State: \_\_\_\_\_\_\_\_ Date reported to health department: \_\_\_/\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) Date interview completed: \_\_\_/\_\_\_/\_\_\_\_\_ (MM/DD/YYYY)

Form Approved

OMB No. 0920-1011

Exp. Date 03/31/2017

State Epi ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State Lab ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Household ID (*CDC use only*):\_\_\_\_\_\_\_\_\_CDC ID (*CDC use only*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cluster ID (*CDC use only*):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. At the time of this report, is the case

[ ]  Confirmed [ ]  Probable [ ]  Case under investigation (skip to Q.3) [ ]  Not a case (skip to Q.3)

1. What is the subtype?

[ ]  Influenza A(H1N1) **variant** [ ]  Influenza A(H1N2) **variant** [ ]  Influenza A(H3N2) **variant** [ ]  Influenza A(H5N1) [ ]  Influenza A(H7N9) [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown

**Demographic Information**

1. Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY)
2. Country of usual residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If usual resident of U.S., county of residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Race: [ ]  White [ ]  Asian [ ]  American Indian/Alaska Native [ ]  Black [ ]  Native Hawaiian/Other Pacific Islander

(check all that apply)

1. Ethnicity: [ ] Hispanic or Latino [ ]  Not Hispanic or Latino
2. Sex: [ ]  Male [ ] Female

**Symptoms, Clinical Course, Treatment, Testing, and Outcome**

1. What date did symptoms associated with this illness start? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)
2. During this illness, did the patient experience any of the following?

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptom** | **Symptom Present?** | **Symptom** | **Symptom Present?** |
| Fever (highest temp \_\_\_\_\_\_\_\_\_ oF) | [ ]  Yes [ ]  No [ ]  Unk | Shortness of breath | [ ]  Yes [ ]  No [ ]  Unk |
|  If fever present, date of onset \_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY) | Vomiting | [ ]  Yes [ ]  No [ ]  Unk |
| Felt feverish | [ ]  Yes [ ]  No [ ]  Unk | Diarrhea | [ ]  Yes [ ]  No [ ]  Unk |
|  If felt feverish, date of onset \_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY) | Eye infection/redness | [ ]  Yes [ ]  No [ ]  Unk |
| Cough | [ ]  Yes [ ]  No [ ]  Unk | Rash | [ ]  Yes [ ]  No [ ]  Unk |
| Sore Throat  | [ ]  Yes [ ]  No [ ]  Unk | Fatigue | [ ]  Yes [ ]  No [ ]  Unk |
| Muscle aches | [ ]  Yes [ ]  No [ ]  Unk | Seizures | [ ]  Yes [ ]  No [ ]  Unk |
| Headache | [ ]  Yes [ ]  No [ ]  Unk | Other, specify | [ ]  Yes [ ]  No [ ]  Unk |

1. Does the patient still have symptoms?

[ ]  Yes (skip to Q.12) [ ]  No [ ]  Unknown (skip to Q.12)

1. When did the patient feel back to normal? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY)
2. Did the patient receive any medical care for the illness?

[ ]  Yes [ ]  No (skip to Q.29) [ ]  Unknown (skip to Q.29)

1. Where and on what date did the patient seek care (check all that apply)?

[ ]  Doctor’s office **date**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) [ ]  Emergency room **date**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) [ ]  Urgent care clinic **date**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) [ ]  Health department **date**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **date**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) [ ]  Unknown

1. Was the patient hospitalized for the illness?

[ ]  Yes [ ]  No (skip to Q.23) [ ]  Unknown (skip to Q.23)

1. Date(s) of hospital admission? **First** **admission** **date:**\_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY) **Second admission** **date:**\_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY)
2. Was the patient admitted to an intensive care unit (ICU)?

[ ]  Yes [ ]  No (skip to Q.18) [ ]  Unknown (skip to Q.18)

1. Date of **ICU admission:** \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) Date of **ICU discharge:** \_\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)
2. Did the patient receive mechanical ventilation / have a breathing tube?

[ ]  Yes [ ]  No (skip to Q.20) [ ]  Unknown (skip to Q.20)

1. For how many days did the patient receive mechanical ventilation or have a breathing tube? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ days
2. Was the patient discharged?

[ ]  Yes [ ]  No (skip to Q.23) [ ]  Unknown (skip to Q.23)

1. Date(s) of hospital discharge? **First** **discharge** **date:**\_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY) **Second discharge** **date:**\_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY)
2. Where was the patient discharged?

