

Human Influenza A (H5) Domestic Case Investigation Form

1. Reporter Information

Assigned Case ID _____ Date Reported to GDPH ___/___/_____
Name of Reporter: Last _____ First _____
Telephone Number _____ Fax _____ Email _____
County or District Health Department _____ District Number _____

2. Patient Information

Patient Name: Last _____ First _____
Address: Street _____ City _____ State _____
Zip _____ County _____
Telephone _____ Cell/Other Phone _____
Date of Birth ___/___/_____
Age _____
Sex: Male Female
Race: White American Indian/Alaska Native Native Hawaiian/Pacific Islander
 Black Asian Unknown
Ethnicity: Hispanic Non-Hispanic Unknown

3. Signs and Symptoms

1. Date of Symptom Onset ___/___/_____
2. Signs and symptoms experienced within the last 7 days:

- | | | | |
|---|------------------------------|-----------------------------|----------------------------------|
| a. Coughing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| b. Diarrhea | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| c. Difficulty breathing (shortness of breath) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| d. Eye infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| e. Fever $\geq 38^{\circ}\text{C}$ (100.4°F) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| f. Feverishness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| g. Muscle aches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| h. Rash | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| i. Runny nose | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| j. Seizures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| k. Sore throat | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| l. Vomiting | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Unknown |
| m. Other symptom(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Specify _____ |

3. Is the patient pregnant?

Yes (weeks pregnant) _____ No Unknown

4. Medical History – Location(s) Where Treatment Sought for this Illness

1. Outpatient History

Clinic #1: Name _____ Doctor's Name _____ Date ___/___/___
Address _____ Telephone _____ Fax _____

Clinic #2: Name _____ Doctor's Name _____ Date ___/___/___
Address _____ Telephone _____ Fax _____

2. Hospital Admission(s)

Hospital #1: Name _____ Doctor's Name _____ Admission Date ___/___/___
Address _____ Telephone _____ Fax _____

Held in isolation? Yes No Unknown

Date Isolation Started ___/___/___ Type of Isolation _____

Discharged (specify date) ___/___/___ (specify disposition) _____

Transferred (specify date) ___/___/___ (specify hospital) _____

Hospital #2: Name _____ Doctor's Name _____ Admission Date ___/___/___
Address _____ Telephone _____ Fax _____

Held in isolation? Yes No Unknown

Date Isolation Started ___/___/___ Type of Isolation _____

Discharged (specify date) ___/___/___ (specify disposition) _____

Transferred (specify date) ___/___/___ (specify hospital) _____

5. Travel History

1. In the 10 days prior to illness, did the patient travel?

Yes No Unknown

IF YES, please provide specific information.

WITHIN GEORGIA

a. City (County) _____ Arrival Date ___/___/___ Departure Date ___/___/___
Mode of Transportation _____ Flight/Ship # _____

b. City (County) _____ Arrival Date ___/___/___ Departure Date ___/___/___
Mode of Transportation _____ Flight/Ship # _____

WITHIN THE U.S.

a. State _____ Arrival Date ___/___/___ Departure Date ___/___/___
Mode of Transportation _____ Flight/Ship # _____

b. State _____ Arrival Date ___/___/___ Departure Date ___/___/___
Mode of Transportation _____ Flight/Ship # _____

INTERNATIONAL

a. Country _____ Arrival Date ___/___/___ Departure Date ___/___/___
Mode of Transportation _____ Flight/Ship # _____

b. Country _____ Arrival Date ___/___/___ Departure Date ___/___/___
Mode of Transportation _____ Flight/Ship # _____

6. Animal Exposure(s)

I. In the 10 days prior to illness, did the patient have contact with any of the following animals (at their home, neighborhood, workplace, etc.)?

Chickens/Poultry Wild Birds Pigs Other (specify)_____

IF YES to I, please fill in the following questions.

1. What was the nature of the contact(s)?

Direct touching (specify animal(s))_____

Proximity within 3 feet but not touching (specify animal(s))_____

IF DIRECT TOUCHING, what did the patient do with the animal? (check all that apply)

Carry/Handle Slaughter/Butcher Prepare for Consumption

Other (specify)_____

2. Where did the contact occur? (check all that apply)

Live animal market Commercial animal farm Backyard animals Inside home

Cockfighting Slaughterhouse Veterinary Contact Hunting

Wildlife Other contact_____

3. What was the status of the animal(s) at time of contact?

Well-appearing Diseased Deceased (approx date of death)___/___/___

IF DISEASED OR DECEASED, has the death/outbreak been reported to the GA Department of Agriculture?

Yes No Unknown

4. In what location(s) did the contact(s) occur?

City_____ State/Province_____ Country_____ Date___/___/___

City_____ State/Province_____ Country_____ Date___/___/___

II. Fill in the following questions for the 10 days prior to the patient's onset of illness.

1. Did the patient touch animals (including poultry, wild birds, or swine) or their remains in an area where influenza infection in animals or novel influenza infection in humans has been suspected or confirmed in the past month?

Yes No Unknown

2. Was the patient exposed to environments contaminated by animal feces (including poultry or wild birds) in an area where influenza infection in animals or novel influenza infection in humans has been suspected or confirmed in the past month?

Yes No Unknown

3. Did the patient consume raw or undercooked animals (including poultry or wild birds) in an area where influenza infection in animals or novel influenza infection in humans has been suspected or confirmed in the past month?

Yes No Unknown

7. Occupational Exposure(s)

1. What is the patient's current job? (check all that apply)

- Laboratory worker Health care worker Poultry farm worker Wildlife worker
 Veterinary worker Other animal farm worker Other _____

2. How long has the patient worked in their current job? _____ days / months / years (circle one)

If less than 10 days, list previous job held: _____ days / months / years at previous job

3. Does the patient work in a health care setting?

- Yes (specify name of site) _____ No Unknown

4. In the 10 days prior to onset of illness, did the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

- Yes No Unknown

8. Human Exposure(s)

1. Does the patient have any family members or close contacts with pneumonia or severe influenza-like-illness? (Close contact is defined as contact within 3 feet of a person {e.g. caring for, speaking with, or touching.})

- Yes No Unknown

2. In the 10 days prior to illness, did the patient have close contact (within 3 feet) with a person with fever and cough, pneumonia, or that died of a respiratory illness?

- Yes No Unknown

IF YES, where did the contact occur?

- Close to home While travelling (specify location) _____ (and dates) _____

(Be sure to enter any travel information in "Section 5: Travel History".)

3. In the 10 days prior to illness, did the patient have close contact (within 3 feet) with a person who is a suspected, probable, or confirmed novel (including avian and pandemic) human influenza A case?

- Yes No Unknown

4. If the patient has been diagnosed with novel influenza A infection that has not been laboratory confirmed, is there an epidemiologic link between the patient and a laboratory confirmed or probable novel influenza A case?

- Yes No Unknown

9. Medical History – Vaccination Status

1. Was the patient vaccinated against seasonal human influenza in the past year?

- Yes No Unknown

IF YES, date of vaccination: ____/____/____

Type of vaccine: Inactivated Live Attenuated Unknown

2. Was the patient vaccinated against avian influenza A/H5N1?

- Yes No Unknown

IF YES, date of vaccination: ____/____/____

Type of vaccine: _____

10. Medical History – *Treatment*

1. Did the patient receive antiviral medications?

Yes No Unknown

IF YES, complete table below.

Drug	Dose#1	Dose #1 Date Initiated (MM/DD/YYYY)	Dose #1 Date Discontinued (MM/DD/YYYY)	Dose #2	Dose #2 Date Initiated (MM/DD/YYYY)	Dose #2 Date Discontinued (MM/DD/YYYY)
Oseltamivir (Tamiflu)	mg			mg		
Zanamivir (Relenza)	mg			mg		
Rimantadine (Flumadine)	mg			mg		
Amantadine (Symmetrel)	mg			mg		
Other _____	mg			mg		

2. Did the patient receive antibacterial medications?

Yes No Unknown

IF YES, complete table below.

Drug	Date Initiated	Date Discontinued	Dosage (if known)
			mg
			mg
			mg

3. Did the patient receive mechanical ventilation?

Yes No Unknown

4. Did the patient have acute respiratory distress syndrome (ARDS)?

Yes No Unknown

5. What was the patient's outcome?

Alive Expired Unknown

IF ALIVE, what is the patient's current disposition?

Still hospitalized Discharged to home Unknown
 Discharged to long term care facility (specify name) _____ Other (specify) _____

IF EXPIRED, please list the date of death. ____/____/____

And disposition (autopsy, funeral home, etc.) _____

11. Medical History – *Diagnostic and Laboratory Testing*

1. Was a chest x-ray or chest CT scan performed?

Yes No Unknown

IF YES, what was the result?

Normal Abnormal Unknown

IF ABNORMAL, was there evidence of pneumonia?

Yes No Unknown

12. Medical History – Influenza Diagnostic Testing

Influenza Test Results (GPHL)

Specimen #1 **Date Received** ___/___/___

NP Swab NP Aspirate Nasal Swab Nasal Aspirate Sputum Serum Date Collected
 OP Swab Endotracheal Aspirate Bronchoalveolar Lavage (BAL) Other _____ ___/___/___

Test Type:
 RT-PCR Direct florescent antibody (DFA)
 Viral Culture
 Rapid Antigen Test (specify name) _____

Test Result:
 Influenza A Influenza B Influenza (type unk)
 Negative Pending
 Date Resulted ___/___/___

Specimen #2 **Date Received** ___/___/___

NP Swab NP Aspirate Nasal Swab Nasal Aspirate Sputum Serum Date Collected
 OP Swab Endotracheal Aspirate Bronchoalveolar Lavage (BAL) Other _____ ___/___/___

Test Type:
 RT-PCR Direct florescent antibody (DFA)
 Viral Culture
 Rapid Antigen Test (specify name) _____

Test Result:
 Influenza A Influenza B Influenza (type unk)
 Negative Pending
 Date Resulted ___/___/___

Specimen #3 **Date Received** ___/___/___

NP Swab NP Aspirate Nasal Swab Nasal Aspirate Sputum Serum Date Collected
 OP Swab Endotracheal Aspirate Bronchoalveolar Lavage (BAL) Other _____ ___/___/___

Test Type:
 RT-PCR Direct florescent antibody (DFA)
 Viral Culture
 Rapid Antigen Test (specify name) _____

Test Result:
 Influenza A Influenza B Influenza (type unk)
 Negative Pending
 Date Resulted ___/___/___

Specimens sent to reference laboratory (CDC)

Select a source and fill in for each specimen: NP Swab, NP Aspirate, Nasal Swab, Nasal Aspirate, OP Swab, Endotracheal Aspirate, Bronchoalveolar Lavage (BAL), Sputum, Serum, Tissue, Other

Specimen 1			
ID#	Source:	Date Collected: / / Date Sent: / /	Outbreak #:
Specimen 2			
ID#	Source:	Date Collected: / / Date Sent: / /	Outbreak #:
Specimen 3			
ID#	Source:	Date Collected: / / Date Sent: / /	Outbreak #:
Specimen 4			
ID#	Source:	Date Collected: / / Date Sent: / /	Outbreak #:

13. Patient Follow-Up

1. If patient was discharged to home, is public health following up?

Yes No Unknown

Follow-up health department (county name, district number, or state name) _____