivated ☐ Live attenuated ☐ Unknown

Does the patient have any underlying medical conditions? ☐ Yes ☐ No ☐ Unk

If yes, please specify _____

Is the patient immune compromised for reason such as HIV infection, cancer, chronic corticosteroid therapy, diabetes, or organ transplantation recipient? ☐ Yes ☐ No ☐ Unk

If yes to immune compromised specify reason: _____

In the 7 days prior to the onset of symptoms did the case:

Traveled within Iowa? ☐ Yes ☐ No ☐ Unk City in Iowa: ____________ Departure date: ___/___/___ Return date: ___/___/___

Traveled within U.S.? ☐ Yes ☐ No ☐ Unk State: ______ City: ____________ Departure date: ___/___/___ Return date: ___/___/___

Traveled outside U.S.? ☐ Yes ☐ No ☐ Unk Country: ____________ Departure date: ___/___/___ Return date: ___/___/___

Has the patient had family members or close contacts with pneumonia or influenza-like illness? ☐ Yes ☐ No ☐ Unk

Did the patient have close contacts (within 6 feet of a person who is a suspect, probable, or confirmed Novel influenza A case with significant personal interaction (i.e. caring for, speaking to, or touching))? ☐ Yes ☐ No ☐ Unk

CONTACTS

Number of people living in case's household: _____

Close contacts of the case (For more contacts, print/copy additional contact pages.)

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	____________ Zip code: Phone: - -

Relationship to case		List symptoms		Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	☐ Cough ☐ Sore throat ☐ Runny nose ☐ Conjunctivitis ☐ Diarrhea	☐ Seizures ☐ Headache ☐ Shortness of breath ☐ Vomiting ☐ Other specify below	/ /	☐ Yes ☐ No
Other symptoms:					

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	____________ Zip code: Phone: - -

Relationship to case		List symptoms		Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	☐ Cough ☐ Sore throat ☐ Runny nose ☐ Conjunctivitis ☐ Diarrhea	☐ Seizures ☐ Headache ☐ Shortness of breath ☐ Vomiting ☐ Other specify below	/ /	☐ Yes ☐ No
Other symptoms:					

Name	DOB	Gender	Address/Phone
	/ /	☐ Male ☐ Female	____________ Zip code: Phone: - -

Relationship to case		List symptoms		Symptom onset date	Is contact a case?
☐ Spouse ☐ Child ☐ Sibling ☐ Roommate ☐ Parent/ guardian	☐ Sexual contact ☐ Family member (non-household) ☐ Friend/acquaintance ☐ Contact- work/school/etc ☐ Unknown/Other	☐ Cough ☐ Sore throat ☐ Runny nose ☐ Conjunctivitis ☐ Diarrhea	☐ Seizures ☐ Headache ☐ Shortness of breath ☐ Vomiting ☐ Other specify below	/ /	☐ Yes ☐ No
Other symptoms:					

NOTES: