Form Approved
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Novel and Pandemic Influenza A Virus Infection Case Investigation Form

Case Information

Date of Report: _____/_____/_____(DD/MM/YYYY)

State/Local Case Identification Number: _____

CDC Case Identification Number: _____

Name of case-patient: Last _____ First_____ Initials of case-patient (if not US case):_____

Postal address: Street_____ Village/Town/City _____County/District_____

State/Province_____ _____Zip Code/Postal Code_____

GIS coordinates of residence (Latitude Degrees/Minutes/Seconds X Longitude Degrees/Minutes/Seconds) _____

Telephone #_____ Cell/Mobile _____ Fax _____ E-mail _____

Immigration status: US resident Resides abroad but visiting US

Reporter Information

Name of reporter: Last_____ First_____

Postal address: Street_____ City _____ State/Province_____ Zip Code/Postal Code_____

Telephone #_____ Cell/Mobile _____ Fax _____ E-mail _____

Reporter's Organization:

State or County Health Department: _____ City_____ State/Province_____

Source of Information

Case-patient

Proxy; IF YES, relationship of proxy to case-patient_____ Reason for use of proxy_____

Name of proxy: Last_____ First_____

Postal address: Street_____ Village/Town/City _____County/District_____

State/Province_____ _____Zip Code/Postal Code_____

Telephone #_____ Cell/Mobile _____ Fax _____

E-mail _____

Case-Patient Demographic Information

Date of Birth: _____/_____/_____(DD/MM/YYYY)

Race: White Asian American Indian/Alaska Native
Black Native Hawaiian/Other Pacific Islander Unknown

Ethnicity: Hispanic Non-Hispanic Unknown

Sex: Male Female

Social History and Contact Tracing

Number of household members (including case patient) _____

Does the case-patient have family members or close contacts with pneumonia or severe influenza-like-illness?
[close-contact defined as contact within 1 meter (or 3 feet) with a person (e.g. caring for, speaking with, or touching)]

Yes (complete contact form) No N/A Unknown

[If YES, list any identified contacts on the contact tracing form]

What is the current job of the case-patient? (check all that apply)

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

How long has the case-patient worked in their current job? (number) _____ months
years

If less than six months, list the type of job previously held: (specify job) _____ (specify length of time at previous job) _____

Does the case-patient work in a health care facility or setting?

Yes (specify name)_____ No Unknown

Exposures- *Travel history*

In the 10 days prior to illness onset, did the case-patient travel?

Yes No Unknown

If YES, please fill in the arrival and departure dates for all countries visited.

a. Country_____ Arrival_____Departure_____
Mode of Transportation_____ Flight/Ship #_____

b. Country_____ Arrival_____Departure_____
Mode of Transportation_____ Flight/Ship #_____

c. Country_____ Arrival_____Departure_____
Mode of Transportation_____ Flight/Ship #_____

d. Country_____ Arrival_____Departure_____
Mode of Transportation_____ Flight/Ship #_____

e. Country_____ Arrival_____Departure_____
Mode of Transportation_____ Flight/Ship #_____

f. Country_____ Arrival_____Departure_____
Mode of Transportation_____ Flight/Ship #_____

g. Country_____ Arrival_____Departure_____

Mode of Transportation_____ Flight/Ship #_____

Exposures-*Contact with probable or confirmed case-patients*

In the 10 days prior to illness onset:

Did the case-patient have close contact (within 1 meter (or 3 feet)) with a person (e.g. caring for, speaking with, or touching) with fever and cough, or pneumonia, or that died of a respiratory illness in the 10 days prior to illness onset?

Yes No Unknown

If YES, was the contact in the U.S.A. or international?

US International Unknown

If International, in which country or countries?

County: _____ Date(s) of Contact:

_____

County: _____ Date(s) of Contact:

_____

In the 10 days prior to illness onset:

Did the case-patient have close contact (within 1 meter (3 feet)) with a person (e.g. caring for, speaking with, or touching) who is a suspected, probable or confirmed novel (including avian and pandemic) human influenza A case within the week prior to illness onset?

YES No Unknown

If YES:

a. Did the patient directly touch or provide physical care for the probable or confirmed case?

YES No Unknown

b. Did the patient speak to or touch or any items belonging to the probable or confirmed case?

YES No Unknown

In the 10 days prior to illness onset:

Did the case-patient visit or stay in the same household with anyone who died during or following the visit?

Yes No Unknown

If this case-patient has a diagnosis of novel influenza A virus infection that has not been laboratory confirmed, is there an epidemiologic link between this patient and a laboratory-confirmed or probable novel influenza A case?

