Form Approved
OMB Number 0925-XXXX
Exp. Date: XX/XX/XXX

Study ID: __ __ __ __ __ __ __ __ __ __

CEIRS Human Influenza Surveillance Study
Form 8A: Follow-up Assessment

1. How many attempts were made? _____attempts
   At most 4 attempts of phone follow-up should be made unless requested otherwise by subject.

Attempt 1:
Date:_____/_____ /_____(mm/dd/yyyy)
Time:_____/_____ /_____(hh:mm) (24-hour clock)
Successful Contact: ☐ No ☐ Yes

Attempt 2:
Date:_____/_____ /_____(mm/dd/yyyy)
Time:_____/_____ /_____(hh:mm) (24-hour clock)
Successful Contact: ☐ No ☐ Yes

Attempt 3:
Date:_____/_____ /_____(mm/dd/yyyy)
Time:_____/_____ /_____(hh:mm) (24-hour clock)
Successful Contact: ☐ No ☐ Yes

Attempt 4:
Date: / / __ __ __ __
Time: : (hh:mm)(24-hour clock)
Successful Contact: ☐ No ☐ Yes

2. Did the follow-up assessment occur? ☐ No ☐ Yes
   If Yes, specify date: _____ / /_____(mm/dd/yyyy) If
   Yes, how did the follow-up occur? ☐ In-person ☐ Telephone
   If No, specify reason:
   _____ Subject unavailable for follow-up
   _____ Minimum of 4 failed attempts at phone follow-up
   _____ Contact numbers non-functional
   _____ Subject requested no further contact
   _____ Other, specify: _____

If the Follow-up was performed via the phone, please use the following script:

"Hello Mr. /Ms. (Insert Subject Last Name)
My name is (Insert Research Coordinator Name), I am [calling] from the Emergency Department at (Insert Name of Medical Center) where you were seen about 3 weeks ago. At that time, you agreed to enroll in our study on influenza testing in the emergency department. As part of this research study we are following up with you. The purpose of this call is to get some more information from you regarding your illness and the outcome.

Are you still willing to answer a few questions?" ☐ No ☐ Yes

If No, stop
If Yes, research coordinator proceeds with the follow-up assessment questions:

Follow-up Assessment Questions

1. Have you returned to an Emergency Department since you were enrolled in this study?

   ☐ No ☐ Yes ☐ Unknown

   a. If Yes, how many times? _____

   What was the approximate date and the reason you came to the ED? (Record up to 3 visits):

   ED Visit 1

   Which ED was it? ☐ JHH ☐ BVMC ☐ Linkou ☐ Taipei ☐ Keelung ☐ Other ☐ Unknown

   Date: / / (mm/dd/yyyy)

   Reason: _____

   ED Visit 2

   Which ED was it? ☐ JHH ☐ BVMC ☐ Linkou ☐ Taipei ☐ Keelung ☐ Other ☐ Unknown

   Date: / / (mm/dd/yyyy)

   Reason: _____

   ED Visit 3

   Which ED was it? ☐ JHH ☐ BVMC ☐ Linkou ☐ Taipei ☐ Keelung ☐ Other ☐ Unknown

   Date: / / (mm/dd/yyyy)

   Reason: _____

2. Have you been admitted to the hospital (stayed overnight) since you were enrolled in this study?

   ☐ No ☐ Yes ☐ Unknown

   a. If Yes, how many times? _____

   What was the approximate date and the reason for your hospitalizations? (Record up to 3 visits):

   Hospitalization 1

   Admit Date: / / (mm/dd/yyyy)

   Reason: _____

   Length of Stay _____

   Hospitalization 2

   Admit Date: / / (mm/dd/yyyy)

   Reason: _____

   Length of Stay _____

   Hospitalization 3

   Admit Date: / / (mm/dd/yyyy)

   Reason: _____

   Length of Stay _____

3. Following the ED visit during which you were enrolled in this study, did you receive any antiviral medications to treat influenza? (Note: Do not include any antiviral medications that were prescribed during the initial ED visit) ☐ No ☐ Yes ☐ Unknown

   a. If yes, What influenza antirviral treatment did you take?

   ☐ Zanamavir

   ☐ Oseltamivir

   ☐ Amantadine

   ☐ Rimantadine

   ☐ Other, specify;_____

   ☐ Unknown

   ☐ None

   b. If yes, Date antiviral was started: / / (mm/dd/yyyy)
   Duration taken for:_____days

4. Following the ED visit during which you were enrolled in this study, did you receive any antibiotic medications? (Note: Do not include any antibiotic medications that were prescribed during the initial ED visit)

   ☐ No ☐ Yes ☐ Unknown

   a. If yes, how many did you take?_____ (Record up to three)
   Antibiotic 1
   Name of antibiotic received: _____
   Date antibiotic was started: / / __ __ __ __
   Duration taken for:_____ days
   Antibiotic 2
   Name of antibiotic received: _____
   Date antibiotic was started: / / __ __ __ __
   Duration taken for:_____days
   Antibiotic 3
   Name of antibiotic received: _____
   Date antibiotic was started: / / __ __ __ __
   Duration taken for:_____days

5. Have you been diagnosed with a heart attack since you were enrolled in this study?

   ☐ No ☐ Yes ☐ Unknown

6. Have you been diagnosed with a stroke since you were enrolled in this study?

   ☐ No ☐ Yes ☐ Unknown

   a. If yes, date of stroke diagnosis: / / (mm/dd/yyyy)

7. Have you been diagnosed with pneumonia since you were enrolled in this study?

   ☐ No ☐ Yes ☐ Unknown

Follow up Blood (Serum) Sample

Blood (Serum) Sample:

- ☐ Collected
- ☐ Patient refused: Reason_____
- ☐ Phone follow up – unable to obtain successful contact
- ☐ Coordinator Unable to Obtain: Reason_____
- ☐ Other:_____

If collected:

Collection:
Date: / / __ __ __ __
Time: : (hh:mm) (24-hour clock)
Coordinator initials: _____

Placed in refrigerator:
Date: / / __ __ __ __
Time: : (hh:mm) (24-hour clock)
Coordinator initials: _____

Final sample processing:
Date: / / __ __ __ __
Time: : (hh:mm) (24-hour clock)
Coordinator initials: _____

Subject notes: