CALIFORNIA CASE REPORT FORM FOR LABORATORY-CONFIRMED AVIAN (H5N1) INFLUENZA

- For use in the World Health Organization Pandemic Phase 3 (no or very limited human-to-human transmission)
- Refer to http://www.oie.int/downld/AVIAN%20INFLUENZA/A_AI-Asia.htm and click on "GRAPH" at the top for a list of affected countries.
- Please report any suspect or laboratory-confirmed cases to the San Mateo County Disease Control and Prevention at (650) 573-2346 or San Mateo County On-call Health Officer 24/7 at (650) 363-4981.

FAX completed form to (650) 573-2919

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 with close contact to patients, patient care areas or patient care items (e.g., linens or clinical specimens)?

☐ Yes ☐ No ☐ Unk *If yes*, specify:

Health care worker type: ☐ Physician ☐ Nurse/ PA ☐ Laboratory ☐ 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) ____

☐ Chronic neurologic disease (e.g. seizure disorder) ____

☐ Immunosuppression (e.g., HIV, transplant, malignancy, steroids) ____________________

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

☐ Pregnancy (note 1st, 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 ☐ Otitis ☐ Diarrhea

☐ Nausea/vomiting ☐ Abdominal pain ☐ Apnea ☐ Lethargy ☐ Altered mental status ☐ Other: ____________________

Complications: ☐ Viral pneumonia ☐ Encephalitis ☐ Myocarditis ☐ Seizures ☐ Sepsis ☐ Reyes Syndrome

☐ Multi-organ failure ☐ 2º bacterial pneumonia ☐ Other____

Antiviral medications: ☐ Yes ☐ No ☐ Unk

If yes, specify: ☐ Amantadine ☐ Rimantadine ☐ Oseltamivir ☐ Zanamavir Dose: ____________________

Date started: ____ /_____/______ Date completed: ____ /_____/_____

Received flu vaccine for current/most recent season: ☐ Yes ☐ No ☐ Unk *If yes*, specify date: ____/_____/_____

Comments: ____

Section 4. Clinical Status

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

Laboratory results (note most abnormal value): Hct: _____ Platelet: _____ WBC: _____ Differential: ________________________

AST: ______ ALT: ______ Alk phos: ______ Tbili: ______ LDH: _______ CPK: _______ BUN: ______ Creatinine: ______

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?** ☐ Yes ☐ No ☐ Unk
If yes: Name of hospital: ____________________________________ Medical Record Number:________________________
City: ____ County/State: ____
Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____

Was the patient seen or transferred from another clinic or facility after first symptom onset? ☐ Yes ☐ No ☐ Unk
If yes, clinic or facility name: __________________________ Dates seen/hospitalized: _____/_____/_____ - _____/______/______
(If more, please list on back of page).

Was the patient ever in the ICU? ☐ Yes ☐ No ☐ Unk
Was the patient ever 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.

Pathologist name: ____ Phone number: ____________________________

Section 5. Avian (H5N1) Influenza Epidemiological Risk Factors

In the 10 days prior to symptom onset:

1. Did the patient travel to an area with documented avian (H5N1) influenza in poultry, wild birds and/or humans?
   ☐ Yes ☐ No ☐ Unk *If yes,* complete section 6.
2. Did the patient have history of any of the following exposures in an H5N1-affected country?
   a. Direct contact with (e.g. touching) sick or dead domestic poultry* ☐ Yes ☐ No ☐ Unk
   b. Consumption of raw or incompletely cooked poultry* or poultry* products ☐ Yes ☐ No ☐ Unk
   c. Direct contact with surfaces contaminated with poultry* feces ☐ Yes ☐ No ☐ Unk
   d. Direct contact with sick or dead wild birds suspected or confirmed to have influenza H5N1 ☐ Yes ☐ No ☐ Unk
   e. Close contact (within 1 meter) of a person who was hospitalized or died due to unexplained respiratory illness ☐ Yes ☐ No ☐ Unk
3. Did the patient come in close contact (within 1 meter) of an ill patient who was confirmed or suspected to have H5N1
   ☐ Yes ☐ No ☐ Unk *If yes*, please fill out source case information in ANNEX 1.
4. Did the patient work with live influenza H5N1 virus in laboratory? ☐ Yes ☐ No ☐ Unk *If yes*, please give further detail below.

Comment on exposures listed above: ____

____

____

*The definition of poultry is domestic fowls, such as chickens, turkeys, ducks, or geese, raised for meat or eggs.

Section 6. Travel History

Complete if travel to area with documented or suspected transmission of H5N1 in birds or humans. 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:______________________________

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: ____

Section 6 continued:

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:____________________

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: ____

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:____________________

Contact with live or dead domestic poultry or their excretions (e.g., visited a poultry farm, bird market, etc)? ☐ Yes ☐ No

Comment: ____

Section 7. Local Clinic/Hospital Laboratory Results

*****NOTE: VIRAL CULTURE SHOULD NOT BE PERFORMED IN SUSPECT AVIAN INFLUENZA CASES*****

☐ Rapid influenza test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

If positive, result: ☐ Influenza A ☐ Influenza B ☐ Influenza A/B, not distinguished

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify ____________________

Test performed: ☐ Directigen Flu ☐ FLU OIA ☐ QuickVue Influenza Test ☐ ZstatFlu ☐ NOW Flu Test

☐ Rapid RSV test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify____________________

☐ Respiratory culture: ☐ Neg ☐ Pos ☐ Unk Organism isolated: ____________________ Collection Date: _____/_____/_____

Specimen type: ☐ nasopharyngeal swab ☐ nasopharyngeal wash ☐ oropharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify____________________

☐ Blood culture: ☐ Neg ☐ Pos ☐ Unk Organism isolated: ____________________ Collection Date: _____/_____/_____

☐ Other test results:

Test: ________________________ Result: ________________________ Collection date: _____/_____/_____

Test: ________________________ Result: ________________________ Collection date: _____/_____/_____

Were other respiratory co- pathogens/bacterial infections detected in the patient? ☐ Yes ☐ No ☐ Unk

If yes, indicate which pathogen(s): ____

Comments: ____

Section 8. Local Public Health Laboratory Results

Influenza A Results (check all tests that were performed):

☐ Rapid influenza test: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify____________________

Test performed: ☐ Directigen Flu ☐ FLU OIA ☐ QuickVue Influenza Test ☐ ZstatFlu ☐ NOW Flu Test

☐ DFA: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify____________________

☐ PCR for influenza ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify____________________

If subtyping available: ☐ H1 positive ☐ H3 positive ☐ H5 positive ☐ untypeable ☐ other, specify ____________________

Were respiratory co-pathogens other than influenza A detected by PCR or other testing? ☐ Yes ☐ No ☐ Unk

If yes, check pathogen: ☐ influenza B ☐ RSV ☐ adenovirus ☐ human metapneumovirus ☐ other ___________________

Method of detection: ☐ EIA ☐ DFA ☐ PCR ☐ other, specify ____

Comments: ____

Section 9. Trace Forward Contact Information

Trace –forward contact information refers to those individuals the patient has had contact with **since** becoming ill. In WHO Pandemic Phase 3, CDPH recommends that information be collected on all "trace-forward" contacts for the purposes of symptom monitoring, laboratory testing and possible administration of antiviral medication. A sample template for recording trace-forward contact information is provided in Annex 2.

Section 10. Submitted by:

Last Name: ____________________________ First Name: ____________________________ Phone: (____)____________________

Affiliation: _____________ County: ______________________Fax:___________________ E-mail: ____________________________

If you would like to consult with a member of the avian influenza team at CDHS, please contact the CDHS Duty Officer of the Day, or the CDPH Viral and Rickettsial Disease Laboratory (Janice Louie or Carol Glaser).

Section 11. Additional Comments

Annex 1. **Source Case Information**

Please complete Annex 1 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.

Was the source case a laboratory-confirmed case of influenza A (H5N1)? ☐ Yes ☐ No ☐ Unk

List country/area(s) where contact with the source case occurred: ____

____

Name: ____ Age:_______ ☐ Years ☐ Months Gender: ☐ Male ☐ Female

Address: ____

City/Province: ____ Telephone: (____)__________________________

Nature of contact: ☐ Household ☐ Co-worker ☐ Health care ☐ Other, specify ______________________________

Please describe the nature of the contact: ____

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

Comments: ____

____

ANNEX 2: AVIAN INFLUENZA A (H5N1) CONTACT FOLLOW-UP SHEET

For use in WHO Pandemic Phase 3

For each contact to a laboratory-confirmed influenza A (H5N1) case, record the information itemized below. Besides household contacts, consider best friends and the information they can provide about contacts that the case may have had. Medical personnel who had contact with the case's oral secretions should also be reported.