Yes No Unknown

In the 10 days prior to illness onset:

Did the case-patient seek care for an unrelated health condition in a healthcare facility known to be simultaneously caring for other suspected or confirmed human cases of avian or novel influenza?

Yes No Unknown

Exposures-*Contact with Poultry and Other Animals*

Are any sick or dead animal(s) present in the case-patient's home, village, neighborhood, or workplace?

Yes No Unknown

If YES, which of following are present? (check all that apply)

Chickens/poultry Wild birds Pigs Other (specify)_____

If YES, what is the status of the animals during the two weeks prior to case-patient illness onset?

Well-appearing Diseased Dead (approximate date of death) _____

If there are sick poultry, are they vaccinated against influenza?

Yes No Unknown

If there are sick pigs, are they vaccinated against influenza?

YES No Unknown

In the 10 days prior to illness onset, did the case-patient have contact with any of the following animals? (check all that apply)

Chickens/poultry Wild birds Pigs Other (specify)_____

If the patient had contact with animals, please answer the following questions, otherwise skip to the Medical History section:

What was the nature of the contact (check all that apply)?

Direct touching (specify animal(s)) _____

Proximity within 1 meter but not touching (specify animal(s))_____

If the case-patient directly touched the bird(s) or other animal(s), which of the following did the patient do with the animal:

(check all that apply)

Carry/handle Slaughter/butcher Prepare for consumption Other (specify) _____

If the case-patient directly touched the bird(s) or other animal(s), approximately how many sick or dead birds/animals did the patient touch?

One only 2-5 6-20 21-100 >100

What species of bird(s) or other animal(s) did the case-patient come in contact with? (directly or within 1 meter)

Species #1_____ Species #2_____ Species #3_____

What was the status of the bird(s) or other animal(s) during the two weeks PRIOR to case-patient illness onset?

Well-appearing Diseased Dead (approximate date of death) _____

What is the status of the bird(s) or other animal(s) AFTER the onset of illness in the case-patient?

Well-appearing Diseased Dead (approximate date of death)

_____

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_____

Are the bird(s) or other animal(s) that the case-patient came in contact with vaccinated with any of following influenza vaccines?

H1 H3 H5 Not vaccinated

Unknown vaccination status

Was the contact in the US or international?

US International Unknown

If contact was in the US, in which city and state did it occur?

City: _____ State: _____ Date: _____

City: _____ State: _____ Date: _____

If contact was international, in which country or countries did it occur?

City_____ Province_____ Country: _____ Dates: _____

City_____ Province_____ Country: _____ Dates: _____

Answer the remaining questions in this section in terms of the 10 days prior to the onset of the patient's illness:

Did the case-patient touch (handle, slaughter, butcher, prepare for consumption) animals (including poultry, wild birds, or swine) or their remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

Yes No Unknown

Was the case-patient exposed to animal (including poultry, wild birds, or swine) remains in an area where influenza infection in animals or novel influenza in humans has been suspected or confirmed in the last month?

Yes No Unknown

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

Yes No Unknown

Did the case-patient consume raw or undercooked animals (including poultry, wild birds, or swine products) in an area where influenza infections in animals or novel influenza in humans has been suspected or confirmed in the last month?

Yes No Unknown

Did the patient visit an agricultural event, farm, petting zoo or place where pigs live or were exhibited (state or county fair) in the last month?

Yes No Unknown

Did the patient have direct contact with pigs at an agricultural event, farm, petting zoo or place where pigs were exhibited (state or county fair) in the last month?

Yes No Unknown

Did the case-patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

Yes No Unknown

Medical History-*Vaccination Status*

Was the case-patient vaccinated against human influenza in the past year?

Yes No Unknown

If YES, date of vaccination ____/____/____

Type of vaccine: Inactivated Live Attenuated Unknown

Was the case-patient vaccinated against avian influenza A (H5N1)?

Yes No Unknown

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

Type of vaccine: _____

Medical History-*Past Medical History*

Is the case-patient pregnant?

Yes (weeks pregnant)_____ No Unknown

Does the case-patient have any of the following?

a.	Asthma	yes	no	unknown	
b.	Other chronic lung disease	yes	no	unknown	(If YES, specify) _____
c.	Chronic heart or circulatory disease	yes	no	unknown	(If YES, specify) _____
d.	Metabolic disease (including diabetes mellitus)	yes	no	unknown	(If YES, specify) _____
e.	Kidney disease	yes	no	unknown	(If YES, specify) _____
f.	Cancer in the last 12 months	yes	no	unknown	(If YES, specify) _____

g. Immunosuppressive condition (such as HIV infection, cancer, chronic corticosteroid therapy, diabetes, or organ transplant recipient)

yes no unknown (If YES, specify)

_____

h. Other chronic diseases yes no unknown (If YES, specify)

_____

Is the case-patient on chronic drug therapy?

