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 <u>within the last 7 days</u>:

a.	Coughing	☐ Yes	☐ No	☐ Unknown
b.	Diarrhea	☐ Yes	☐ No	☐ Unknown
c.	Difficulty breathing (shortness of breath)	☐ Yes	☐ No	☐ Unknown
d.	Eye infection	☐ Yes	☐ No	☐ Unknown
e.	Fever ≥ 38°C (100.4°F)	☐ Yes	☐ No	☐ Unknown
f.	Feverishness	☐ Yes	☐ No	☐ Unknown
g.	Muscle aches	☐ Yes	☐ No	☐ Unknown
h.	Rash	☐ Yes	☐ No	☐ Unknown
i.	Runny nose	☐ Yes	☐ No	☐ Unknown
j.	Seizures	☐ Yes	☐ No	☐ Unknown
k.	Sore throat	☐ Yes	☐ No	☐ Unknown
l.	Vomiting	☐ Yes	☐ No	☐ Unknown
m.	Other symptom(s)	☐ Yes	☐ 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 ☐ Broncheoalveolar Lavage (BAL) ☐ Other_____ ____/____/_____

Test Type:	Test Result:
☐ RT-PCR ☐ Direct florescent antibody (DFA)	☐ Influenza A ☐ Influenza B ☐ Influenza (type unk)
☐ Viral Culture	☐ Negative ☐ Pending
☐ Rapid Antigen Test (specify name)_____	Date Resulted ____/____/_____

Specimen #2 **Date Received** ____/____/_____

☐ NP Swab ☐ NP Aspirate ☐ Nasal Swab ☐ Nasal Aspirate ☐ Sputum ☐ Serum Date Collected

☐ OP Swab ☐ Endotracheal Aspirate ☐ Broncheoalveolar Lavage (BAL) ☐ Other_____ ____/____/_____

Test Type:	Test Result:
☐ RT-PCR ☐ Direct florescent antibody (DFA)	☐ Influenza A ☐ Influenza B ☐ Influenza (type unk)
☐ Viral Culture	☐ Negative ☐ Pending
☐ Rapid Antigen Test (specify name)_____	Date Resulted ____/____/_____

Specimen #3 **Date Received** ____/____/_____

☐ NP Swab ☐ NP Aspirate ☐ Nasal Swab ☐ Nasal Aspirate ☐ Sputum ☐ Serum Date Collected

☐ OP Swab ☐ Endotracheal Aspirate ☐ Broncheoalveolar Lavage (BAL) ☐ Other_____ ____/____/_____

Test Type:	Test Result:
☐ RT-PCR ☐ Direct florescent antibody (DFA)	☐ Influenza A ☐ Influenza B ☐ Influenza (type unk)
☐ Viral Culture	☐ Negative ☐ Pending
☐ Rapid Antigen Test (specify name)_____	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, Broncheoalveolar 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)_____