Novel and Pandemic Influenza 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?
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 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
   (If YES, specify) _______________________

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

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<tr>
<th>Drug</th>
<th>Dose</th>
<th>Frequency</th>
<th>Date Initiated</th>
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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  □ YES □ NO □ Unknown
   (or shortness of breath)
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 □ Unknown
   (specify)________________________

Medical History-Treatment, Clinical Course, and Outcome

Did the case-patient receive antiviral medications?
□ Yes □ No □ Unknown
If yes, complete table below

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose # 1 Date Initiated (DD/MM/YYYY)</th>
<th>Dose #1 Date Discontinued (DD/MM/YYYY)</th>
<th>Dose #2 Date Initiated (DD/MM/YYYY)</th>
<th>Dose #2 Date Discontinued (DD/MM/YYYY)</th>
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<td>Amantadine</td>
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<td>Other ________</td>
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Did the case-patient receive antibacterial medications?
□ Yes □ No □ Unknown
If yes, complete table below

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<tr>
<th>Drug</th>
<th>Date Initiated</th>
<th>Date Discontinued</th>
<th>Dosage (if known)</th>
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Did the case-patient receive steroids?

☐ Yes  ☐ No  ☐ Unknown

If yes, complete table below

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<th>Drug</th>
<th>Date Initiated</th>
<th>Date Discontinued</th>
<th>Dosage (if known)</th>
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Did the case-patient receive aspirin or other non-steroidal anti-inflammatory drugs (NSAIDs)?

☐ Yes  ☐ No  ☐ Unknown

If yes, complete table below

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<tr>
<th>Drug</th>
<th>Date Initiated</th>
<th>Date Discontinued</th>
<th>Dosage (if known)</th>
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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

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 ☐ Unknown
Were bacterial cultures performed?

- Yes
- No
- Unknown

If YES, were any positive?

If positive, complete table below

<table>
<thead>
<tr>
<th>Site (Urine, Blood, CSF, Pleural, Ascitic)</th>
<th>Date Performed</th>
<th>Date Positive</th>
<th>Organism grown</th>
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Were non-influenza viral tests performed?

- Yes
- No
- Unknown

If yes, complete table below

<table>
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<tr>
<th>Site (Urine, Blood, CSF, Pleural, Ascitic)</th>
<th>Date Performed</th>
<th>Result</th>
<th>Organism</th>
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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: __/__/__

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

<table>
<thead>
<tr>
<th></th>
<th>RT-PCR</th>
<th>Direct fluorescent antibody (DFA)</th>
<th>Viral culture</th>
<th>Rapid antigen test</th>
<th>CDC RT-PCR</th>
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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)

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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)

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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#_________________