Yes No Unknown

If yes, complete table below

Drug	Dose	Frequency	Date Initiated
	mg		
	mg		
	mg		
	mg		
	mg		

Has the case-patient smoked at least 100 cigarettes in their life? (100 cigarettes = approximately 5 packs) yes no unknown

If YES, does the patient now smoke cigarettes: everyday some days not at all

Medical History-*Illness onset and presenting symptoms*

Date of illness onset _____ (DD/MM/YYYY)

Date(s) of outpatient medical presentation(s) (clinic location, name):

Clinic #1 name: _____ Date(s): _____ (DD/MM/YYYY) Telephone #: _____

Fax #: _____

Address: _____

Clinic #2 name: _____ Date(s): _____ (DD/MM/YYYY) Telephone #: _____

Fax #: _____

Address: _____

Date(s) of hospital admission(s):

Hospital #1 Name: _____ Telephone#_____ Fax #:

_____

Address: _____

Admission date: _____ (DD/MM/YYYY)

Discharged (specify date) _____ Transferred (specify date) _____

Hospital #2 Name: _____ Telephone#_____ Fax #:

_____

Address: _____

Admission date: _____ (DD/MM/YYYY)

Discharged (specify date) _____ Transferred (specify date) _____

Within the last 7 days, has the case-patient experienced any of the following medical conditions:

a.	Coughing	YES	NO	Unknown
b.	Diarrhea	YES	NO	Unknown
c.	Difficulty breathing (or shortness of breath)	YES	NO	Unknown
d.	Eye infection	YES	NO	Unknown
e.	Fever (_____°) temp if known	YES	NO	Unknown
f.	Feverishness	YES	NO	Unknown
g.	Headache	YES	NO	Unknown
h.	Muscle aches	YES	NO	Unknown
i.	Rash	YES	NO	Unknown
j.	Runny nose	YES	NO	Unknown
k.	Seizures	YES	NO	Unknown
l.	Sore throat	YES	NO	Unknown
m.	Vomiting	YES	NO	Unknown
n.	Other symptom(s)	YES	NO	

(specify)_____

Medical History-*Treatment, Clinical Course, and Outcome*

Did the case-patient receive antiviral medications?

Yes No Unknown

If yes, complete table below

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

Did the case-patient receive antibacterial medications?

Yes No Unknown

If yes, complete table below

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

Did the case-patient receive steroids?

Yes No Unknown

If yes, complete table below

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

Did the case-patient receive aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs)?

Yes No Unknown

If yes, complete table below

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

Was the case-patient admitted to an intensive care unit (ICU)?

Yes No Unknown

Did this case-patient receive mechanical ventilation?

Yes No Unknown

Did the case-patient have acute respiratory distress syndrome (ARDS)?

Yes No Unknown

What was the outcome for the case-patient?

Alive Died Unknown

If the patient is ALIVE, what is the current disposition of the case-patient?

Still hospitalized Discharged to home Discharged to nursing care facility (specify name) _____

Unknown Other (specify) _____

If the patient DIED, please list date of death _____(DD/MM/YYYY)

List the ICD-9CM diagnoses at ADMISSION and for each indicate if the diagnosis is a new diagnosis.

1. _ _ _. _ _ New Unknown
2. _ _ _. _ _ New Unknown
3. _ _ _. _ _ New Unknown
4. _ _ _. _ _ New Unknown
5. _ _ _. _ _ New Unknown
6. _ _ _. _ _ New Unknown

List the ICD-10 diagnoses at ADMISSION and for each indicate if the diagnosis is a new diagnosis.

1. _ _ _. _ _ New Unknown
2. _ _ _. _ _ New Unknown
3. _ _ _. _ _ New Unknown
4. _ _ _. _ _ New Unknown
5. _ _ _. _ _ New Unknown
6. _ _ _. _ _ New Unknown

List the ICD-9CM diagnoses at discharge and for each indicate if the diagnosis is a new sequelae of this hospitalization

1. _ _ _. _ _ New Unknown
4. _ _ _. _ _ New Unknown

2. _ _ _. _ _ New Unknown 5. _ _ _. _ _ New Unknown

3. _ _ _. _ _ New Unknown 6. _ _ _. _ _ New Unknown

List the ICD-10 diagnoses at discharge and for each indicate if the diagnosis is a new sequelae of this hospitalization

1. _ _ _. _ _ New Unknown 4. _ _ _. _ _ New Unknown

2. _ _ _. _ _ New Unknown 5. _ _ _. _ _ New Unknown

3. _ _ _. _ _ New Unknown 6. _ _ _. _ _ New Unknown

If ICD-9CM or ICD-10 diagnoses at ADMISSION are not available, write in diagnosis and indicate if the diagnosis is a new diagnosis.

1. _____ New Unk 4. _____ New Unk

2. _____ New Unk 5. _____ New Unk

3. _____ New Unk 6. _____ New Unk

If ICD-9CM or ICD-10 diagnoses at DISCHARGE are not available, write in diagnosis and indicate if the diagnosis is a new sequelae of this hospitalization.

1. _____ New Unk 4. _____ New Unk

2. _____ New Unk 5. _____ New Unk

3. _____ New Unk 6. _____ New Unk

Medical History-*Laboratory and Diagnostic Testing*

Did the case-patient have a chest x-ray or chest CT scan performed?

Yes No not performed Unknown

If YES, which test was performed? (check all that apply)

Chest CT Chest X-ray

If either test was performed, what was the result?

Normal Abnormal Unknown

If abnormal, was there evidence of pneumonia?

Yes No Unknown

Did the case-patient have a CT scan/MRI of the head or brain?

Yes No not performed Unknown

If YES, were there any acute neurologic abnormalities?

Yes No Unknown

List the following laboratory test results UPON initial admission:

White blood cell (WBC) count _____ Unknown

Lymphocyte count _____ Unknown

Neutrophil count _____ Unknown

Platelet count _____ Unknown

Did the patient have any of the following laboratory abnormalities at any time during the hospitalization?

Leukopenia (white blood cell count <5,000 leukocytes/mm3)

Yes No Unknown

Lymphopenia (total lymphocytes <800/mm3 or lymphocytes <15% of total WBC)

Yes No Unknown

Thrombocytopenia (total platelets <150,000/mm3)

Yes No Unknow

Were bacterial cultures performed?

Yes No Unknown

If YES, were any positive?

If positive, complete table below

Site (Urine, Blood, CSF, Pleural, Ascitic)	Date Performed	Date Positive	Organism grown

Were non-influenza viral tests performed?

Yes No Unknown

If yes, complete table below

Site (Urine, Blood, CSF, Pleural, Ascitic)	Date Performed	Result	Organism

Influenza Specific Diagnostic tests:

Test 1

Specimen type:

NP swab NP aspirate Nasal swab Nasal aspirate Sputum

Oropharyngeal swab Endotracheal aspirate Chest tube fluid

Broncheoalveolar lavage specimen (BAL) Serum

Other

Date collected: __/__/__

	RT-PCR Yes or No	Direct fluorescent antibody (DFA)	Viral culture	Rapid antigen test	CDC RT-PCR
Influenza A	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested
H1	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H3	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H5	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H7	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
Influenza B	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested

Test type and result: (check all boxes that apply)

Test Location if not Hospital Laboratory_____

Test 2

Specimen type:

NP swab NP aspirate Nasal swab Nasal aspirate Sputum

Oropharyngeal swab Endotracheal aspirate Chest tube fluid

Broncheoalveolar lavage specimen (BAL) Serum

Other

Date collected: __/__/__

Test type and result: (check all boxes that apply)

	RT-PCR Yes or No	Direct fluorescent antibody (DFA)	Viral culture	Rapid antigen test	CDC RT-PCR
Influenza A	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested
H1	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H3	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H5	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H7	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
Influenza B	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested

Test Location if not Hospital Laboratory_____

Test 3

Specimen type:

NP swab	NP aspirate	Nasal swab	Nasal aspirate	Sputum
Oropharyngeal swab	Endotracheal aspirate	Chest tube fluid		
Broncheoalveolar lavage specimen (BAL)		Serum		
Other				

Date collected: __/__/__

Test type and result: (check all boxes that apply)

	RT-PCR Yes or No	Direct fluorescent antibody (DFA)	Viral culture	Rapid antigen test	CDC RT-PCR
Influenza A	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested
H1	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H3	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H5	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
H7	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested		Negative Positive Inconclusive Pending Not tested
Influenza B	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested	Negative Positive Inconclusive Pending Not tested

Test Location if not Hospital Laboratory_____

Specimen Tracking

Indicate when and what type of specimens (including sera) were sent to CDC and CDCID number, if known

__/__/__ Specimen type _____CDCID#_____

__/__/__ Specimen type _____CDCID#_____

__/__/__ Specimen type _____CDCID#_____