[ ]  Home [ ]  Nursing facility/rehab [ ]  Hospice [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown

1. Did the patient have a new abnormality on chest x-ray or CAT scan?

[ ]  No, x-ray or scan was normal [ ]  Yes, x-ray or scan detected new abnormality [ ]  No, chest x-ray or CAT scan not performed [ ]  Unknown

1. Did the patient receive a diagnosis of pneumonia?

[ ]  Yes [ ]  No [ ]  Unknown

1. Did the patient receive a diagnosis of ARDS?

[ ]  Yes [ ]  No [ ]  Unknown

1. Did the patient have leukopenia (white blood cell count <5000 leukocytes/mm3) associated with this illness?

[ ]  Normal [ ]  Abnormal [ ]  Test not performed [ ]  Unknown

1. Did the patient have lymphopenia (total lymphocytes <800/mm3 or lymphocytes <15% of WBC) associated with this illness?

[ ]  Normal [ ]  Abnormal [ ]  Test not performed [ ]  Unknown

1. Did the patient have thrombocytopenia (total platelets <150,000/mm3) associated with this illness?

[ ]  Normal [ ]  Abnormal [ ]  Test not performed [ ]  Unknown

1. Did the patient experience any other complications as a result of this illness? [ ]  Yes (please describe below) [ ]  No [ ]  Unknown

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did the patient receive influenza antiviral medications prior to becoming ill (within 2 weeks) or after becoming ill?

[ ]  Yes, (please complete table below) [ ]  No [ ]  Unknown

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Drug | Start date(MM/DD/YYYY) | End date(MM/DD/YYYY) | Total number of days receiving antivirals | Dosage (if known) |
| Oseltamivir (Tamiflu) |  |  |  | mg |
| Zanamivir (Relenza) |  |  |  | mg |
| Other influenza antiviral\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  | mg |

1. Did the patient die as a result of this illness?

[ ]  Yes, **Date of death**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (MM/DD/YYYY) [ ]  No [ ]  Unknown

**Influenza Testing**

1. When was the specimen collected that indicated novel influenza A virus infection by Reverse Transcription-Polymerase Chain Reaction (RT-PCR)? \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)
2. Where was the specimen collected? [ ]  Doctor’s office [ ]  Hospital [ ]  Emergency room [ ]  Urgent care clinic [ ]  Health department [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  Unknown
3. Was a rapid influenza diagnostic test (RIDT) used on any respiratory specimens collected?

[ ]  Yes [ ]  No (skip to Q.38) [ ]  Unknown (skip to Q.38)

1. When was the RIDT specimen collected? \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)
2. What was the result? [ ]  Influenza A [ ]  Influenza B [ ]  Influenza A/B (type not distinguished) [ ]  Negative [ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. What brand of RIDT was used? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History -- Past Medical History and Vaccination Status**

1. Does the patient have any of the following chronic medical conditions? Please specify **ALL** conditions that qualify.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Asthma/reactive airway disease
 | [ ]  Yes | [ ]  No | [ ]  Unknown |  |
| 1. Other chronic lung disease
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Chronic heart or circulatory disease
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Diabetes mellitus
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Kidney or renal disease
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Non-cancer immunosuppressive condition
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Cancer chemotherapy in past 12 months
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Neurologic/neurodevelopmental disorder
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. Other chronic diseases
 | [ ]  Yes | [ ]  No | [ ]  Unknown | (If YES, specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. Does the patient frequently use a stroller or wheelchair? If yes, please describe.

[ ]  Yes [ ]  No [ ]  Unknown

1. Was patient pregnant or ≤6 weeks postpartum at illness onset?

[ ]  Yes, pregnant (weeks pregnant at onset)\_\_\_\_\_\_\_\_ [ ] Yes, postpartum (delivery date) \_\_\_/\_\_\_/\_\_\_\_ (MM/DD/YYYY) [ ]  No [ ]  Unknown

1. Does the patient currently smoke?

[ ]  Yes [ ]  No [ ]  Unknown

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

[ ]  Yes [ ]  No (skip to Q.45) [ ]  Unknown (skip to Q.45)

1. Month and year of influenza vaccination? **Vaccination** **date 1:**\_\_\_\_/\_\_\_\_\_ (MM/YYYY) **Vaccination date 2:**\_\_\_\_/\_\_\_\_\_ (MM/YYYY)
2. Type of influenza vaccine (check all that apply): [ ]  Inactivated (injection) [ ]  Live attenuated (nasal spray) [ ]  Unknown

**Epidemiologic Risk Factors**

1. In the 7 days prior to illness onset, did the patient travel outside of his/her usual area? [ ]  Yes [ ]  No (skip to Q.48) [ ]  Unknown (skip to Q.48)
2. When and where did the patient travel? **Please describe details of the patient’s travel in the notes section at the end of the form.**

 **Trip 1**: Dates of travel: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ City/County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Trip 2**: Dates of travel: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ City/County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did the patient travel in a group (check all that apply)?

