

## 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

Public reporting burden of this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-0004).



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<br>(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	Dose #1	Dose #2	Dose #2	Dose #2
		Date Initiated (DD/MM/YYYY)	Date Discontinued (DD/MM/YYYY)		Date Initiated (DD/MM/YYYY)	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 4. \_\_\_\_\_.\_\_\_ New Unknown
- 2. \_\_\_\_\_.\_\_\_ New Unknown 5. \_\_\_\_\_.\_\_\_ New Unknown
- 3. \_\_\_\_\_.\_\_\_ 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 4. \_\_\_\_\_.\_\_\_ New Unknown
- 2. \_\_\_\_\_.\_\_\_ New Unknown 5. \_\_\_\_\_.\_\_\_ New Unknown
- 3. \_\_\_\_\_.\_\_\_ 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 |     |     |    |       |

<b>Medical History-Laboratory and Diagnostic Testing</b>
--

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/mm <sup>3</sup> )	
Yes	No	Unknown
Lymphopenia	(total lymphocytes <800/mm <sup>3</sup> or lymphocytes <15% of total WBC)	
Yes	No	Unknown
Thrombocytopenia	(total platelets <150,000/mm <sup>3</sup> )	
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  
 Bronchoalveolar 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  
 Bronchoalveolar 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  
 Bronchoalveolar 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# \_\_\_\_\_