Full Name of Contact/Associate <u>Last</u> First	DOB or Age	Type of Contact[1]	Contact Information <u>Phone Number</u> Address	Symptoms[2]	Influenza Test Result		Antivirals		Vaccinated	Quarantined	Isolation
							Prophylaxis	Treatment			
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________ No Reason: _______ _________________	Yes Date: ________ Drug: _____________ No Reason: _______ _________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________ No Reason: _______ _________________	Yes Date: ________ Drug: _____________ No Reason: ________ _________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________ No Reason: ________ _________________	Yes Date: ________ Drug: _____________ No Reason: ________ _________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					
				Yes No	H5N1	Pos Neg UNK ND	Yes Date: ________ Drug: _____________ No Reason: ________ _________________	Yes Date: ________ Drug: _____________ No Reason: ________ _________________	Yes No UNK	Yes No	Yes No
				Onset Date	REGULAR	Pos Neg UNK ND					

1. Type of contact:
(1) Health care worker (HCW) providing direct patient care to suspect cases;
(2) Close contacts: persons in close proximity (1 meter) and with prolonged exposure to the case such as those who have shared a defined setting (household, extended family, hospital or other residential institution);
(3) Close contacts: persons who otherwise had direct contact with respiratory, oral or nasal secretions (e.g. face to face during coughing or sneezing, sharing water bottles or kissing) during the infectious period (1 day prior to symptom onset to 14 days after symptom onset).

2. Symptoms: Monitor for fever and/or respiratory symptoms for 10 days after the last date of exposure to the confirmed case.
- <u>Close contacts/HCWs with fever</u> should be placed on isolation precautions for suspect H5N1 patients. After specimen collection, treat with antivirals on the assumption of H5N1 infection; complete clinical evaluation.
- <u>Close contacts/HCWs with respiratory symptoms but no fever</u> should remain at home in isolation until H5N1 is ruled out by laboratory testing. Decisions on whether to treat a close contact/HCW with other symptoms but no fever should be made on a case-by-case basis but a specimen should be collected prior to treatment. Consider arranging for H5N1 testing if respiratory symptoms are present.
- Consider post-exposure prophylaxis for <u>asymptomatic close contacts/HCWs</u> who have had an unprotected exposure to infectious aerosols or other secretions. Collect appropriate specimens prior to starting treatment.
- If testing of contact is positive for H5N1, fill out a new case report form. Continue precautions for 14 days post-onset and if not already done, start treatment with antivirals for case and treat complications, as indicated

Annex 3. **(To be filled out by DHS personnel)**

VRDL Results:

☐ DFA: ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid ☐ other, specify____________________

☐ PCR for influenza ☐ Neg ☐ Pos ☐ Unk Collection Date: _____/_____/_____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ sputum

☐ endotracheal asp ☐ bronchoalveolar lavage ☐ pleural fluid

☐ biopsy/autopsy tissue, specify source____

☐ other specimen type, specify____

Subtyping result: ☐ H1 positive ☐ H3 positive ☐ H5 positive ☐ untypeable ☐ other ___________________________

PCR for other pathogens ☐ Neg ☐ Pos ☐ Not done ☐ Unk

If yes, check pathogen: ☐ influenza B ☐ RSV ☐ adenovirus ☐ human metapneumovirus ☐ parainfluenza 1-3

☐ enterovirus ☐ coronavirus ☐ Legionella ☐ Chlaymdia ☐ Mycoplasma

☐ other ____

Other test results:

Test: ___________________________ Result: ____ Collection date: _____/_____/_____

Test: ___________________________ Result: ____ Collection date: _____/_____/_____

Notes: ____

____

____

____

CDC Results (if available):

Date of specimen: ____/_____/____

Specimen type: ☐ oropharyngeal swab ☐ nasopharyngeal wash ☐ nasopharyngeal swab ☐ endotracheal asp
☐ sputum ☐ bronchoalveolar lavage ☐ pleural fluid ☐ blood/serum
☐ biopsy/autopsy tissue, specify source ____
☐ other specimen type, specify____

Results:____

____

____

CDC Contact:

Last Name: ___________________________ First Name: __________________________ Phone: (____)_____________________

E-mail: ______________________________ Date reported to CDC: _____/____/_____ CDC ID#: _______________________