[ ]  No, travelled alone [ ]  Yes, with household members [ ]  Yes, with non-household members [ ]  Unknown

**Risk Factors—Domestic and Agricultural Animals**

1. In the 7 days before becoming ill, did the patient attend an agricultural fair/event or live animal market?

[ ]  Yes (specify name, if >1 fair, please describe in the notes section \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ]  No (skip to Q.50) [ ]  Unknown (skip to Q.50)

1. In the 7 days before becoming ill, on what days did the patient attend an agricultural fair/event or live animal market (check all that apply)?

[ ]  on the day of illness onset [ ]  1 day before illness onset [ ]  2 days before illness onset [ ]  3 days before illness onset [ ]  4 days before illness onset [ ]  5 days before illness onset [ ]  6 days before illness onset [ ]  7 days before illness onset

1. In the 7 days before becoming ill, did the patient have **DIRECT** contact with (touch or handle) any livestock animals like poultry or pigs?

[ ]  Yes [ ]  No (skip to Q.53) [ ]  Unknown (skip to Q.53)

1. What type(s) of animals did the patient have direct contact with (check all that apply)?

[ ]  Horses [ ]  Cows [ ]  Poultry/wild birds [ ]  Sheep [ ]  Goats [ ]  Pigs/hogs [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

[ ]  Home [ ]  Work [ ]  Agricultural fair or event [ ]  Live animal market [ ]  Petting zoo [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the 7 days before becoming ill, did the patient have **INDIRECT** contact with (walk through an area containing or come within 6 feet of) any livestock animals?

[ ]  Yes [ ]  No (skip to Q.56) [ ]  Unknown (skip to Q.56)

1. What type(s) of animals did the patient have indirect contact with (check all that apply)?

[ ]  Horses [ ]  Cows [ ]  Poultry/wild birds [ ]  Sheep [ ]  Goats [ ]  Pigs/hogs [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

[ ]  Home [ ]  Work [ ]  Agricultural fair or event [ ]  Live animal market [ ]  Petting zoo [ ] Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the 7 days before becoming ill, did the patient have direct or indirect contact with any animal exhibiting signs of illness?

[ ]  Yes (specify animal type and location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) [ ]  No [ ]  Unknown

***Please answer Q.57–58 if ANY contact (direct, indirect, or both) with pigs/hogs identified above. If no contact identified, please skip to Q.59*.**

1. In the 7 days before becoming ill, on what days did the patient have **ANY** contact (direct, indirect, or both) with pigs (check all that apply)?

[ ]  on the day of illness onset [ ]  1 day before illness onset [ ]  2 days before illness onset [ ]  3 days before illness onset [ ]  4 days before illness onset [ ]  5 days before illness onset [ ]  6 days before illness onset [ ]  7 days before illness onset

1. From Q. 57, what was the total number of different days the patient reported **ANY** pig contact (direct, indirect, or both)? \_\_\_\_\_\_\_\_\_\_\_\_ days
2. Does anyone else in the household own, keep or care for livestock animals?

[ ]  Yes [ ]  No (skip to Q.61) [ ]  Unknown (skip to Q.61)

1. What type(s) of animals are kept or cared for by household members (check all that apply)?

[ ]  Horses [ ]  Cows [ ]  Poultry/wild birds [ ]  Sheep [ ]  Goats [ ]  Pigs/hogs [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Risk Factors—Household, Occupational, Nosocomial, and Secondary Spread**

1. Does the patient reside in an institutional or group setting (e.g. nursing home, boarding school, college dormitory)?

[ ]  Yes (skip to Q.63) [ ]  No [ ]  Unknown (skip to Q.63)

1. How many people resided in the patient’s household(s) in the week before or after illness onset (excluding the patient)? \_\_\_\_\_\_\_\_

**A household member is anyone with at least one overnight stay +/- 7 days from patient’s illness onset, and the patient may have resided in >1 household. Please complete the table below for each household member and continue in the notes section if more space is needed.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ID | Household (HH) | Relation to patient (e.g. parent, brother, friend) | Sex (M/F) | Age | Fever or any respiratory symptom +/– 7 days from case patient’s onset? | Date of illness onset | If HH member **ILL** | If HH member **NOT ILL** |
| Any pig/hog contact ≤7 days before his/her onset? | Attend agricultural fair ≤7 days before his/her onset? | Pig/hog contact or fair attendance ≤10 days before patient’s onset? |
| 1 | [ ] A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  U |  | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U |
| 2 | [ ] A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  U |  | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U |
| 3 | [ ] A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  U |  | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U |
| 4 | [ ] A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  U |  | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U |
| 5 | [ ] A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  U |  | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U |
| 6 | [ ] A [ ]  B [ ]  C |  |  |  | [ ]  Y [ ]  N [ ]  U |  | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U | [ ]  Y [ ]  N [ ]  U |

1. In the 7 days before or after becoming ill, did the patient attend or work at a child care facility?

[ ]  Yes (before becoming ill) [ ]  Yes (after becoming ill) [ ]  No (skip to Q.65) [ ]  Unknown (skip to Q.65)

1. Approximately how many children are in the patient’s class or room at the child care facility? \_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. In the 7 days before or after becoming ill, did the patient attend or work at a school?

[ ]  Yes (before becoming ill) [ ]  Yes (after becoming ill) [ ]  No (skip to Q.67) [ ]  Unknown (skip to Q.67)

1. Approximately how many students are in the patient’s class at the school? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ children
2. In the 7 days before or after the patient became ill, did anyone else in the patient’s household(s) work at or attend a child care facility or school?

[ ]  Yes [ ]  No (skip to Q.69) [ ]  Unknown (skip to Q.69)

1. List ID numbers from Q.62 (the table above) for household members working at or attending a child care facility or school:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Does the patient handle samples (animal or human) suspected of containing influenza virus in a laboratory or other setting?

[ ]  Yes [ ]  No [ ]  Unknown

1. In the 7 days before or after becoming ill, did the patient work in or volunteer at a healthcare facility or setting?

[ ]  Yes [ ]  No (skip to Q.73) [ ]  Unknown (skip to Q.73)

1. Specify healthcare facility job/role:

 [ ]  Physician [ ]  Nurse [ ]  Administration staff [ ]  Housekeeping [ ]  Patient transport [ ]  Volunteer [ ]  Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Did the patient have direct patient contact while working or volunteering at a healthcare facility?

[ ]  Yes [ ]  No [ ]  Unknown

1. In the 7 days before becoming ill, was the patient in a hospital for any reason (i.e., visiting, working, or for treatment)?

[ ]  Yes [ ]  No [ ]  Unknown

If yes, what were the dates? \_\_\_\_/\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_\_ City/Town \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the 7 days before becoming ill, was the patient in a clinic or a doctor’s office for any reason?

[ ]  Yes [ ]  No [ ]  Unknown

If yes, what were the dates? \_\_\_\_/\_\_\_\_/\_\_\_\_\_, \_\_\_\_/\_\_\_\_/\_\_\_\_\_ City/Town \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In the 7 days before becoming ill, did the patient have close contact (e.g. caring for, speaking with, or touching) with anyone **other than a household member** who routinely has contact with pigs/hogs?

[ ]  Yes [ ]  No [ ]  Unknown

1. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **in the 7 days BEFORE** the case patient’s illness onset?

[ ]  Yes (**please list those ill before the case patient in the table below**) [ ]  No [ ]  Unknown

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relationship to patient | Sex (M/F) | Age | Date ofillness onset | Any pig/hog contact or fair attendance ≤7 days before his/her onset? | Comments |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |

1. Does the patient know anyone **other than a household member** who had fever, respiratory symptoms like cough or sore throat, or another respiratory illness like pneumonia **beginning AFTER** the case patient’s illness onset?

[ ]  Yes (**please list those ill after the case patient in the table below**) [ ]  No [ ]  Unknown

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Relationship to patient | Sex (M/F) | Age | Date ofillness onset | Any pig/hog contact or fair attendance ≤7 days before his/her onset? | Comments |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |
|  |  |  |  | [ ]  Y [ ]  N [ ]  U |  |

1. Is the patient a contact of a confirmed or probable case of novel influenza A infection?

[ ]  Yes (**please list patient’s confirmed or probable contacts in the table below**) [ ]  No [ ]  Unknown

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Relationship to patient | State Epi ID  | State Lab ID | Case status | Sex (M/F) | Age | Date of illness onset(MM/DD/YYYY) |
|  |  |  | [ ]  Confirmed [ ]  Probable |  |  |  |
|  |  |  | [ ]  Confirmed [ ]  Probable |  |  |  |
|  |  |  | [ ]  Confirmed [ ]  Probable |  |  |  |
|  |  |  | [ ]  Confirmed [ ]  Probable |  |  |  |

1. Any additional comments or notes (e.g. travel details, names/dates of fairs attended by case patient, dates of household members fair attendance and location of fair, information about other ill contacts)?

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**This is the end of the case report form. Thank you very much for your time.**

**Please fax completed forms to 1.888.232.1322**

**If you have any questions please feel free to contact the Epidemiology and Prevention Branch at 404.639.3747.**